Record of Death

Provided by LA Department of Public Safety and Corrections on 10/04/2023

2022

Name: Harrison Jones

DOC #: 109712

Age / Race: 63 / Black or African American

Gender: Male

First Admission Date to DOC: 1/27/2022

Sentence: 20 years

Facility / Housing Unit: Local - Richland DC / J Dorm

Date of Death: 2/25/2022

Time of Death: 1:45:00 PM

Manner of Death: Heart -any type of heart related death including cardiopulmonary arrest

Expected / Unexpected: Unexpected

Autopsy Required: Yes

Location: Local - Richland DC

Form AM-I-4-x-1 12
September 2021

Medical Summary Report for a Deceased Offender

(Must be submitted within 72 hours of death excluding weekends and holidays)

DATE: 02/28/22

TO: DPS&C Medical/Mental Health Director

FROM: Kindra Vaughn LPN/Medical Director

Medical Director or Treating Physician

FACILITY: RICHLAND PARISH DETENTION CENTER Housing Unit: J DORM

Name/DOC#: HARRISON JONES III/_ ___ __

Age/DOB: _ __ Date of Death: 02/25/2022

Place of Death: OCHSNER LSU HEALTH MONROE
(Facility)

_____
(Other)

(Attach ER, D/C summary, Hospital notes, etc.)

Medical Conditions:PMH HTN, NEWLY DX DIABETES

MAR: SEE LIST

Medical Summary: OFFENDER HARRISON JONES III_ ___! WAS SENT TO RMC WITH CHEST PAIN ON FEB 23, 2022. AFTER CARDIAC WORK UP IT WAS DETERMINED THAT IT WAS NON CARDIAC BUT HE WAS A NEWLY DX DIABETIC. PLANNED TO ADMIT FOR OBSERVATION. I, KINDRA VAUGHN LPN SPOKE WITH DR PROCTOR FROM RMC AND REQUESTED A TRANSFER TO OCHSNER'S LSU HEALTH MONROE. HE WAS TRANSFERRED AND ADMITTED TO UHC ON 2/23/22. ON 02/25/22 HE WAS SCHEDULED FOR LHC AFTER STRESS TEST SHOWED REVERSIBLE ISCHEMIA. HE HAD TWO STENTS PLACED THEN SENT TO PACU FOR OBSERVATION HE BECAME BRADYCARDIC AND HYPOTENSIVE AFTER APPROX 30MINS EKG SHOWED SIGNIFICANT STEMI IN LEADS V2,V3,V4, V5, V6. REPEATED LHC NOTED WAS SIGNIFICANT THROMBOSIS POST PCI STENT. ST. FRANCIS CARDIOTHORACIC SURGEON WAS NOTIFIED FOR EMERGENT CABG. OFFENDER JONES CODED WITHIN MINUTES. AFTER APPROX 30 MINS ROSC WAS NOT ACHIEVED AND OFFENDER HARRISON JONES III 109712 WAS PRONOUNCED EXPIRED AT 1350 BY RAMAN SAHARAN, MD. END OF REPORT

Autopsy: No X Yes

Manner of Death:
Expected
Unexpected X
Suicide
Accident
Homicide

Physician Signature	Date	Time
Kindra Vaughn LPN/Medical Director	2/28/22	10:25AM
Medical Director's Signature	Date	Time

Comments: _____

Form AM-I-4-x 12 September 2021

Louisiana Department of Public Safety and Corrections

Standardized Death Report Format

Unit Name: RICHLAND PARISH DETENTION CENTER

DATE OF REPORT: 02/28/2022

TO: James M. Le Blanc
Secretary

FROM: KINDRA VAUGHN LPN
Unit Head or Designee

Title MEDICAL DIRECTOR

RE:

Offender's Name: HARRISON JONES III

Offender's DOC [redacted]

Housing Unit J DORM

Age: 63

Manner of Death: (Please check one of the following boxes)

Expected X Unexpected

Autopsy: OBTAINED

Medical Diagnosis: PMH HTN, NEW DX DIABETES

NARRATIVE: OFFENDER HARRISON JONES III [redacted] WAS SENT TO RMC WITH CHEST PAIN ON FEB 23, 2022. AFTER CARDIAC WORK UP IT WAS DETERMINED THAT IT WAS NON CARDIAC BUT HE WAS A NEWLY DX DIABETIC. PLANNED TO ADMIT FOR OBSERVATION. I, KINDRA VAUGHN LPN SPOKE WITH DR PROCTOR FROM RMC AND REQUESTED A TRANSFER TO OCHSNER'S LSU HEALTH MONROE. HE WAS TRANSFERRED AND ADMITTED TO UHC ON 2/23/22. ON 02/25/22 HE WAS SCHEDULED FOR LHC AFTER STRESS TEST SHOWED

REVERSIBLE ISCHEMIA. HE HAD TWO STENTS PLACED THEN SENT TO PACU FOR OBSERVATION HE BECAME BRADYCARDIC AND HYPOTENSIVE AFTER APPROX 30MINS EKG SHOWED SIGNIFICANT STEMI IN LEADS V2,V3,V4, V5, V6. REPEATED LHC NOTED WAS SIGNIFICANT THROMBOSIS POST PCI STENT. ST. FRANCIS CARDIOTHORACIC SURGEON WAS NOTIFIED FOR EMERGENT CABG. OFFENDER JONES CODED WITHIN MINUTES. AFTER APPROX 30 MINS ROSC WAS NOT ACHIEVED AND OFFENDER HARRISON JONES III 109712 WAS PRONOUNCED EXPIRED AT 1350 BY RAMAN SAHARAN, MD. END OF REPORT

AUTOPSY REPORT

Case No: 2022-0191 **Date of Examination:** February 26, 2022

Name: JONES, Harrison

Age: 63 years **Race:** Black **Sex:** Male

Investigating Agency: Richland Parish Coroner's Office

FINDINGS

I. Hypertensive arteriosclerotic cardiovascular disease:
   A. Cardiomegaly with left ventricular hypertrophy, 600 grams.
   B. Recent stent placement in left anterior descending and left circumflex coronary arteries with acute thrombosis.
   C. Atherosclerosis of aortic valve and abdominal aorta.
   D. Myocardial fibrosis.
   E. Atherosclerosis of cerebral blood vessels, severe.
   F. Nephrosclerosis with bilateral renal cortical cysts.

II. Benign nodular hyperplasia of the prostate, severe:
   A. Trabeculation of the urinary bladder.

III. Diabetes mellitus, clinical.

IV. No evidence of trauma.

CAUSE OF DEATH: Coronary Artery Thrombosis due to Hypertensive Arteriosclerotic Cardiovascular Disease

OPINION:

This 63-year-old, black male, Harrison Jones, died of acute coronary artery thrombosis due to hypertensive arteriosclerotic cardiovascular disease. Investigation of the circumstances of death revealed that the decedent was transferred from Richland Medical Center in Bienville Parish to Ochsner Medical Center, Shreveport, where he underwent coronary artery angioplasty. There, two stents were placed. It was noted he had 90% stenosis of the left anterior descending and significant stenosis of the left circumflex artery. Approximately twenty minutes post-cath, he became bradycardia and hypertensive, and went into cardiac arrest and could not be resuscitated.

Autopsy demonstrated no evidence of perforations or dissections. Stents were in place. Proximal to the stent in the left anterior descending coronary artery was an acute thrombus. In addition, there was atherosclerosis of the coronary arteries, aortic valve, abdominal aorta, and cerebral blood vessels. The heart was markedly enlarged, and the kidneys showed scarring with cyst formation, due to the effects of hypertension and diabetes mellitus. The presence of multifocal areas of myocardial fibrosis indicates that the decedent sustained a myocardial infarct(s) (heart attack(s)) in the remote past.

Frank J. Peretti, M.D.
Forensic Pathologist

EXTERNAL EXAMINATION

The body was that of a well-developed, well-nourished, black male, clad in a hospital gown and socks. The body weighed 230 pounds, measured 71 inches in length and appeared compatible with the stated age of 63 years. The body was cold. Multiple tattoos were present on the torso and extremities. Rigor mortis was present and fixed to an equal degree in all extremities. Lividity was present and fixed on the posterior surface of the body except in areas exposed to pressure. The scalp hair was black. The deceased wore a mustache and beard. The irides were brown. The corneae were cloudy. The sclerae and conjunctivae were congested with no petechial hemorrhages. The external nares and oral cavity contained serosanguineous fluid. The teeth were natural with the upper teeth capped in yellow metal. Examination of the neck revealed no evidence of injury. The chest was unremarkable. No evidence of injury of the ribs or the sternum was evident externally. The abdomen was flat with no scars or injuries noted. The external genitalia were that of a normal adult male. The lower extremities showed a few old irregular scars. There was bilateral ankle edema. The ankles and feet were clean. The toenails were mycotic. A yellow metal ring was present on the right middle finger, and a white metal ring was present on the left 5th finger. The posterior torso was unremarkable.

EVIDENCE OF MEDICAL ATTENTION:

An endotracheal tube was in place. A catheter was present on the left supraclavicular region. EKG electrodes and defibrillator pads were present on the front of the chest. A Foley catheter was in place. Hospital identification bracelets encircled the wrists. Needle puncture sites were present on the backs of the hands.

EVIDENCE OF INJURY:

None.

INTERNAL EXAMINATION

The subcutaneous fat layer measured up to 1/2 inch. No adhesions or abnormal collections of fluid were present in the body cavities. Petechiae were not present on the thoracic organs. All body organs were present in normal anatomic position and diffusely congested. There was no internal evidence of blunt force or penetrating injury to the thoraco-abdominal region.

CARDIOVASCULAR SYSTEM:

The pericardial surfaces were smooth, glistening, and unremarkable. The pericardial sac contained a few milliliters of fluid and there were no adhesions. The heart was enlarged and globoid in configuration. The coronary arteries arose normally, followed the usual distribution. Stents were present in the left anterior descending and left circumflex arteries. Proximal to the stent in the left anterior descending, there was an acute thrombus. The right coronary artery was patent. The myocardium was dark red-brown, with multifocal areas of dense fibrosis. The atrial and ventricular septa were intact. There was mild atherosclerosis involving the aortic valve and abdominal aorta. The vena cava and its major tributaries returned to the heart in the usual distribution and were free of thrombi. The heart weighed 600 grams.

RESPIRATORY SYSTEM:

The pleural surfaces were smooth and glistening. The pulmonary arteries were normally developed, patent and without thrombus or embolus. The upper and lower airways contained an abundant amount of bloody froth. The pulmonary parenchyma was grayish-purple and diffusely congested with no focal lesions. The right lung weighed 1000 grams; the left 900 grams.

NECK:

Examination of the soft tissues of the neck, including strap muscles, thyroid gland, and large vessels, revealed no abnormalities or hemorrhage. The hyoid bone and larynx were intact. The epiglottis and vocal cords were unremarkable.

ALIMENTARY TRACT:

The tongue, esophagus, stomach, small and large bowel, rectum, and anus showed no lesions or abnormalities. The stomach was contracted and empty. The appendix was present.

LIVER AND BILIARY SYSTEM:

The hepatic parenchyma was maroon with no focal lesions. The gallbladder contained a few milliliters of bile. The liver weighed 1820 grams.

GENITOURINARY SYSTEM:

The cortical surfaces were red-brown and granular with a few smooth-walled cysts filled with clear serous fluid. The calyces, pelves and ureters were unremarkable. The urinary bladder contained 25 mL of urine. The bladder mucosa was markedly trabeculated. There was severe nodular hyperplasia of the prostate. The right kidney weighed 160 grams; the left 180 grams.

RETICULOENDOTHELIAL SYSTEM:

The spleen had a smooth, intact capsule covering red-purple, parenchyma. The regional lymph nodes were not enlarged and appeared normal. The spleen weighed 200 grams.

ENDOCRINE AND EXOCRINE SYSTEMS:

The pituitary, thyroid, adrenal glands, and pancreas were free of obvious disease.

MUSCULOSKELETAL SYSTEM:

Muscles were red-brown and within normal development. No bone or joint abnormalities were noted. The cervical, thoracic, and lumbar spine showed no obvious old fractures or other abnormalities.

CENTRAL NERVOUS SYSTEM:

The scalp showed no edema or hemorrhage. The calvarium and base of the skull showed no fractures. The dura and falx cerebri were intact. There was no epidural, subdural or subarachnoid hemorrhage present. The leptomeninges were clear. The cerebral hemispheres were symmetric. The cranial nerves were intact. The circle of Willis and related blood vessels showed moderate to severe calcific atherosclerosis. Sections through the cerebral hemispheres, brain stem and cerebellum revealed no focal lesions. The brain weighed 1420 grams.