NEW YORK STATE | Commission of Correction

Final Report of the New York State Commission of Correction:

In the Matter of the Death of

Milik Burnett, an incarcerated individual of the Oneida County Jail

June 25, 2024

To: Sheriff Robert M. Maciol
Oneida County Sheriff's Office
6065 Judd Road
Oriskany, New York 13424

Allen Riley
Chairman

Yolanda Canty
Commissioner

Elizabeth Gaynes
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 Milik Burnett, who died on April 27, 2023 , as a result of circumstances which occurred while an incarcerated individual in the custody of the Oneida County Sheriff at the Oneida County Jail, the Commission has determined that the following final report be issued.

FINDINGS:

1. Milik Burnett was a 25-year-old male who died on 4/27/23 from an accidental drug overdose, involving Fentanyl. Burnett was found with a diminished level of responsiveness and emesis on his face in his cell while in the custody of the Oneida County Sheriff at the Oneida County Jail (CJ). The Medical Review Board has found that the facility's medical provider failed to initiate treatment for a person with a diagnosed substance use disorder and failed to complete Burnett's health screening and physical within his first 14 days of admission as required by Minimum Standards. The Medical Review Board also found that corrections staff failed to properly conduct housing area supervision tours prior to Burnett's incident as required by Minimum Standards.

2. [redacted] In the instant offense, Burnett was arrested on 3/31/23 by the Utica Police Department (PD) on a warrant for Grand Larceny 4th Degree. Burnett was remanded to the Oneida CJ. His charges were abated by his death.

3. [redacted]

4. On 3/31/23, Burnett was arrested by Utica PD. At 5:43 p.m., Burnett was admitted into the Oneida CJ charged with Grand Larceny 4th Degree and had a Parole violation hold. [redacted]

[redacted]. At 6:38 p.m., Correction Officer (CO) J.T. completed Burnett's suicide prevention screening. CO J.T. documented that Burnett stated that a friend had recently committed suicide and that Burnett stated that he used heroin daily and methadone once a week. Burnett's appearance was documented as being flat and he appeared to be under the influence. Burnett scored a "four" and was referred to medical due to his stated heroin use. CO J.T. also completed an initial risk assessment of Burnett that documented that Burnett had asthma and was receiving methadone in the community at that time. The documentation also indicated that Burnett appeared under the influence as he was slow to respond. Burnett stated that he violated parole and had been previously incarcerated at Oneida CJ. Burnett stated that he had been arrested six times previously with his first arrest being at the age of 15.

5. [redacted].

6. [redacted]

7. [redacted]

8. [redacted]

[redacted] This is a violation of 9 NYCRR §7011.5(a) which states:

Without unnecessary delay, but no later than seventy-two (72) hours following a referral, an incarcerated individual shall receive a medical screening to determine if the individual suffers from a substance use disorder for which medication assisted treatment exists.

9. [redacted]

10. [redacted]

11. [redacted]

12. [redacted]

13. [redacted]. A review of the record by the Medical Review Board revealed that Burnett was not seen for his admission medical history and physical assessment within the 14 days of his admission. This is a violation of 9 NYCRR §7010.2(b)(1) which states:

Each prisoner shall be examined by a physician licensed to practice in the State of New York or by a medical personnel legally authorized to perform such examination at the

time of admission or as soon as thereafter, but no later than 14 days after admission.

14. [redacted]

15. [redacted] The Medical Review Board finds that the decision not to initiate medication therapy by NP [redacted]. was not in comportment with the requirements of 9 NYCRR §7011.5(b) and (c) Program screening, placement, and participation which states:

b) Following the medical screening, an incarcerated individual who is determined to suffer from a substance use disorder for which medication assisted treatment exists shall be offered placement in the medication assisted treatment program. Placement in such program shall not be mandatory. The offer of placement shall be made in writing, and the decision to accept or deny placement shall be verified by the incarcerated individual's signature and witnessed and signed by an appropriate staff member. If, for any reason, the incarcerated individual is not able to verify, or refuses to verify the decision, the same must be recorded in writing on the offer of placement and witnessed and signed by two (2) appropriate staff members.

c) Participation in the medication assisted treatment program shall not be unreasonably withheld from a qualified incarcerated individual. An incarcerated individual using medication assisted treatment prior to such individual's incarceration shall be eligible to, upon request by such individual, continue such treatment in the medication assisted treatment program for any period of time during such individual's incarceration.

16. [redacted]

17. On 4/27/23 at 3:43 a.m., Burnett wrote an electronic message on the individual tablet system to a relation in the community in which he asked the person to marry him.

18. On 4/27/23 at 6:11 a.m., Captain T.A. documented in the housing area logbook that he

was on the housing unit. At 6:29 a.m., CO E.K. documented in the housing area logbook his last supervisory watch tour for his shift. During an interview with Commission staff, CO E.K. stated that during this housing area watch tour, he completed his final headcount for his shift. CO E.K. continued that nothing from this shift stood out to him and he could not recall anything about Burnett other than in general, he was quiet. CO E.K. stated that it was not unusual for incarcerated individuals to be up at night on their tablets and that he didn't believe that at that time, there were time restrictions on tablet usage at night. At 6:58 a.m., CO E.K. documented in the housing area logbook a closing head count of 54. At approximately 6:59 a.m., CO J.M. entered the housing area as the new oncoming housing unit officer. At 7:01 a.m., CO E.K. documented in the housing area logbook "out". During an interview with Commission staff, CO E.K. stated that CO J.M. entered the housing area just before 7:00 a.m. and that he did not have much to say.

19. Commission staff reviewed the housing area logbook and the housing area security camera video and observed the following:

- On 4/27/23 at 7:00 a.m., CO J.M. was observed opening doors behind the officer's desk and re-stocking the desk.
- At 7:06 a.m. an unknown member of the Oneida CJ security staff entered and exited the housing area. CO J.M. continued restocking and swept the floor around the officer's desk.
- At 7:13 a.m., CO J.M. walked the interior perimeter of the day space in the housing area. CO J.M. was not observed on the second floor of the housing unit during this tour or observing any incarcerated individuals in their cells.
- At 7:16 a.m., CO J.M. sat at the officer's desk. CO J.M. retrieved something from behind the officer's desk and returned to a seated position where he remained until 7:18 a.m. At this time, CO J.M. documented in the housing area logbook that the TV remote was found at the TV on the left side.
- At 7:20 a.m., CO J.M. documented in the housing area logbook that the opening head count was "54 total".
- At 7:20 a.m., CO J.M. walked through the right side of the housing area day space to a cell door to the right of the first-floor showers and then back to the officer's desk.
- At 7:22 a.m., CO J.M. documented in the housing area logbook "opening security check performed: completed all appears in order at this time".
- At 7:22 a.m., an unknown member of the Oneida CJ security staff entered and exited the housing area.
- At 7:24 a.m., CO J.M. documented in the housing area logbook "recreation yard inspected / rec yard closed".
- At 7:30 a.m., CO J.M. documented in the housing area logbook, "unit is active supervision and unsecured".
- At 7:31 a.m. CO J.M. documented in the housing area logbook a supervisory watch tour.

A review of the housing area recorded video revealed that the 7:00 a.m. opening shift supervisory watch tour and the documented supervisory watch tour at 7:31 a.m. were not completed. The Medical Review Board finds that the failure to complete supervisory watch tours was not in comportment with the requirements of 9 NYCRR 7003.3(c) which states:

At a minimum, general supervision shall be maintained in all facility housing areas when all prisoners are secured in their individual housing units.

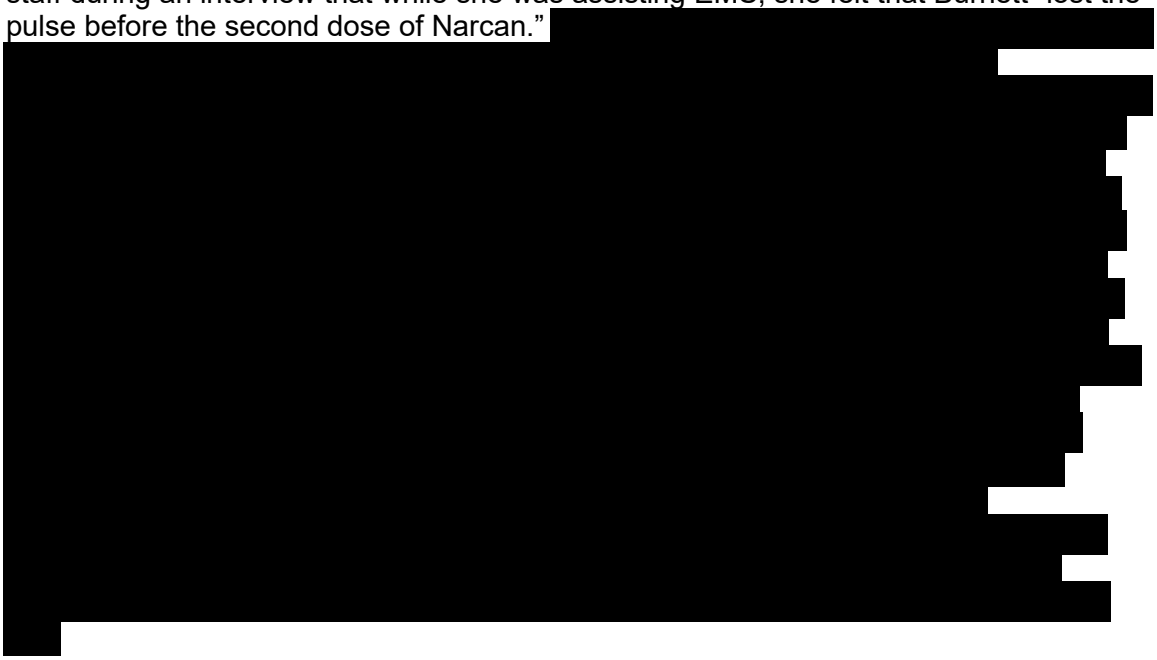
Additionally this was found to be in violation of Oneida CJ Policy and Procedures CD 05-01-03, Inmate Supervision; Personal Observation and Documentation.

20. The security staff who entered the housing unit at 7:06 a.m. and 7:22 a.m. did not document their entry into the housing area nor did CO J.M document this information.

21. On 4/27/23 at 8:00 a.m., CO J.M. documented in the housing area logbook that a supervisory watch tour was completed. CO J.M. documented in a supporting deposition post incident that at approximately 8:02 a.m., he observed Burnett laying on his bunk with an unknown red and white substance around his mouth and nose that appeared to drip down his neck. CO J.M. called to Burnett but Burnett did not respond at that time. CO J.M. observed that Burnett had agonal breathing and appeared to be choking on the foam coming from his mouth. CO J.M. called a medical emergency. CO J.M. called to Burnett again and this time Burnett sat up and looked at the officer but did not appear to be with it. Burnett did not appear to be fully conscious and appeared to be drowsy. Burnett attempted to stand at this point and CO J.M. observed a four-foot facility issued bed sheet tied around the window bars in Burnett's cell. This sheet was not observed to be tied around Burnett. Additional security and medical personnel arrived. RN [redacted] arrived [redacted] At 8:07 a.m., Emergency Medical Services (EMS) was activated. [redacted] During an interview with Commission staff, CO J.P. stated that Burnett was assisted by herself as well as CO R.G. down the stairs and then transported via wheelchair to a facility triage room just outside the housing unit. [redacted]

22. At 8.28 a.m., Central Oneida County Ambulance EMS arrived at the triage room. [redacted] CO J.P. stated to Commission

staff during an interview that while she was assisting EMS, she felt that Burnett "lost the pulse before the second dose of Narcan."



23. On 5/4/23, an internal investigation into CO J.M. was initiated by the Oneida County Sheriff's Office and the Criminal Investigation Division for providing a false statement and the falsification of facility tour logs . Both reported that the allegations were substantiated.

24. On 5/24/23, CO J.M. was arrested on misdemeanor charges of Falsifying Business Records 2nd Degree and Making a False Written Statement. On 9/11/23, CO J.M. plead guilty to Falsifying Business Records: Make False Entry. CO J.M. was sentenced to a conditional discharge with community service. CO J.M. was terminated from the Oneida County Sheriff's Office.

ACTIONS REQUIRED:

TO THE OFFICE OF THE ONEIDA COUNTY SHERIFF;

The Board acknowledges the administrative action taken regarding the failure of the correction officer to comply with the requirements of 9 NYCRR 7003.3(c). The Board requests a review by jail administration be conducted with correction staff to assure compliance with the standard requirements is being maintained.

In a response to the Commission's preliminary report Oneida County Jail Administration indicated that the requested review was completed.

TO THE ONEIDA COUNTY JAIL PHYSICIAN:

The Jail Physician shall conduct a comprehensive quality assurance review of the care provided to Burnett to include why he was not seen for his admission medical history and physical assessment within 14 days of his admission as well as why Burnett was not seen within 72 hours of his admission for a medical screening to determine if he suffered from a substance use

disorder for which medication assisted treatment exists.

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

In a response dated 5/2/24 the jail physician indicated that the requested review was completed with corrective action taken. This will be subject to further review and follow up by the Commission at a later scheduled health services evaluation.

TO THE ONEIDA COUNTY JAIL PHYSICIAN AND MAT SERVICES COORDINATOR:

The Board requests that the Jail Physician and MAT services coordinator review the policy and procedures regarding assessing individuals identified as having Opioid Use Disorder and that qualify for MAT services to assure compliance with the requirements on 9 NYCRR §7011.5 (b) and (c).

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

In a response dated 5/2/24 to the Commission's preliminary report, the jail physician indicated that the requested review was completed and compliance with the requirements of the cited minimum standards were met in this matter. The Commission did not find compliance with the requirements cited in Part 7011 of Minimum Standards and will be forwarding the open issue for further review at a later scheduled health services evaluation.

WITNESS, HONORABLE YOLANDA CANTY, Commissioner, 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 25th day of June 2024.

Yolanda Canty
Commissioner
Commission of Correction

YC:MB:vc
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