



**Commission of
Correction**

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

In the Matter of the Death of

**Thomas Lasher (16B1969),
an incarcerated individual of the
Attica 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 Thomas Lasher, who died on April 6, 2022, 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. Thomas Lasher was a 56-year-old male who died on 4/6/22 from an upper gastrointestinal hemorrhage due to liver cirrhosis from primary sclerosing cholangitis and ulcerative colitis while in the custody of the New York State Department of Corrections and Community Supervision (NYS DOCCS) at the Attica Correctional Facility (CF). The Medical Review Board has identified deficiencies in medical assessments and follow ups of Lasher prior to his terminal event.
2. Lasher was born in Lewiston, NY. Lasher was survived by his wife and four children. Lasher received his high school diploma and earned an associate degree in massage therapy. Lasher worked as a Heating, Ventilation, and Air Conditioning (HVAC) technician prior to his incarceration.
3. Lasher's first and only contact with the criminal justice system was the instant offense. On 12/31/14 in Niagara, NY, Lasher intentionally shot a victim in the stomach with a shot gun. Lasher was arrested on 1/1/15 by New York State Police and charged with Attempted Murder and Criminal Possession of a Weapon 4th Degree. On 1/1/15, Lasher was arraigned in Niagara Town Court and charged with Attempted Murder and Criminal Possession of a Weapon 4th Degree. On 6/21/16, Lasher was convicted of Attempted Murder and Assault 1st degree after trial. Lasher was sentenced to 15-years in NYS DOCCS with five years post release supervision.
4. [REDACTED]
5. [REDACTED]
6. On 7/12/16, Lasher was admitted into NYS DOCCS at Wende CF Reception for his first state incarceration. On 7/14/16, Lasher was transferred from Wende CF Reception to Elmira CF Reception for program purposes. On 7/29/16, Lasher was transferred from Elmira CF Reception to Attica CF to be assessed. This is where Lasher remained until the terminal event.
7. [REDACTED]

[REDACTED]

[REDACTED]

8. During Lasher's incarceration, Lasher received one Tier 2 infraction at Attica CF for loss/damage of property. Lasher's sanction included keep lock, no packages, and no commissary for 11days.

9. [REDACTED] Per NYS DOCCS Men's Health Primary Care Practice Guidelines, Males 50-years-old and older are to have a history and physical every two years. Per the facility Mortality Review Report, this issue was identified, the Health Service staff were advised, and corrective training was completed on updating the history and physicals.

10. [REDACTED]

11. [REDACTED]

12. [REDACTED]

13. [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] The Medical Review Board finds that Lasher did not receive appropriate mental health care due to him not being seen by a primary therapist per the Correction-Based Treatment Plan Goal Plan.

[REDACTED]
[REDACTED]

14. [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

15. [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

16. [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] Additionally, it was not clear to the Medical Review Board when Lasher began to complain of symptoms as the medical records provided to the Commission from 4/1/21 through the terminal event, did not include any documentation of a sick call encounter or a medical provider encounter to indicate that Lasher had complaints of rectal bleeding.

17. [REDACTED]
[REDACTED]
[REDACTED]

18. [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

[REDACTED]

The Medical Review Board finds that RN [REDACTED] did not obtain vital signs on Lasher, complete an assessment of Lasher's back pain, and that RN [REDACTED] issued Lasher a Non-steroidal anti-inflammatory medication (NSAIDs) (Motrin). Documentation in the Attica Mortality Review identified the absence of vital signs and an assessment on Lasher who had complaints of lower back pain, and that Lasher, who had a history of ulcerative colitis and rectal bleeding, was issued Motrin. The facility completed a corrective action plan for the medical staff to obtain vital signs, complete assessments, and to review medical history's prior to distributing over the counted medications.

19.

[REDACTED]

Documentation in the Attica Mortality Review identified the absence of vital signs and an assessment of Lasher who had complaints of back pain. The facility completed a corrective action plan for the medical staff to obtain vital signs and complete assessments. The Medical Review Board finds that RN [REDACTED] should have had Lasher seen by the medical provider that day for having continued back pain for one week with the request for additional pain medication for the relief of pain.

20.

[REDACTED]

Documentation in the Attica Mortality Review identified the absence of vital signs, and an assessment on Lasher who had complaints of lower back pain, and that Lasher, who had a history of ulcerative colitis and rectal bleeding, was issued Motrin. The facility completed a corrective action plan for the medical staff to obtain vital signs, complete assessments, and to review medical histories prior to distributing over the counter medications.

21.

[REDACTED]

22.

[REDACTED]

The Medical Review Board finds that RN [REDACTED] did not assess Lasher or obtain vital signs on Lasher during the medical emergency. RN [REDACTED] left Lasher in critical condition with no medical intervention for an undisclosed amount of time, to go and get the doctor instead of having another staff member get the doctor. RN [REDACTED] did not document clearly the care that was given to Lasher during the medical emergency. Documentation in the Attica Mortality Review

identified that RN [REDACTED] did not document vital signs, an assessment, or a timeline of the events. RN [REDACTED] had difficulty starting an intravenous line and asked the phlebotomist for help. [REDACTED]

[REDACTED] The phlebotomist's scope of practice was addressed. [REDACTED]

23.

[REDACTED]

24.

Per the documentation from the Monroe Ambulance report, on 4/6/22 at 10:15 a.m., they received a call from Attica CF for an emergent response. Advanced Emergency Medical Technician (AEMT) Paramedic [REDACTED]. documented arriving at Lasher's side at 10:47 a.m.

[REDACTED]

25.

[REDACTED]

[REDACTED]

ACTIONS REQUIRED:

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

The Deputy Commissioner shall convene a comprehensive quality assurance review on the health care provided to Lasher at Attica CF with a focus on:

1. Why, on 11/22/21 at 9:45 a.m., RN [REDACTED] did not notify a facility medical provider that Lasher refused his transplant consult.
2. Why, on 1/12/22, there was no documentation if Lasher had a Flex Sigmoidoscopy performed at Wyoming County Community Hospital (WCCH) for rectal bleeding and if there was any physician follow up provided.
3. Why, on 3/29/22 at 6:30 a.m., RN [REDACTED] did not have Lasher seen by the medical provider that day for having continued back pain for one week.

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

In a response dated 5/9/25 to the Commission's preliminary report, the Deputy Commissioner for Health Services indicated that a mortality review was completed, and a Quality Improvement Plan was developed regarding documentation of refusals and for medical staff to obtain vital signs and complete assessments. The Medical Review Board has found that the response did not fully address the specific identified issues in Lasher's medical care and will require further review.

TO THE DIVISION OF FORENSIC SERVICES, OFFICE OF MENTAL HEALTH:

The Division shall conduct a quality assurance review with the facility's process for appointment scheduling to address why Lasher was not properly scheduled for his psychiatry and primary therapist follow-up appointments.

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

In a response dated 4/7/25 to the Commission's preliminary report, Office of Mental Health (OMH) provided additional documentation [REDACTED]

[REDACTED]
[REDACTED]
[REDACTED] OMH indicated that they have reminded staff to assure treatment

