



**Commission of  
Correction**

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

**In the Matter of the Death of**

**Dustin Provost,  
an incarcerated individual of the  
Clinton County Jail**

**December 17, 2025**

**To: Sheriff David N. Favro  
Clinton County Sheriff's Office  
25 McCarthy Drive  
Plattsburgh, New York 12901**

**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 Dustin Provost, who died on December 17, 2023 , as a result of circumstances which occurred while an incarcerated individual in the custody of the Clinton County Sheriff at the Clinton County Jail, the Commission has determined that the following final report be issued.

FINDINGS:

1. Dustin Provost was a 39-year-old male who died on 12/17/23 from sepsis and early peritonitis due to an infarction of the entire large intestine. Provost was found alone in his cell by a corrections officer at the Clinton County Jail (CJ) while in the custody of the Clinton County Sheriff. The Medical Review Board has found that there was a failure to provide necessary medical care to Provost who presented with symptoms of acute illness days prior to the terminal event. The Board opines that had Provost received proper medical care in response to his continued complaints of obstipation, abdominal pain, and vomiting, his condition could have been detected, emergency surgical intervention obtained, and his death prevented.

2. [REDACTED] In the instant offense, Provost was charged with Burglary 2<sup>nd</sup> Degree, Criminal Mischief 3<sup>rd</sup> Degree, Criminal Contempt 2<sup>nd</sup> Degree, Criminal Possession of a Weapon 3<sup>rd</sup> Degree, and Menacing 2<sup>nd</sup> Degree. These charges were abated by his death.

3. [REDACTED]

4. [REDACTED]

5. On 10/7/23 at 10:53 a.m., Provost was received at the Clinton CJ. Provost was charged with Burglary 2<sup>nd</sup> Degree, Criminal Contempt 2<sup>nd</sup> Degree, and Criminal Possession of a Weapon 3<sup>rd</sup> Degree. Correction Officer (CO) C.H. completed Provost's initial risk assessment. CO C.H. documented that Provost reported having asthma, neuropathy and a traumatic brain injury. [REDACTED]

[REDACTED]

[REDACTED] Provost was referred to medical. At 11:04 a.m., CO C.H. completed Provost's suicide prevention screening. Provost scored a '4.' Provost was documented as having no thoughts of self-harm at the time of the assessment but had made suicidal comments to the transporting officer. Provost was placed on 15-minute watch tours until he could be cleared by mental health.

6. [REDACTED]

7. [REDACTED]

8. [REDACTED]

[REDACTED] This is a violation of 9 NYCRR §7010.2(j) which states:

*Adequate health service and medical records shall be maintained which shall include but shall not necessarily be limited to such data as: date, name(s) of inmate(s) concerned, diagnosis of complaint, medication and/or treatment prescribed. A record shall also be maintained of medication prescribed by the physician and dispensed to a prisoner by a staff person.*

9. [REDACTED]

10. [REDACTED]

11. [REDACTED]

12. [REDACTED]

13. [REDACTED]

14. [REDACTED]

15. [REDACTED] This is a violation of 9 NYCRR §7010.2(j).

16. [REDACTED]

17. [REDACTED]

18. [REDACTED]

19. [REDACTED]

20. [REDACTED]

21. [REDACTED]

22. [REDACTED].

23. [REDACTED]

24. [REDACTED]

25. On 12/8/23 at 9:05 a.m., CO S.A. documented in an incident report that Provost was observed removing one Subutex pill from his mouth and putting it in his right hand while taking a drink of water. Provost was ordered to open his right hand and the Subutex was retrieved, secured in a plastic cup, and brought to medical. [REDACTED]

[REDACTED] . Provost [REDACTED] received three days of lock-in status. This is a violation of the requirements of 9 NYCRR §7011.5(d) which states:

*No individual shall be denied participation in the program on the basis of a positive drug screening upon entering custody or upon intake into the program; nor shall any individual receive a disciplinary infraction for such positive drug screening. No individual shall be removed from or denied participation in the program on the basis of having received any disciplinary infraction before entry into the program, or during participation in the program.*

26. [REDACTED]

27. [REDACTED]

[REDACTED]

The Medical Review Board opines that per nursing practice guidelines, nurses may not administer any standing orders and the administering of a medication without the proper authorization from a licensed medical provider is unauthorized. Additionally, Provost's complaints of constipation for three weeks should have prompted, at a minimum, a nursing sick call evaluation and a referral to a medical provider prior to prescribing over the counter medications.

28.

[REDACTED]

RN [REDACTED] stated that incarcerated individuals would submit another sick call or would talk with the nurse at medication pass if their symptoms persisted. The Medical Review Board opines that Provost should have received an assessment as a follow-up to his complaint of being constipated for three weeks. Furthermore, the follow-up to medical complaints made through the sick call system are the responsibility of the facility's medical staff and should not be the responsibility of the incarcerated individual. The facility must have an established sick call system for the incarcerated individual population.

29.

On 12/15/23 at 10:57 p.m., CO T.R. documented that he assumed the post duties of the M-linear north post to include the '6' block housing unit for the 11:00 p.m. through 7:00 a.m. shift. CO T.R. documented completing housing area supervisory rounds throughout the tour at approximately 30-minute intervals. Sergeant (Sgt.) M.F. documented completing supervisory tours of the housing unit on 12/15/23 at 11:21 p.m. and on 12/16/23 at 2:05 a.m. There was no documentation relating to Provost in the logbook for this time period.

30.

On 12/16/23 at 6:56 a.m., CO A.B. documented that he assumed the post duties of the M-linear north post to include the '6' block housing unit for the 7:00 a.m. through 3:00 p.m. shift. CO A.B. documented completing housing area supervisory rounds throughout the tour at approximately 30-minute intervals. There was no documentation relating to Provost in the logbook for this time period. It was documented in the logbook that medication pass was completed at 9:00 a.m. with CO S.F. passing the medications. [REDACTED]

[REDACTED] A second medication pass was documented in the logbook at 1:13 p.m. with CO S.F. passing the medications. [REDACTED]

[REDACTED]. Sgt. C.T. documented completing a supervisory tour of the housing unit on 12/16/23 at 2:12 p.m. During an interview with Commission staff, Sgt. C.T. stated that during this supervisory round, he was informed by the officer that Provost had made complaints of his stomach bothering him. Provost had stated that he had not had a bowel movement in a couple of days and was bound. Sgt. C.T. asked Provost if he had seen medical to which Provost stated "no." Sgt. C.T. attempted to confirm this by speaking with the intake officer who informed Sgt. C.T. that Provost had seen medical a day or two prior.

[REDACTED] Sgt. C.T. stated that he observed Provost acting like his normal self with no other symptoms. Sgt. C.T. could not recall if Provost had asked to see medical or to go to the hospital.

31. During an interview with Commission staff, CO R.W. stated that on 12/16/23, in the pre-shift briefing, she was informed that Provost had been complaining of feeling ill throughout the day and that the Sergeant communicated that Provost was not going to go to the hospital as it was believed that he was over exaggerating and trying to get to the hospital.
32. On 12/16/23 2:54 p.m., CO R.W. documented that she assumed the post duties of the M-linear north post to include the '6' block housing unit for the 3:00 p.m. through 11:00 p.m. shift. During an interview with Commission staff, CO R.W. stated that the off going officer reiterated that Provost had been complaining of feeling ill all day. CO R.W. added that she was informed that Provost had been seen by medical previously and was already told that he was not going to the hospital. CO R.W. stated that Provost showed no obvious signs of being ill, that he was up throughout the shift and began to become disruptive including throwing his inhaler and a shoe. CO R.W. documented that the housing area supervisory rounds were completed throughout the tour at approximately 30-minute intervals. During an interview with Commission staff, CO R.W. stated that during her shift, Provost stated multiple times that he was not feeling well and that he had thrown up. CO R.W. stated that she did not observe any evidence that Provost had thrown up. CO R.W. stated that sometime after dinner, the other incarcerated individuals in the block yelled for her attention as Provost had fallen in his cell. CO R.W. stated that Provost did not state any reason for the fall, nor did he show any obvious signs of injury from the fall. CO R.W. stated that Provost had requested medical throughout the night but with no medical staff in the facility at that time, he was not seen by them. Sgt. C.T. documented conducting a supervisory tour of the housing unit on 12/16/23 at 8:48 p.m. Sgt. M.F. documented a supervisory tour of the housing unit on 12/16/23 at 10:38 p.m. There was no documentation pertaining to Provost in the logbook for this time period. The medication pass was documented in the logbook at 7:23 p.m. with CO B. passing the medications. [REDACTED].
33. On 12/16/23 at 10:54 p.m., CO E.H. documented that he assumed the duties of the M-linear north post to include the '6' block housing unit for the 11:00 p.m. through 7:00 a.m. shift. CO E.H. documented in an incident report that he was informed by the off-going officer, CO R.W., that Provost had been complaining all night about not being able to have a bowel movement. CO R.W. informed CO E.H. that the "C-Tour Sergeant" had checked on Provost and said he was fine. During an interview with Commission staff,

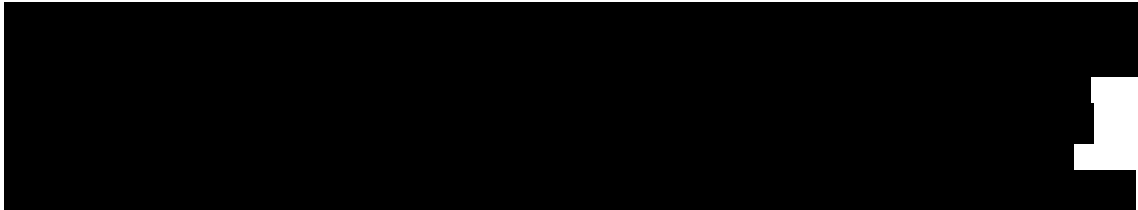
CO R.W. indicated that she was referring to Sgt. C.T. as he was the jail sergeant that day. CO R.W. stated that she informed CO E.H. that Provost wasn't feeling well and complained of vomiting but that she did not observe any vomit from Provost. During an interview with Commission staff, CO E.H. stated that he was informed at the pre-shift briefing that Provost was feeling ill but could not recall exactly what was said. CO E.H. stated that CO R.W. informed him that the Sergeant had just been down to see Provost and that the Sergeant told CO R.W. that Provost was fine. CO E.H. stated that upon his entering the M-6 housing unit, the other incarcerated individuals on the unit were yelling about Provost. CO E.H. called for Sgt. M.F. to observe Provost regarding his complaint of not feeling well. CO E.H. conducted the housing count accounting for 21 incarcerated individuals.

34. At approximately 11:13 p.m., Provost yelled for an officer. Provost stated that he was not feeling well. CO E.H. observed vomit on Provost's cell floor that was watery and dark in color but had no smell. At approximately 11:15 p.m., Sgt. M.F. arrived on the housing unit to speak with Provost. Sgt. M.F. took Provost's temperature which was recorded as 98.2 and exited the housing area. CO E.H. documented this encounter in the logbook as "Sgt. M.F. was on the floor, above inmate (Provost) complained not feeling well." During an interview with Commission staff, CO E.H. stated that he did not recall Provost asking for medical or to go to the hospital but did recall Provost asking him to get a Sergeant. There was nothing documented which indicated that Sgt. M.F. attempted making any contact with medical to consult about Provost's complaints.
35. On 12/17/23 at approximately 4:00 a.m., CO E.H. observed vomit on Provost's cell floor and Provost again reported that he was not feeling well. CO T.R. reported in a supporting deposition that at approximately 4:00 a.m., he relieved CO E.H. of his post duties on M-linear north. CO E.H. returned to the housing unit approximately five minutes later with Sgt. M.F. and CO J.W. All four personnel retrieved a mop bucket and proceeded into Provost's cell. Provost was instructed to mop his floor as it was covered in a brown liquid. Provost mopped the floor without issue but complained that he had not had a bowel movement in 11 days and did not feel well. The incarcerated individual in the cell next to Provost's stated that Provost had been complaining all day and Provost's complaints were keeping him from sleeping. CO T.R. documented that he went back to his duties. CO J.W. documented that at approximately 4:30 a.m., Provost complained that he was having difficulty breathing. CO J.W. provided Provost with his inhaler and Provost used the inhaler and returned it to the officer. A review of all of the documentation provided to the Commission and all of the staff interviews conducted, there was no indication that there was any attempt to contact any of the on-call medical staff regarding Provost's complaints. The Medical Review Board opines that there was a complete failure by corrections staff to address Provost's repeated complaints of abdominal pain, reports of constipation, and observed vomiting. Despite repeated requests for medical attention, Provost was denied access to medical care by the corrections supervisors and the corrections supervisors failed to make any attempt to contact any on-call medical staff for a consultation. Additionally, the Medical Review Board finds that the act of having Provost mop his cell due to the vomit and not getting him medical attention was inhumane treatment.
36. CO E.H. documented in an incident report that at 4:45 a.m., CO E.H. observed Provost lying on his mattress and appeared to be okay. At approximately 5:00 a.m., Provost was observed as lying on his mattress with his right hand on the cell gate and appeared okay as he rolled onto his side. At approximately 5:30 a.m., CO E.H. observed Provost curled

up on his cell floor near his toilet.

37. Sgt. C.S. documented that at approximately 5:30 a.m., he received a tour report from Sgt. M.F. Sgt. M.F. reported that he had just called down to the medium north housing unit via telephone in order to check on Provost who was complaining of a medical issue. Sgt. M.F. was advised that a check was just completed, and that Provost was lying on his mattress and appeared to be okay.
38. At approximately 5:31 a.m., CO E.H. observed that Provost was on the floor of his cell curled up by his toilet. CO E.H. documented that he was unable to verify if Provost was asleep or not due to the position that Provost was in. CO E.H. called for CO T.R. to come and check on Provost. CO T.R. documented that he was unable to tell if Provost was sleeping due to the position that Provost was in. CO E.H. indicated that he completed the housing area watch tour and went back to 'M-6" along with CO T.R. CO E.H. documented that he told CO T.R. to get Sgt. M.F. to make sure that Provost was okay. During an interview with Commission staff, CO T.R. stated that officers are not able to open the cells on the overnight shift unsupervised, so he was unable to tell if Provost was breathing or not. CO T.R. indicated that he decided to physically go to the Sergeant's office to explain the entire situation instead of doing a radio transmission for the Sergeants to respond to.
39. At approximately 5:35 a.m., CO T.R. entered the Sergeant's office and informed Sgt. M.F. and Sgt. C.S. that Provost did not respond when spoken to. Sgt. M.F., Sgt. C.S. and CO T.R. returned to Provost's cell. CO E.H. opened Provost's cell, and Provost was observed to be unresponsive. Provost was rolled from his left side onto his back and an audible gurgling sound was heard. Sgt. C.S. documented that Provost's lips were blue and he was not responsive. Smelling salts were placed under Provost's nose with no response. At approximately 5:38 a.m., Cardiopulmonary resuscitation (CPR) was initiated, and Emergency Medical Services (EMS) was activated. At approximately 5:42 a.m., Narcan was administered without the desired effect. The Automated External Defibrillator (AED) was applied but there were no shocks advised. The Medical Review Board opines that a seven-minute delay from when Provost was first found to be unresponsive by the Officers to when CPR was started is unacceptable.
40. At 5:48 a.m., Champlain Valley Physicians Hospital EMS arrived and assumed the care of Provost. [REDACTED]
41. [REDACTED] The Medical Review Board opines that had Provost's received a proper and timely medical assessment, his bowel inactivity could have been recognized, had proper diagnostic tests ordered, and then a referral for immediate colorectal surgery, an intervention that could have prevented his death.

42.



However, the Medical Review Board noted the autopsy did not include a trace of the vascular obstruction and to where its exact location was.



43.



44. The Clinton CJ Administration's investigation into this incident revealed several deficiencies with CO R.W. and CO E.H.'s job performance due to the failures to maintain proper documentation in the logbooks and the failing to address Provost regarding obstructing the view into his cell with a blanket for one hour and 45 minutes. Both officers received formal counseling.

ACTIONS REQUIRED:

TO THE OFFICE OF THE CLINTON COUNTY SHERIFF:

The Sheriff shall conduct an investigation into the corrections staff responsible for supervising Provost regarding:

1. Why Provost was not referred to the facility's medical staff or Emergency Medical Services when he presented with unresolved complaints of abdominal pain, vomiting and difficulty breathing.
2. Why there was a seven-minute delay between when Provost was first observed unresponsive and the initiation of CPR.
3. What training is given to corrections staff when an incarcerated individual presents with a medical issue when medical staff is not present within the facility.

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

TO THE MEDICAL DIRECTOR OF CLINTON COUNTY JAIL:

The Medical Director shall conduct a comprehensive quality assurance review of the care provided to Provost regarding:

1. Why Provost's medical records were not maintained in compliance with 9 NYCRR §7010.2(j).
2. Why there is no documentation of the administration of a controlled substance to Provost between 10/10/23 and 11/25/23.

3. Why Provost's removal from the MAT program was not in comportment with 9 NYCRR §7011.5(d).
4. Why Provost was provided with medications that were not authorized by or prescribed by the facility medical provider. The practice of using standing medication orders by nursing staff must cease immediately.
5. Why medications provided to Provost were not documented as administered.
6. Why there was no response from the medical staff to sick calls submitted on 10/26/23, 11/5/23, 11/14/23 and 11/17/23.
7. Why there was no medical assessment performed or a referral to a medical provider for Provost after complaints of obstipation of three weeks on 12/11/23 and 12/14/23.

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

*In a joint response dated 9/25/25 to the Commission's preliminary report, the sheriff and jail physician indicated that the requested reviews were completed and that corrective actions have been implemented including refresher training for nursing staff on documentation, a review of non-medical staff roles in medication delivery and expanded quality assurance audits. The jail physician however did mostly disagree with the Medical Review Boards findings. The Board remains affirmed in its opinion and findings on the cause and manner of Provost's death and that it was preventable. The stated corrective actions will be verified by the Commission at a later scheduled health services evaluation.*

TO THE CHAIR OF THE CLINTON COUNTY LEGISLATURE:

As the appointing authority for the delivery of jail incarcerated individual health services pursuant to Correction Law section 501, the County Legislature shall review the above findings and conduct an inquiry into the fitness of the formally designated provider.

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 17<sup>th</sup> day of December 2025.



Yolanda Canty  
Commissioner  
Commission of Correction

YC:MB:vc  
2023-M-0136  
December 17, 2025