Commission of Correction

Final Report of the New York State Commission of Correction:

In the Matter of the Death of

Gregory Heckstall (05A1755), an incarcerated individual of the Attica Correctional Facility

December 18, 2024

To: Honorable Daniel F. Martuscello, III
Commissioner
NYS Department of Corrections
And Community Supervision
The Harriman State Campus
1220 Washington Avenue
Albany, New York 12226

Allen Riley
Chairman

Yolanda Canty
Commissioner

Elizabeth Gaynes
Commissioner

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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 Gregory Heckstall, who died on May 8, 2023, while an incarcerated individual in the custody of the NYS Department of Corrections and Community Supervision at the Attica Correctional Facility, the Commission has determined that the following final report be issued.

FINDINGS:

1. Gregory Heckstall was a 57-year-old male who died on 5/8/23 due to an Acute Fentanyl intoxication while in the custody of the New York State Department of Corrections and Community Supervision (NYS DOCCS) at the Attica Correctional Facility (CF).

2. Heckstall was born in Brooklyn, NY. Heckstall received his GED and was unemployed. There was no further demographic or social history available to the Commission regarding Heckstall.

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6. Heckstall was admitted to NYS DOCCS at Downstate CF Reception on 4/12/05 to serve a Life sentence for Murder 1st Degree and Conspiracy 2nd Degree. Heckstall was transferred from Downstate CF to Attica CF on 4/26/05. This is where Heckstall remained until the terminal event.

7. Between April 2011 through February 2022, Heckstall accrued two Tier III and three Tier II infractions that included drug use, refusal to obey a direct order, obstruction of visibility, altered item, tamper with electric, harassment, and creating a disturbance. Heckstall's sanctions included a loss of packages, a loss of commissary, a loss of phone, a loss of recreation, and keeplock time.

8. During Heckstall's incarceration at Attica CF, he was seen occasionally in medical for minor medical complaints. Heckstall was assessed and treated appropriately.

9. [redacted]

10. [redacted]

11. [redacted]

12. A review of the Facility's Mortality Review by Commission staff found that during a facility comprehensive medical review of Heckstall's medical records, there was no evidence that the pharmacy received a prescription from PA [redacted] on 4/26/23 to increase Heckstall's Lipitor from 10mg to 20mg daily. The facility's corrective action recommendations were for the Superintendent/DSH to have Health Services Administrative Staff develop a QI Project/Corrective Action Plan to improve in the prescription process and to complete a medication error report for the Lipitor dose not being increased as ordered.

13. [redacted]

14. Per a NYS DOCCS Memorandum written by Corrections Officer (CO) D.S., the following was documented: "On 5/8/23 I CO D.S. was working tour 1 (11-7) shift in B-2. I made rounds on 20 Company at approximately 12:12 AM. While walking by 20-30 cell I observed II Heckstall 05A1755 sitting on his bed watching TV. He was alive at that time and did not appear to be in any kind of distress".

15. On 5/8/23, per the NYS DOCCS Unusual Incident Report, documentation indicated that CO D.P. was conducting rounds on B Block at 1:32 a.m. and observed Heckstall unresponsive and slumped over sitting on his bed in cell # 30. CO D.P. called a medical emergency. At approximately 1:35 a.m., Sergeant (Sgt.) A.H. and CO D.P. entered Heckstall's cell and checked for a pulse. Heckstall did not have a pulse and Sgt. A.H. and CO D.P. moved Heckstall from his cell out to the company. Sgt. A.H. initiated Cardiopulmonary Resuscitation (CPR) while CO D.P. applied the Bag valve Mask (BVM) to assist with respirations. CO B.Z. arrived at the scene and assumed CPR. Sgt. A.H. applied the Automated External Device (AED) which indicated no shock advised. At 1:37

a.m., CO J.G. arrived at the scene and administered the first dose of Narcan in Heckstall's right nostril without effect. At 1:36 a.m., CO J.R. called for Emergency Medical Services (EMS) to respond to the facility. At 1:41 a.m., Registered Nurse (RN) . arrived at the scene

16. Per the documentation from the Monroe Ambulance report, the arrival time at the scene on 5/8/23 was at 2:02 a.m.

17.

18. A review of the Facility's Mortality Review by Commission staff found that during a facility comprehensive medical review of Heckstall's medical records, the following findings were identified:
    - There was no evidence that oxygen was used with the BVM.
    - There was no evidence of a provider order for the finger stick blood sugar that was completed.

    The Corrective Action Recommendation was to review, advise, and to train Health Services staff related to the findings.

ACTIONS REQUIRED:

TO THE DEPUTY COMMISSIONER OF THE NYS DEPARTMENT OF CORRECTIONS AND COMMUNITY SUPERVISION, DIVISION OF HEALTH SERVICES:

The Deputy Commissioner shall provide the Medical Review Board verification that recommended correction action plan(s) were completed.

In a response dated 10/30/24 to the Commission's preliminary report, NYS DOCCS provided verification of corrective action training completed with cited medical staff.

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 18th day of December 2024.

Yolanda Canty
Commissioner
Commission of Correction

YC:BB:vc
2023-M-0049
December 18, 2024

cc: Dr. Carol Moores, Deputy Commissioner Chief Medical Officer
James Donahue, Associate Commissioner of Mental Health
Superintendent Julie Wolcott, Attica CF