



**Commission of  
Correction**

**Final Report of the  
New York State Commission of Correction:**

**In the Matter of the Death of**

**Rodney Horn (96A4073),  
an incarcerated individual of the  
Clinton Correctional Facility**

**June 25, 2025**

**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*

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 Rodney Horn, who died on July 6, 2021, while an incarcerated individual in the custody of the NYS Department of Corrections and Community Supervision at the Clinton Correctional Facility, the Commission has determined that the following final report be issued.

FINDINGS:

1. Rodney Horn was a 55-year-old male who died on 7/6/21 due to a gastric ulcer with acute perforation and peritonitis while in the custody of the New York State Department of Corrections and Community Supervision (NYS DOCCS) at the Clinton Correctional Facility (CF). The Medical Review Board has found that the care provided to Horn on 7/1/21 at the Clinton Correctional Facility was substandard with failure of the Nurse Practitioner (NP) to properly assess and manage Horn's persistent complaints of abdominal pain. The Board has also found that there was a lack of proper supervision of Horn by correction officers as Horn had significant post-mortem changes when discovered unresponsive in his cell. The Medical Review Board opines that had Horn received a proper physical examination, a referral to a physician, and had there been proper supervision of the nurse practitioner by a physician, Horn's death would have been preventable.
2. Horn was born in New York. Horn was single and did not have any children. Horn received his GED and was unemployed.
3. [REDACTED]
4. On 6/26/96, Horn was admitted into NYS DOCCS at Downstate CF Reception [REDACTED]. On 8/5/96, Horn was transferred from Downstate CF Reception to Attica CF Reception for program purposes. Horn spent time in Wende CF, Sing Sing CF, Clinton CF, Green Haven CF, and Five Points CF before being transferred back to Clinton CF [REDACTED] on 4/14/11 [REDACTED]. Horn was returned to Clinton CF general population on 12/24/20. This is where Horn remained until the terminal event.
5. [REDACTED]

6. [REDACTED]

7. [REDACTED]

8. [REDACTED]

[REDACTED] Horn was scheduled for a reappearance with the parole board in December 2021.

9. [REDACTED]

10. [REDACTED]

11. [REDACTED]

12. [REDACTED]

13. [REDACTED]

14. [REDACTED]

[REDACTED]

15. [REDACTED]

16. [REDACTED]

[REDACTED] The Medical Review Board finds that although Horn's physical examination was "normal," NP [REDACTED] should have obtained a

blood pressure reading with a different cuff, offered Horn medication to reduce his extremely elevated blood pressure, admit Horn to the infirmary, or had Horn sent to the emergency room for an evaluation of a blood pressure reading of 204/123. [REDACTED]

[REDACTED]

17. [REDACTED]

18. [REDACTED]

19. [REDACTED]

20. [REDACTED]

21. [REDACTED]

- 22. [Redacted]
- 23. [Redacted]
- 24. [Redacted]
- 25. [Redacted]
- 26. [Redacted]
- 27. [Redacted]
- 28. [Redacted]

29. [REDACTED]

30. [REDACTED]

[REDACTED] The Medical Review Board opines that there was a failure by NP [REDACTED] to conduct a proper assessment of Horn and a failure by the Facility Health Services Director to adequately supervise NP [REDACTED]

31. [REDACTED]

32. A review of the [REDACTED] unit logbook by Commission staff found that between the hours of 8:00 a.m. and 7:00 p.m. on 7/6/21, there were no specific logbook entries made regarding Horn.

- 33. On 7/6/21 at 5:00 p.m., Corrections Officer (CO) C.S. documented in the [REDACTED] unit logbook that rounds were made and a count of the unit was taken. During an interview with Commission staff, CO D.C. reported that during the unit count, the incarcerated individuals are either standing up or sitting up on their beds.
- 34. On 7/6/21 at 7:00 p.m., Corrections Officer CO C.S. documented in the [REDACTED] unit logbook that a round was completed on the Unit.
- 35. Per the NYS DOCCS Unusual Incident Report, on 7/6/21 at 7:30 p.m., CO C.S. was making a security round on LF-1 Company and as he approached LF-1-cell # 47 that housed Horn, CO C.S. observed Horn laying on his bed unresponsive. CO C.S. activated a medical emergency via his radio. Sergeant (Sgt.) M.B. and COs C.H., C.S. and M.F. opened Horn's cell and placed Horn on the Company floor. CO C.H. applied the Automated External Defibrillator (AED) with no shock advised. At 7:33 p.m., CO M.F. started chest compressions. At 7:35 p.m., Sgt. F., RN [REDACTED] and other responding staff arrived at the scene. Sgt. M.B. contacted the Watch Commander and at 7:40 p.m., the ambulance was called. A review of the Unusual Incident Report by Commission staff found that Horn was not administered Narcan after being observed unresponsive. The Medical Review Board finds that security first responders failed to follow Directive 4058 Narcan Administration by Uniformed First Responders
- 36. [REDACTED]
- 37. [REDACTED]
- 38. Per the DOCCS Office of Special Investigations (OSI) report, a review of the fixed video from Lower-F-1 Company from 12:00 p.m. to 7:32 p.m. revealed sufficient evidence to substantiate that on 7/6/21, half-hour security rounds were not conducted on LF-1

Company, Special Housing Unit, [REDACTED] by CO C.S. and CO D.C. Fixed video from LF-1 Company revealed rounds were conducted at 12:49 p.m., 3:23 p.m., 3:58 p.m., 4:54 p.m., 5:26 p.m., 6:28 p.m., and 6:56 p.m. This was in violation of Directive 4948 Protective Custody. Additionally, a review of the F-1 company logbook from 7/6/21 revealed that CO C.S. made inaccurate logbook entries by documenting that rounds were made every half hour. Additionally, the Medical Review Board has found that the amount of post-mortem changes (full body rigor mortis) documented by the EMS providers would indicate that Horn was deceased in excess of eight hours when discovered. On 7/6/21, security first responders failed to follow Directive 4058 Narcan Administration by Uniformed First Responders and did not administer Narcan from the first aid bag to Horn when he was found unresponsive at 7:30 p.m. OSI documented that a referral of the matter to the DOCCS Bureau of Labor Relations would be time barred from discipline based on the 9-month contractual limitation for security staff.

### ACTIONS REQUIRED:

#### TO THE COMMISSIONER OF THE DEPARTMENT OF CORRECTIONS AND COMMUNITY SUPERVISION:

1. The Commissioner shall take notice of the Medical Review Board's finding of the presence of postmortem changes as observed by the nursing staff and initiate a review of the supervision of the Lower-F-1 Company and assure compliance by security staff with directive requirements is being maintained.
2. The Commissioner shall conduct a review with the security first responders who failed to follow Directive 4058 Narcan Administration by Uniformed First Responders.

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

*In a response dated 5/13/25 to the Commission's preliminary report, the Deputy Commissioner indicated that the requested reviews were completed with corrective action taken with staff in the form of counseling and retraining.*

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

1. The Deputy Commissioner shall convene a comprehensive quality assurance review on the health care provided to Horn at the Clinton CF with a focus on:
  - Why, on 3/25/21 at 10:00 a.m., NP [REDACTED] did not obtain a temperature on Horn.
  - Why, on 4/2/21 at 10:00 a.m., NP [REDACTED] did not attempt any medical intervention for Horn who had a blood pressure reading of 204/123.
  - Why, on 4/7/21 at 9:00 a.m., NP [REDACTED] did not obtain a temperature, respirations, or an oxygen saturation on Horn.
  - Why, on 4/16/21 at 12:15 p.m., RN [REDACTED] did not obtain a temperature, respirations, or an oxygen saturation on Horn.
  - Why, on 5/19/21 at 9:00 a.m., NP [REDACTED] did not obtain a temperature on Horn.

-Why, on 5/19/21, Horn was not rescheduled to have his blood pressure rechecked in one month.

-Why, on 7/1/21 at 9:05 a.m., RN [REDACTED] did not obtain a temperature or respirations on Horn.

-Why, on 7/1/21 at 9:00 a.m., NP [REDACTED] did not obtain a temperature or an oxygen saturation on Horn.

-Why, on 7/1/21 at 9:00 a.m., NP [REDACTED] did not complete an abdominal assessment on Horn.

2. The Deputy Commissioner shall convene a comprehensive quality assurance review regarding the oversight and management of the nurse practitioner by the Facility Health Services Director at the Clinton CF.

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

*In a response dated 5/13/25 to the Commission's preliminary report, the Deputy Commissioner indicated that the requested reviews were completed. Corrective actions taken included training with staff on documentation through assessment and the development of a Quality Improvement project in September 2024 covering complete documentation and assessments. Additionally, the Deputy Commissioner indicated that the Regional Medical Director would complete an additional medical record review with the nurse practitioner in June 2025.*

#### TO THE DIRECTOR OF PATHOLOGY FOR CHAMPLAIN VALLEY PHYSICIANS HOSPITAL

The Medical Review Board is requesting a review of the pathology findings in Horn's case. The Board questions the cause of death being Hypercoagulability secondary to gastric perforation due to the lack of any evidenced bodily effects from the coagulation and in the Board's opinion attribute either finding as terminal and secondary phenomenon. The Board opines that the cause of death in this matter should be "gastric ulcer with acute perforation and peritonitis."

WITNESS, HONORABLE YOLANDA CANTY, Commissioner, NYS Commission of Correction, Alfred E. Smith State Office Building, 80 South Swan Street, 12<sup>th</sup> Floor, in the City of Albany, New York 12210 on this 25<sup>th</sup> day of June 2025.



Yolanda Canty  
Commissioner  
Commission of Correction

YC:BB:vc  
2021-M-0092  
June 25, 2025

cc: Dr. Carol Moores, Deputy Commissioner Chief Medical Officer  
James Donahue, Associate Commissioner of Mental Health  
Superintendent Mariejosee King, Clinton CF