Inmate death ruled accident

Columbia prison staff failed to follow policy, witnesses say

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PRESS ENTERPRISE

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Columbia prison staff failed to follow policy, witnesses say

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BLOOMSBURG — The jury for a coroners' inquest ruled Tyler Evans' death in a prison restraint chair was accidental, despite being caused by the actions of others.

During the more than 6-hour session, witnesses spoke about violations of prison policy leading up to the 19-year-old's death on June 2.

Corrections officers failed to get permission from the warden or a mental health expert before extending his time in the chair beyond eight hours, testified Warden David Varano.

The shift on duty when Evans was brought to the prison never filled out the intake form that would have warned later shifts that he had methamphetamine in his system, Varano said on the stand.

That shift also failed to tell later shifts he had methamphetamine in his system, said Corrections Officer Brent Harner.

Policies forbade the officer assigned to watch Evans from taking him out of the restraint chair to perform CPR after his heart stopped —it took 20 minutes for a sergeant to start chest compressions.

Both the warden and deputy warden testified that they didn't know prolonged time in a restraint chair could kill someone.

Rare process

Coroner Jeremy Reese previously ruled Evans died of "complications of an excited state associated with methamphetamine toxicity and restraint chair confinement."

The purpose of the rare inquest was to determine the manner of Evans' death —whether it was homicide, accidental or something else.

Reese told the five jurors and two alternates that to rule the case a homicide, someone had to have voluntarily committed an act to cause fear, harm or death.

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A majority of the five-member panel didn't feel that was the case, and Reese said he agreed.

His investigation is now closed, he said.

'Justice for Tyler'

Tyler's great-grandmother, Judy Evans, was infuriated by the decision.

"You're crooked as hell, all of you," she said as she left the courtroom after the decision.

She had spent much of the hearing muffling her sobs. She wore a T-shirt emblazoned with the words "Justice for Tyler" carefully hidden beneath her cardigan. She had been warned not to show such a shirt in view of the jury, but said she had worn one every day since her grandson's death eight months ago last Sunday.

"I'm not taking it off, no matter what anyone says," she said.

Tyler was arrested around 1 a.m. June 1 after a domestic argument with his stepfather, Justin Ruskuski, at 42 Waterdam Road Lot 14.

Justin Kressler, who was a Briar Creek police officer at the time, testified he eventually determined Tyler's actions deserved only a summary charge, which usually results in a ticket and a fine.

But Evans was screaming and crying incoherently.

His probation officer, Caitlin Letteer, asked police to take him in for testing, and a urinalysis showed he had taken both methamphetamine and marijuana, Kressler said. That was a probation violation, so he was taken to Columbia County Prison.

Judy Evans said he had been approved for medical marijuana. And his upset was partially caused by developmental disabilities — he never learned to read or write, and had the mind of a 10-year-old, she said.

Suicide threats

On the way to the prison, Tyler said he would kill himself there, Kressler testified. So Kressler took him to Geisinger Bloomsburg Hospital for a mental health evaluation.

Dr. Jed Ritter testified Tyler was coherent and said he wasn't currently thinking of hurting himself. He didn't seem to have anything wrong with him other than intoxication, so he released him around 3:55 a.m. after testing him for drugs and alcohol.

But Tyler started threatening to kill himself again and banged his head against the window as Kressler drove him to the prison, Kressler said. He continued to be combative when they arrived at the jail, he testified.

"So they decided to put him in the restraint chair," he said.

Warden not notified

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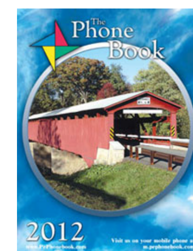

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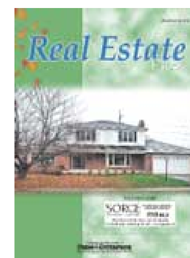
Deputy Warden George Nye said prison staff notified him when they put Tyler in the restraint chair, and again to get permission to move the chair to an area that could be observed from the “bubble” area corrections officers use when not making their rounds.



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But then he heard nothing more, he testified. So he assumed Tyler had been released from the chair.

If he had been told Tyler was still uncontrollable after 8 hours in the chair, he would have come in to evaluate the situation, he said.

Under questioning by attorney Robert Buehner, Warden Varano said that prison policy requires officers to contact him or a mental health staffer before leaving anyone in the restraint chair more than eight hours. But he was never notified, he said.

Normally, the inmate screening report would also have been filled out, listing issues such as drugs in his system and suicidal tendencies, Varano said. But no one had filled out the questions for Tyler.

That’s not necessarily a violation of policy, he added.

When someone enters the prison and is so disruptive and suicidal that he needs to be placed in a restraint chair immediately, that takes precedence over filling out the report, he said.

It’s unusual, he added.

“In five years, I’ve never seen an inmate come in this state,” Varano said.

Medical staff is always available for officers to consult, and in emergencies, staff members are supposed to call for outside assistance, he said.

No officers were disciplined for violating policy, Nye said.

“We were advised to wait until the proceedings were done,” he said.

Young officers

The morning Tyler died, his prison block was being overseen by a young crew, according to testimony.

Officer Brent Harner had just two years of experience in prison work. He was making the rounds checking the inmates of E block in their cells on the third shift.

OfficerPatrick Zielecki, who had started his career as a corrections officer the previous August in Northumberland, was assigned to keeping a constant eye on Tyler.

The officer in charge of the prison that shift was Sgt. Jared Cunfer, who had become a corrections officer five years earlier.

Video from 1:15 a.m. June 2 showed Tyler screaming and thrashing his head back and forth, straining against the straps holding him down.

By 1:30 a.m., Tyler had fallen still, the video showed, shaking only occasionally.

Around 1:45 a.m., Tyler's head was lolling in the chair. Reese said when he examined the video closely, he could see Tyler was still breathing.

Harner said he thought Tyler was just exhausted.

"I thought it was from him thrashing around," he said. "He'd been doing it for a 22-hour period.

"We were sure he was on some kind of drug. But no one said what kind."

No pulse found

Then Tyler's breathing became light.

The video showed Zielecki went out and tried to talk to Tyler, tapping him on the shoulder, but the teen didn't respond.

He tried again at 2:04, then left the view of the video camera. Zielecki testified he called the sergeant, who arrived around 2:13 a.m.

At 2:14 a.m., Zielecki could be seen trying to give him water under Cunfer's supervision, but Tyler remained unconscious.

Cunfer could be seen checking Tyler's pulse repeatedly. At one point, when he wasn't sure if it was there, he asked Zielecki to try, Zielecki said.

But Zielecki said he wasn't sure if he could feel a pulse.

Although he learned CPR in Northumberland and was shown a video on it in Columbia County, he didn't know how to check for a pulse, he said.

CPR begins

Cunfer left at 2:16 a.m., the video showed, and returned with a medical bag at 2:19 a.m. He said he called for an ambulance while he was out. It was 2:25 a.m. by the time he began CPR.

Rank and file corrections officers aren't allowed to remove the restraints, the three officers agreed.

Cunfer said doing so could be dangerous: Tyler could have been faking unconsciousness, he said.

Buehner asked Cunfer why he didn't start CPR immediately and have someone else call the ambulance.

"I did my best," Cunfer said. "I reacted to the best of my ability at the time."

Harner said when ambulance workers arrived, they tried administering Narcan.

Narcan works to reverse opioid overdoses, but has no effect on methamphetamine.

Too late

Dr. Rameen Starling-Roney, the forensic pathologist who did the autopsy on Tyler, said that by then, it was most likely too late.

Methamphetamine releases fight-or-flight hormones, he said. The heart rate increases, which increases its demand for oxygen. At the same time, the drug causes blood vessels to constrict, decreasing the oxygen that can get to the heart, he said.

Add to that heavy physical activity — such as thrashing around — and the heart can give out, he said.

At 1:45 a.m., when Tyler became still but was breathing heavily, he wasn't getting enough oxygen, the doctor said. By the time his breathing had become light at 2:04 a.m., it wouldn't have been enough for him to function.

The 20 minutes it took to begin CPR after that was far too long, he added. After five minutes without oxygen, "life expectancy goes way down," he said.

Chair info missing

Reese asked Varano whether the prison had ever turned over the make and model of the restraint chair used. He'd asked for it repeatedly, he said.

Varano said the chair didn't have any information about its make or model. But judging by pictures, it's the same one used by the Department of Corrections, he said.

"I can't research consumer product information or findings because the make and model isn't given," Reese said.

Later, he said he held the inquest in an effort to be thorough.

"Given the involvement of a county agency and the fact that Mr. Evans was in custody at the time of death, my goal from the time I was notified of the death was to conduct an impartial investigation into the Cause and Manner of Death and to be transparent with my findings with Mr. Evans family and members of the community," he said in a written statement after the inquest.

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