

NEW YORK STATE COMMISSION OF CORRECTION

In the Matter of the Death :
of Arthur Shawcross, an inmate :
at the Sullivan CF :

FINAL REPORT OF THE
NEW YORK STATE COMMISSION
OF CORRECTION

TO: Honorable Brian Fischer
Commissioner
NYS Department of Correctional
Services
State Campus, Building #2
Albany, New York 12226

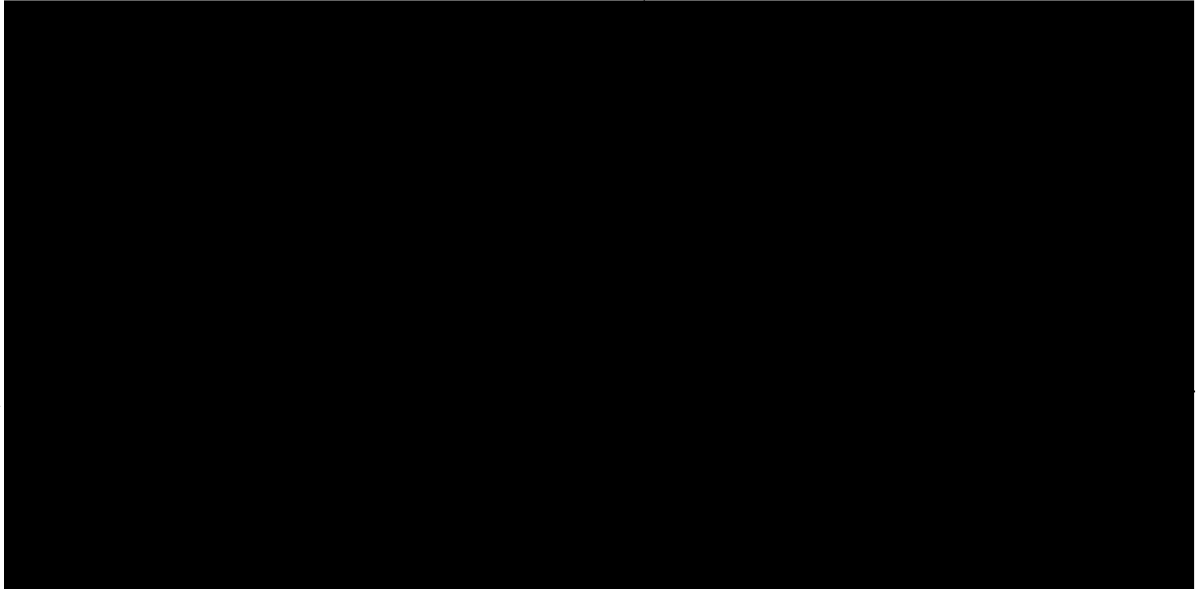
GREETINGS:

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 Arthur Shawcross who died on November 10, 2008 while an inmate in the custody of the NYS Department of Correctional Services at the Sullivan Correctional Facility, the Commission has determined that the following final report be issued.

FINDINGS:

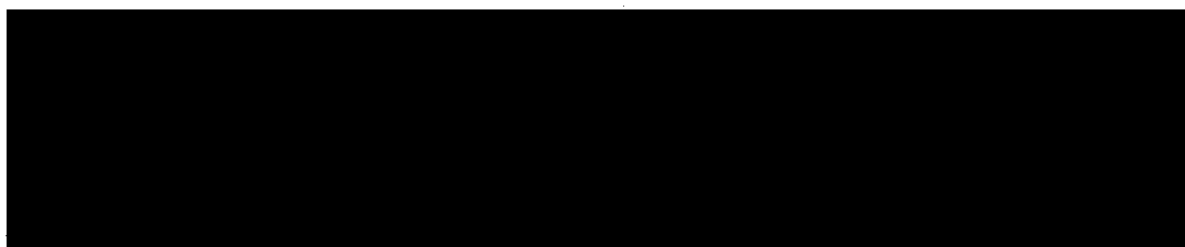
1. Arthur Shawcross was a 63 year old white male who died on 11/10/08 at 9:50 p.m. from a pulmonary thrombo-embolism due to a large impacted thrombus in the deep iliac vein while in the custody of the NYS Department of Correctional Services (DOCS) at the Sullivan Correctional Facility. He received grossly negligent, incompetent and inadequate medical evaluation and treatment which was a contributory factor in his death.

2.

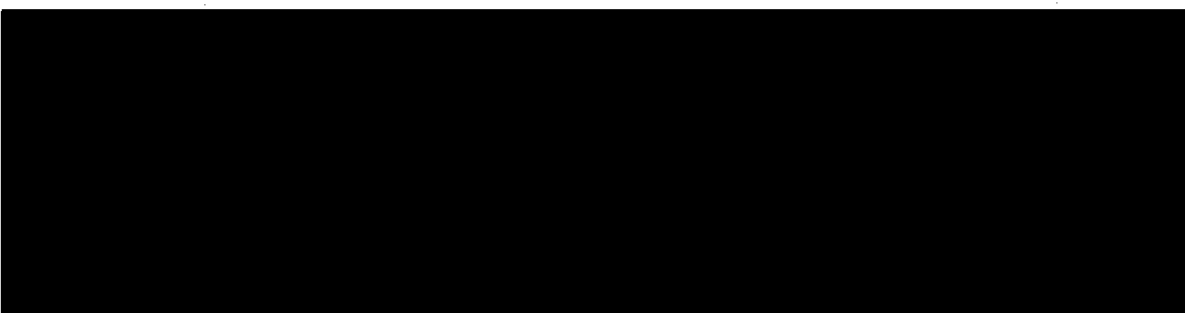


3. On 2/1/91, Shawcross was transferred to DOCS Wende Reception from the Jefferson County Correctional Facility. On 2/11/91, Shawcross was transferred from Wende Reception to Elmira Reception.
4. On 3/22/91, Shawcross was transferred to the Sullivan CF where he remained until his demise.

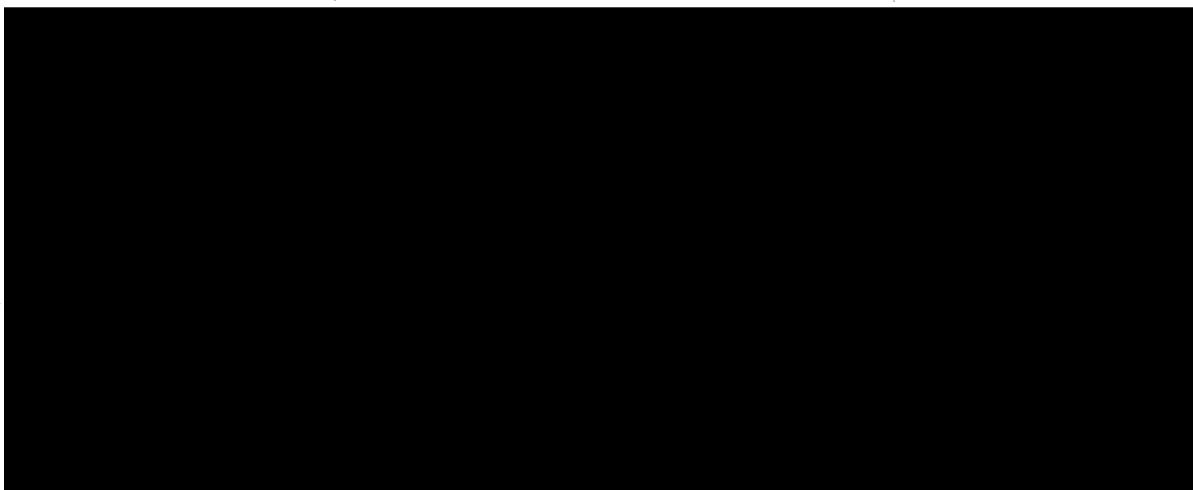
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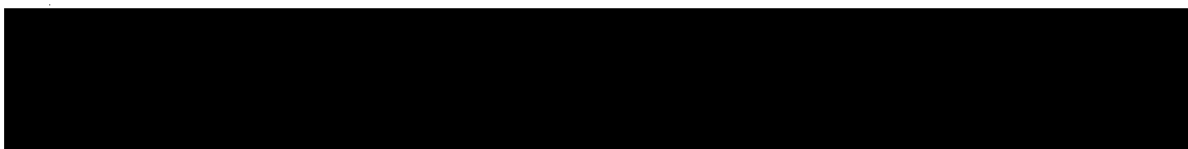
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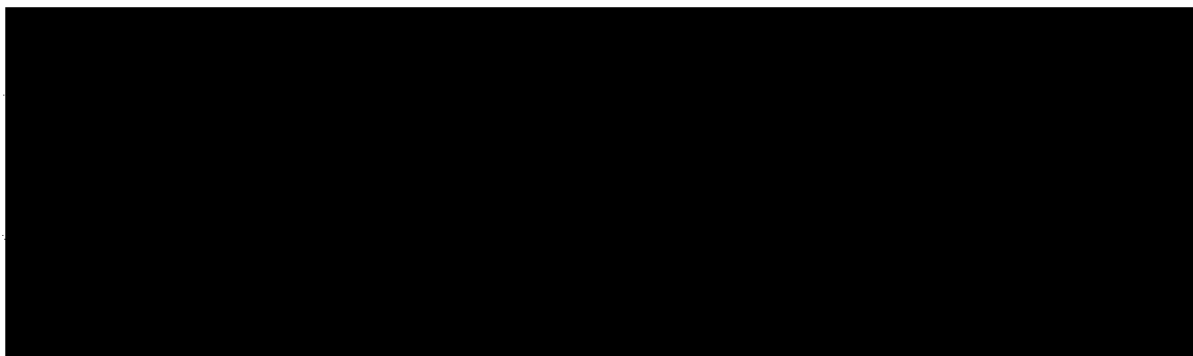
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8.



9.



[REDACTED]

Shawcross was placed in cell AS 132.

10. On 11/7/08 at 8:22 p.m. while in his AS 132 cell, Shawcross complained to Officer D.W. that his leg was painful and he could not walk to the medical unit to receive his medications. Shawcross reported to the officer that he was overdue for his 4:30 p.m. medication, [REDACTED]. The general population inmates' insulin administration takes place in the Sullivan CF health services unit. Officer D.W. stated he called the medical unit and spoke to RN K.D. Officer D.W. stated and documented in the security log that he requested an inmate to come down to the medical unit to obtain a wheelchair for Shawcross to receive his medications as the inmate said he couldn't walk. Officer D.W. stated he also reported to RN K.D. that Shawcross had leg pain. According to the DOCS security log, Officer D.W. documented and stated that RN K.D. had told him that Shawcross could walk and didn't require a wheelchair. Additionally, Officer D.W. stated RN K.D. said Shawcross did not have a wheelchair permit and if she sent a wheelchair for Shawcross, he would have to be admitted to the infirmary. Officer D.W. told Shawcross what the nurse had told him. Shawcross said if he couldn't use a wheelchair to receive his medication, then he wouldn't be receiving his medication as he couldn't walk. Per security log, Sgt. M., who was supervising the AS housing unit, was notified. Sgt. M. stated after the Catholic services he observed Shawcross returning to his housing block and he was assisted in ambulation by two inmates. Sgt. M. stated Shawcross stopped to talk to him and asked the sergeant for assistance in obtaining his medications as he stated his leg was painful and he could not walk on it. Sgt. M. stated he told Shawcross he would have an officer call the medical unit for a wheelchair transport. Upon returning to Shawcross' housing unit, he asked Officer D.W. if medical was notified. The officer responded in the affirmative but reported that the nurse refused to permit Shawcross use of a wheelchair. Sgt. M. stated he instructed the officer to document the incident in the security log.

11. On 11/7/08 at 8:30 p.m., RN K.D., who stated she was working in the medical unit from 2:00 p.m. to 10:00 p.m. that day, received a telephone call from the AS housing officer (Officer D.W.). The officer asked if an inmate could come down to the medical unit to obtain a wheelchair for Shawcross to be transported to the medical unit [REDACTED] as the inmate said he couldn't walk. In interview, RN K.D. stated that she would not allow Shawcross a wheelchair, as "Shawcross was walking in the morning and he did not have a wheelchair permit." RN K.D. stated Shawcross did not declare a "code blue" which is an emergency sick call. RN K.D. stated she did not go to the housing unit to assess the situation herself as the nurses do not go to the inmate housing units unless a "code blue" is formally called. [REDACTED]

[REDACTED] In the course of the investigation, it was verified that the Sullivan CF has inmate helpers, usually two inmates per housing block who have been specifically trained to be wheelchair transporters. Additionally, the facility nurse administrator stated she also keeps a list of trained inmates available to call upon if needed. [REDACTED]

Per Sullivan Correctional Facility policy #5008 dated 5/18/05 entitled Sick Call Procedures for Population, (IV,8) which states:

"Emergency Sick Call-Whenever inmate or/and facility employee has reason to believe that a medical/dental condition has risen that is life/limb threatening, and warrants immediate attention, they are to arrange notification of the Health Unit and advise the RN on duty of the inmate's name, DIN number, exact condition, current situation, and are to receive instructions as how to proceed to the Health Unit. Employee on duty is to provide, to the extent of his/her knowledge and abilities, sufficient emergency treatment as to sustain life and limb until inmate can be either transported to Health Care Unit or appropriate medical personnel arrive on scene."

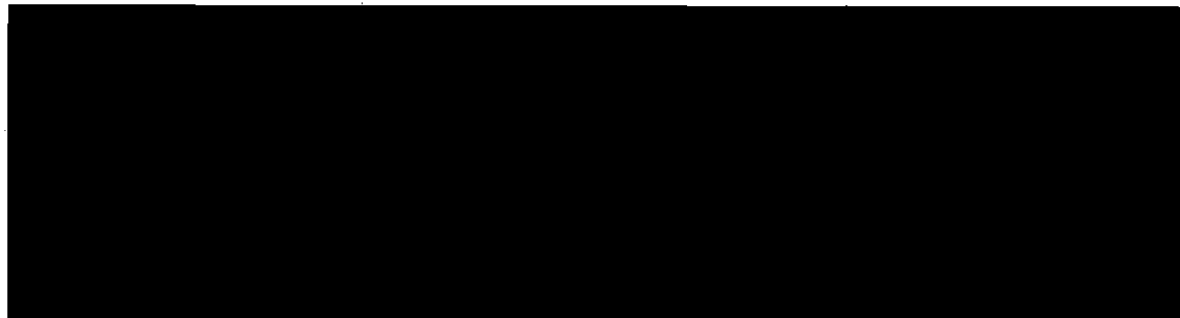
[REDACTED] This is a violation of Sullivan Correctional Facility policy #5017 dated 10/17/08 entitled

Distribution of Medication to Inmate Population (C,7) which states:

"Any inmate refusing to take one to one medication will fill out a refusal form and have the same properly witnessed. Should an inmate refuse to complete the form, the medication nurse and correction officer will so note the observation that the inmate has refused to accept the medication. A copy of this form will be placed in the inmate's health care ambulatory record."

12. On 11/9/08 at 7:35 a.m., Officer L. documented in the security log book that he made a telephone call to the medical unit reporting Shawcross had told him that he could not walk to receive his medications. RN C.C. called the officer back and instructed the officer to find an inmate to obtain a wheelchair to bring Shawcross to the medical unit for his medications.

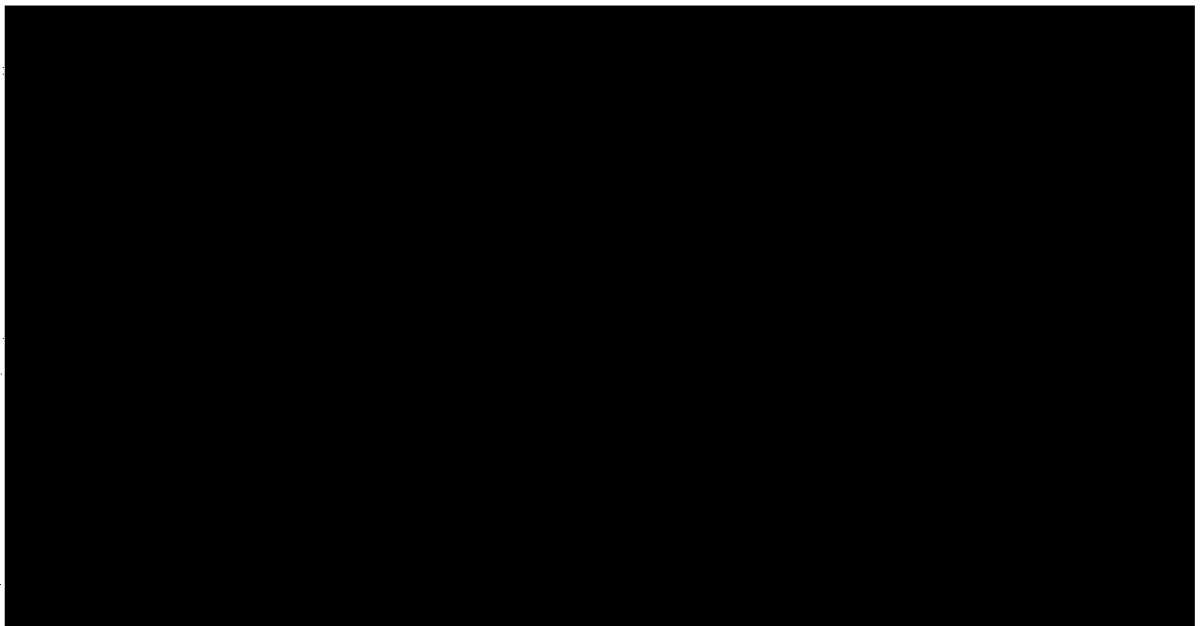
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RN R.C. stated it was the infirmary nurse's responsibility to provide nursing care to the admitted inmate and to call the physician on call, if needed.

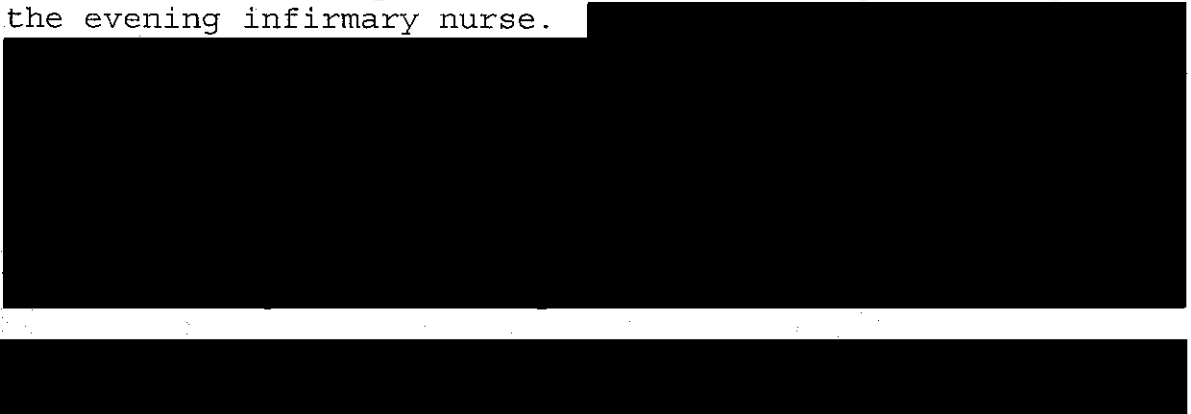
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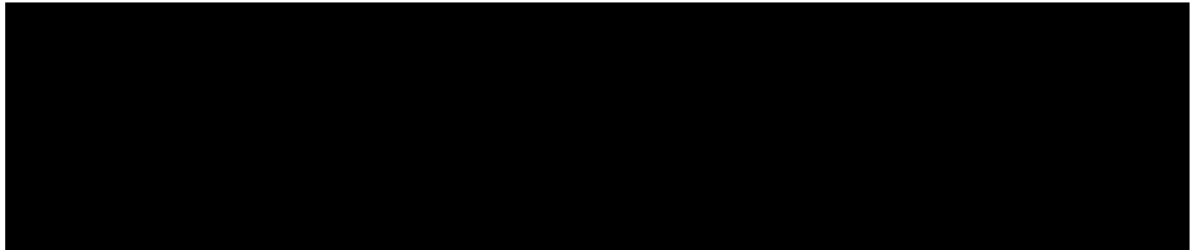


This is a violation of DOCS Division of Health Services #7.1, (B) dated 9/3/03 entitled Infirmary Care which states:

"Inmates will be admitted to an infirmary only upon the order of a primary care provider (i.e., physician, physician assistant or nurse practitioner). The Nurse Administrator or designee may admit upon obtaining the specific approval of the primary care provider on-call."

15. All registered nurses interviewed for this investigation stated that they could admit inmates into the infirmary for twenty-four hours for nursing observation without notifying or having a physician order. However, in DOCS Health Policy 7.1, entitled Infirmary Care, dated 9/3/03, there is no difference cited between a twenty-four hour infirmary admission and a regular infirmary admission.
 16. On 11/9/08 at 3:00 p.m., RN B.B. came on duty at 3:00 p.m. as the evening infirmary nurse.
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17.



18. On 11/9/08 at 11:00 p.m., RN B.S. was assigned as the night infirmary nurse. 

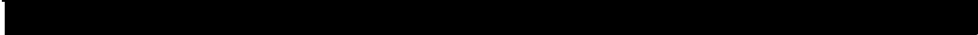
 This is a violation of DOCS Health Services Policy #4.2 entitled Infirmary Health Record (3,a) which states:

"Following are the minimum nursing documentation time frames: New Admission: once per shift for a period of 48 hours."

Additionally stated in DOCS Health Services Policy §4.2A dated 7/17/91 entitled Infirmary Short Form Health Record (D):

"Health provider's Progress Notes-Notations are made according to progress (positive or negative) as required."

19. 

 Shawcross was not evaluated by a medical provider in a timely manner. This is a violation of DOCS Division of Health Services #7.1(c) entitled Infirmary Care which states:

"Within 24 hours of admission, all inmates will be evaluated by a primary care provider and written treatment and nursing care plans will be developed and implemented."

20. 

[REDACTED]

PA G.S. stated that she thought an ambulance would have been called [REDACTED]. She was unaware that he didn't go to AMC by ambulance, and that a wheelchair van was being located for transport instead. According to the documentation, there was a nearly four hour wait for the wheelchair-accessible van to become available from another correctional facility in the hub which precipitated an untimely transfer. There was a lack of communication regarding how Shawcross was to be transported.

21. On 11/10/08, Officers B .M., M.P., and J.H. transported Shawcross by a wheelchair accessible state van to AMC arriving at 8:40 p.m. [REDACTED]

RECOMMENDATIONS:

TO THE NYS DEPARTMENT OF CORRECTIONAL SERVICES, DIVISION OF HEALTH SERVICES:


1. The Division shall provide in-service education colloquium to the professional nursing staff at the Sullivan Correctional Facility regarding the assessment and treatment of common post-operative complications.
2. The Division shall provide an educational in-service colloquium to the professional nursing staff at the Sullivan Correctional Facility for the purpose of complying with the DOCS Division of Health Services #7.1, dated 9/3/03, entitled Infirmiry Care, and the infirmiry admission process.
3. The Division shall provide written educational guidelines to its professional medical staff regarding the timely and appropriate medical transfer of inmates, specifically ambulance versus wheelchair-accessible van for the purpose of facilitating timely medical emergency transfers.

4. The Division shall reinforce compliance with Sullivan Correctional Facility Health Services with DOCS Health Service Policies §4.2 entitled Infirmery Health Record and #4.2A entitled Health Record Services Infirmery Short Form Health Record regarding documentation guidelines for both 24 hour admissions and regular infirmery admissions.
5. The Division shall reinforce compliance with procedures for accurate physician orders transcription by the professional nursing staff at the Sullivan Correctional Facility.
6. The Division shall take administrative action against RN K.D. who on 11/7/08 did not assess Shawcross and prevented his transport to the facility infirmery, an inmate at the Sullivan Correctional Facility, [REDACTED] Additionally, the RN did not comply with Sullivan Correctional Facility policy #5008 Sick Call Procedures for Population by failing to provide direction to a correction officer and policy #5017 entitled Distribution of Medication to Inmate Population by failing to obtain a Refusal of Treatment/Care from Shawcross.
7. The Division shall take administrative action against RN M.L. who failed to adequately examine and assess a patient [REDACTED]

TO THE NYS EDUCATION DEPARTMENT, OFFICE OF PROFESSIONAL DISCIPLINE:

1. That the Office of Professional Discipline investigate RN K.D. for gross negligence and gross incompetence, specifically, for failure to respond to, evaluate and arrange for medical intervention [REDACTED]
2. That the Office of Professional Discipline investigate RN M.L. for gross negligence and gross incompetence, specifically for failure to adequately examine and/or refer to a physician a patient [REDACTED]

WITNESS, HONORABLE PHYLLIS HARRISON-ROSS, M.D., Commissioner,
NYS Commission of Correction, 80 Wolf Road, 4th Floor, in the City
of Albany, New York 12205 this 18th day of December, 2009.


Phyllis Harrison-Ross, M.D.
Commissioner

PH-R:mj
08-M-149
8/09

cc: Superintendent James Walsh, Sullivan CF
Dr. Lester Wright, Chief Medical Officer
Nancy Lyng, Director of Health Services