NEW YORK STATE | Commission of Correction

Final Report of the New York State Commission of Correction:

In the Matter of the Death of

Joseph Walley, an incarcerated individual of the Otsego County Jail

March 27, 2024

To: Sheriff Robert J. Devlin, Jr.
Otsego County Sheriff's Office
172 County Highway 33 West
Cooperstown, New York 13326

Allen Riley
Chairman

Yolanda Canty
Commissioner

GREETINGS:

WHEREAS, the Medical Review Board has reported to the NYS Commission of Correction pursuant to Correction Law, section 47(1)(d), regarding the death of Joseph Walley, who died on May 1, 2022 , as a result of circumstances which occurred while an incarcerated individual in the custody of the Otsego County Sheriff at the Otsego County Jail, the Commission has determined that the following final report be issued.

FINDINGS:

1. Joseph Walley was a 38-year-old male who died on 5/1/22 due to bacterial endocarditis and sepsis while in the custody of the Otsego County Sheriff at the Otsego County Jail. The Medical Review Board has found that there were serious deficiencies in the medical assessments and treatment of Walley during his incarceration that may have led to his death.

2. Walley was born in Bennington, Vermont. Walley did not finish high school and he was not employed. There was no further demographic or social history available to the Commission for Walley.

3. Walley had no significant medical history and was not prescribed any medications.

4. Walley had no mental health history and was not prescribed any medications. [redacted]

5. [redacted]

6. [redacted]

[redacted]

7. On 4/30/22 at 3:33 a.m., in Oneonta, NY, the Oneonta Police Department received a call for a male walking around outside in his underwear. The Oneonta Police responded to the call and activated their body cameras. From a review of the video recording from the Oneonta Police body cameras by Commission staff, the following was observed: Walley was observed independently walking down the street wearing a tee shirt, hooded jacket, underwear, and sneakers. Walley was questioned by the officers, and he was compliant with being transported to the Oneonta Police Department. The Oneonta officers were updated that Walley had an active warrant out for his arrest. Walley was transported by the Oneonta police to the Otsego County Jail (CJ).

8. On 4/30/22 at 4:38 a.m., Walley was admitted to the Otsego County Jail by Correction Officer (CO) M.B. on a bench warrant from the Otego Town Court for Burglary 2nd Degree and other charges. Walley scored a "2" on the Suicide Prevention Screening for having a history of drug abuse and having a hard time focusing during the admission process. Walley was placed on a 15-minute detox watch. From a review of the video recording from the Otsego County Jail intake door and booking area by Commission staff, the following was observed: Walley was observed independently walking into the Otsego County Jail with some difficulty of getting up a step to enter into the hallway, however, Wally did step up and walk through the hallway independently. Walley was observed walking in the booking area with CO M.B. holding on to the back of Walley's county issued jumpsuit by the collar. Walley sat down on the chair in the booking area and placed his head down on the officer's desk. Throughout the booking process, Walley was observed sitting on the chair with his head resting on the desk and he was also observed sitting upright and signing paperwork. At the end of the booking process, CO M.B. assisted Walley under his left arm from sitting in the chair to the standing position, and then Walley independently walked out of the booking area.

9. [redacted] A review of Walley's medical chart by Commission staff found that RN [redacted] did not obtain an oxygen saturation on Walley during his medical admission assessment to establish a baseline oxygen level. [redacted] From a review of the video recording from the medical office by Commission staff, the following was observed: Walley was observed independently walking out of the medical office through the hallway while CO M.B. was holding on to Walley's jumpsuit at the collar area. The Medical Review Board finds that at the time Walley was signing for the OTC medications, RN [redacted] should have asked Walley to sign a Release of Information (ROI) for [redacted]. The Medical

Review Board also finds that RN [redacted] should have called the facility physician and updated the physician to Walley's pulse reading of 124, Walley's reported heroin use with a history of seizures when going through withdrawal, and that Walley had been in the AO Fox hospital ER on the prior day.

10. [redacted]

11. On 4/30/22 at 7:16 a.m., Sergeant (Sgt.) R.S. and Corrections Officer (CO) R.B. assisted Walley from intake to Housing Unit 101, A-wing cell # 3. From a review of the video recording of the A-Wing hallway by Commission staff, the following was observed: Walley was observed independently walking down the hallway with Sgt. R.S. and CO R.B. holding the back of his jumpsuit.

12. On 4/30/22 at 7:22 a.m., CO J.W. documented in the Housing Unit 101 A-wing logbook assuming the special watch of Walley. From 7:22 a.m. through 2:46 p.m., CO J.W. documented in the unit logbook that Walley was lying on his bunk. During an interview with Commission staff, CO J.W. reported that when Walley came on the unit, he went into his cell and sat down on his bunk. CO J.W. offered Wally some juice and then left A-wing to return to the officer's desk. CO J.W. reported that she returned to the A-wing at 7:30 a.m. to do another tour of the unit and Walley was laying on his bunk. CO J.W. reported that Walley was alive, breathing, and moaning a little bit during the rest of her tours of the wing. CO J.W. reported that during one of the tours on the unit, Walley was rolling over to his side and CO J.W. asked Walley if he was okay and if he needed anything and that Walley reported that he was just sore.

13. On 4/30/22 at 2:54 p.m., CO P.S. documented in the Housing Unit 101 A-wing logbook assuming the special watch of Walley. From 2:54 p.m. through 10:47 p.m., CO P.S. documented in the unit logbook that Walley was lying/sitting on his bunk.

14. On 4/30/22 at 10:57 p.m., CO R.H. documented in the Housing Unit 101 A-wing logbook assuming the special watch of Walley. From 10:57 p.m. through 11:31 p.m., CO R.H. documented in the unit logbook that Walley was lying/sitting on his bunk. From 4/30/22 at 11: 45 a.m. through 5/1/22 at 6:47 a.m., CO R.H. documented that Walley was using the toilet/shower.

15. On 5/1/22 at 5:40 a.m., CO R.H. documented in the Housing Unit 101 A-wing logbook that Walley did not eat the breakfast meal.

16. On 5/1/22 at 7:00 a.m., CO R.M. documented in the Housing Unit 101 A-wing logbook assuming the special watch of Walley. From 7:12 a.m. through 8:03 a.m., CO R.M. documented in the unit logbook that Walley was laying on the floor. From 8:16 a.m. through 11:17 a.m., CO R.M. documented that Walley was laying/sitting on the

bunk/floor.

17. [redacted] From a review of the video recording of the A-Wing hallway by Commission staff, the following was observed: Walley was observed slouched and leaning forward while being assisted by two officers out of his cell. The two officers each held Walley up by the arm while Walley unsteadily and slowly ambulate to the unit stool. Once Walley was seated on the stool, two officers had to hold him upright with a hand on each of Walley's shoulders. RN [redacted] was not observed doing an assessment on Walley's heart, lungs, or abdomen. When RN [redacted] finished his assessment on Walley, Walley was assisted back to his cell by two officers holding him up under his arms as Walley was slouched over and slowly ambulating with an unsteady gait back to his cell. A review of Walley's medical record by Commission staff revealed that RN [redacted] did not update the facility physician to Walley's deteriorated condition at that time. The Medical Review Board finds that Walley showed definitive signs of clinical deterioration and opines that RN [redacted] failed to properly assess his patient and failed to have Walley immediately sent to the Emergency Room for an evaluation. The Medical Review Board opines that had Walley been properly assessed and sent out for hospital treatment, his death may have been preventable. Additionally, this was also a violation of 9 NYCRR §7010.2(d) which states: *Every inmate who at the time of admission appears to be intoxicated by alcohol or drugs shall be subject to increased supervision as determined pursuant to section 7003.3(h) of this Title. If, after 12 hours from admission, the inmate still appears to be intoxicated by alcohol or drugs, the inmate shall be immediately examined by a physician.*

18. On 5/1/22 at 11:29 a.m., CO R.M. documented that Walley received his meal tray.

19. On 5/1/22 at 11:34 a.m., CO A.M. documented in the Housing Unit 101 A-wing logbook assuming the special watch of Walley. CO A.M. assumed Housing Unit 101 A-wing for CO R.M.'s meal break. At 11:47 a.m., CO A.M. documented that Walley was laying on his bunk and he had not eaten anything off of the meal tray. At 12:29 p.m., CO A.M. documented that Walley refused his meal.

20. On 5/1/22 at 12:45 p.m., CO R.M. returned to Housing Unit 101 A-wing and documented through 2:44 p.m. that Walley was laying/sitting on his bunk.

21. On 5/1/22 at 2:52 p.m., CO A.M. documented in the Housing Unit 101 A-wing logbook assuming the special watch of Walley. From 3:02 p.m. through 3:47 p.m., CO A.M. documented that Walley was laying/sitting on his bunk. During an interview with Commission staff, CO A.M. reported that Walley moaned a lot since being admitted. CO A.M. reported that her way of knowing that Walley was okay was that he was moaning.

22. On 5/1/22 at 3:58 p.m., CO A.M. was making rounds on Housing Unit 101 A-wing. CO A.M. observed that Walley was not making any noises and he did not respond when his name was called. CO A.M. radioed for Sgt. M.C. to come to the unit.

23. On 5/1/22 at 4:01 p.m., Sgt. M.C. arrived on the unit and observed that Walley was lying supine on the bunk. Sgt. M.C. checked Walley's pulse, performed a sternum rub, and checked his pupils for dilatation. After negative results for any of the tests that he performed, Sgt. M.C. and CO R.S. transferred Walley from the bunk to the floor and CO R.S. immediately initiated Cardiopulmonary Resuscitation (CPR). Sgt. M.C. contacted 911 and CO A.M. retrieved the Automated External Defibrillator (AED). The AED was applied to Walley's chest with no shock advised. Additional security staff arrived at the scene to assist with CPR. Staff continued CPR until the arrival of the Otsego County Emergency Medical Services (EMS).

24. On 5/1/22 at 4:13 p.m., Otsego County EMS arrived at the scene and assumed the care of Walley. [redacted]

25. [redacted]

26. RN [redacted] was placed on Administrative Leave following the death of Walley. On 9/8/23, RN [redacted] was terminated from his position of RN at the Otsego CJ.

ACTIONS REQUIRED:

TO THE OTSEGO COUNTY JAIL PHYSICIAN:

1. The Jail Physician shall conduct a comprehensive quality assurance review regarding the following:

   a. On 4/30/22 at 6:19 a.m., why RN [redacted] did not ask Walley to sign a Release of

Information (ROI) for [redacted].

b. On 4/30/22 at 6:19 a.m., why RN [redacted] did not obtain an oxygen saturation on Walley during his medical admission assessment to establish a baseline oxygen level.
c. On 4/30/22 at 6:19 a.m., why RN [redacted] did not call the facility physician to notify the physician of Walley's pulse reading of 124, Walley's reported heroin use with seizures when going through withdrawal, and that Walley had been in the AO Fox Hospital ER on the previous day.
d. On 5/1/22 at 10:58 a.m., why RN [redacted] did not listen to Walley's heart, lung, and abdominal sounds.
e. On 5/1/22 at 10:58 a.m., why RN [redacted] did not update the facility physician to Walley's deteriorated condition.
f. On 5/1/22 at 10:58 a.m., why RN [redacted] did not send Walley to the ER for an evaluation for his deteriorating condition.

A report of findings and corrective actions taken shall be provided to the Medical Review Board upon completion.

In a response dated 2/5/2024 to the Commission's preliminary report, the Otsego County Sheriff Office indicated that the cited nurse was terminated in September 2023 and that the jail has a new contracted medical provider.

WITNESS, HONORABLE ALLEN RILEY, Chairman, NYS Commission of Correction, Alfred E. Smith State Office Building, 80 South Swan Street, 12th Floor, in the City of Albany, New York 12210 on this 27th day of March 2024.

Allen Riley
Chairman
Commission of Correction

AR:BB:vc
2022-M-0051
March 27, 2024