



**Commission of
Correction**

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

In the Matter of the Death of

**Jose Fernandez,
an incarcerated individual of the
Cape Vincent Correctional Facility**

March 29, 2022

**To: Honorable Anthony Annucci
Acting Commissioner
NYS Department of Corrections
And Community Supervision
The Harriman State Campus
1220 Washington Avenue
Albany, New York 12226**

Allen Riley
Chairman

Thomas J. Loughren
Commissioner

Yolanda Canty
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 Jose Fernandez who died on December 19, 2019, while an incarcerated individual in the custody of the NYS Department of Corrections and Community Supervision at the Cape Vincent Correctional Facility, the Commission has determined that the following final report be issued.

FINDINGS:

1. Jose Fernandez was a 58-year-old Hispanic male who died on 12/19/2019 of a post-surgical small bowel perforation due to a small bowel obstruction and adhesions while in the custody of the New York State Department of Corrections and Community Supervision (NYS DOCCS). The Medical Review Board has found that there was a failure to adequately complete post-operative assessments by nursing and the physician performing the infirmary discharge. Additionally, the Medical Review Board found that there was an unrecognized technical error in Fernandez's surgery whereby a loop(s) of small bowel was strangulated causing peritonitis. This peritonitis went unrecognized and any evidence of such, plus a detailed examination of the surgical was site was not described the forensic pathologist autopsy report.
2. Fernandez was arrested by the New York City Police Department on 11/24/15 and charged with Burglary 3rd Degree: Illegal Entry with Intent to Commit a Crime and Criminal Possession of Stolen Property. On 2/27/17, Fernandez was convicted and sentenced to seven years in state prison.
3. Fernandez was in the custody of the New York City Department of Corrections (NYC DOCS) prior to his transfer to NYS DOCCS. [REDACTED]
4. On 3/9/17, Fernandez was transferred to the Ulster Reception Center. [REDACTED] While in the reception program, Fernandez had no disciplinary sanctions or unusual incident reports filed.
5. On 5/5/17, Fernandez was transferred to Cape Vincent CF. [REDACTED]
6. [REDACTED]

7. [REDACTED]

8. [REDACTED]

9. [REDACTED] The Medical Review Board finds that Dr. [REDACTED] recognized that Fernandez had an abnormal blood pressure but failed to document any interventions, treatment, or reason for treatment not being provided.

10. [REDACTED]

11. [REDACTED]

12. [REDACTED]

13. [REDACTED]

14. [REDACTED] There was no interpreter sent with Fernandez and Fernandez spoke "a little English, but mostly Spanish". RN [REDACTED] documented that another incarcerated individual in the infirmary spoke Spanish and explained the consent to Fernandez. [REDACTED]

[REDACTED]

15. [REDACTED]

16. [REDACTED]

17. Fernandez was admitted to the infirmary at Cape Vincent CF at 6:00 p.m. [REDACTED]

18. [REDACTED] The

Medical Review Board finds a pattern of inadequate nursing assessment of a post-operative patient which would include a visualization of the testicles, abdominal characteristics, and bowel sounds. The Board opines that a proper exam would have identified area swelling and discomfort indicative of the active small bowel obstruction that was occurring in Fernandez.

19. [REDACTED]

20. [REDACTED]

[REDACTED]

21. [REDACTED] The Medical Review Board finds that MD [REDACTED] failed to perform and document an adequate post-operative assessment including abdominal characteristics and bowel sounds on a patient being discharged from the infirmary. [REDACTED]

[REDACTED]

22. Fernandez had no further contact with health staff on 12/17/20 or on 12/18/20.
23. On 12/18/19, CO B.T. began the 3:00 p.m. to 11:00 p.m. tour on the E-2 Cell Block. There were no entries specific to Fernandez on the 3:00 p.m. to 11:00 p.m. tour.
24. On 12/19/19, CO B.T. remained on duty for the 11:00 p.m. to 7:00 a.m. shift. It was documented in the logbook that at 11:00 p.m. all appeared secure. A count was taken with a census of 50 individuals noted. CO B.T. documented that rounds were conducted hourly through the night with no specific information regarding Fernandez. In a written statement, CO B.T. documented that he noted Fernandez made six or seven trips to the bathroom and return to his cubicle throughout the night.
25. As per the written statement, CO B.T. indicated that Fernandez approached him at approximately 5:30 a.m. and requested that CO B.T. speak with the on-coming officer to make arrangements for Fernandez to be excused from programs for the day. CO B.T. agreed.
26. CO B.T. documented in the written statement that at 6:10 a.m., he heard a noise come from cubicle five which sounded like someone collapsing on the floor. CO B.T. responded to the area and noted Fernandez lying face down on the floor. C.O. B.T. documented that he called for a medical emergency via his radio then he checked Fernandez for a pulse. CO B.T. indicated that he felt a pulse and then heard responding officers' keys, so he went to the front door to open it for a quicker response.
27. CO B.T. documented that he and the responding officers turned Fernandez to face up and at that time, health staff arrived. Responding officers consistently documented that health staff arrived at the scene and began CPR.

28. [REDACTED]

29. [REDACTED]

- [REDACTED]
30. As per the EMS record, the service was called at 6:19 a.m. and EMS arrived at 6:45 a.m. [REDACTED]
31. [REDACTED]
32. The Medical Review Board has found that there was a technical error in Fernandez's surgery at SUNY Upstate Medical Center whereby a loop(s) of small bowel were pinched and strangulated causing an acute peritonitis. The signs and symptoms of this were not recognized by the attending medical staff at Cape Vincent CF per the cited lapses in physical assessments. Additionally, the Medical Review Board also found there was a lack of detailed examination of Fernandez's surgical site by the attending forensic pathologist as obvious post procedure findings, such as placement of surgical mesh, were not described in the report.

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 Fernandez at Cape Vincent CF with a focus on:

1. The failure by Dr. [REDACTED] to address Fernandez's documented hypertension on 3/27/19.
2. The inadequate post-operative nursing assessments while Fernandez was admitted to the infirmary.
3. Failure of Dr. [REDACTED] to conduct and document an adequate post-operative assessment on a patient being discharged from infirmary care.

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

In a response to the Commission's preliminary report dated 1/19/22, DOCCS Deputy Commissioner of Health Services indicated that the requested reviews were completed with comprehensive corrective action(s) taken.

TO THE JEFFERSON COUNTY MEDICAL EXAMINER:

The Medical Review Board requests a re-review of the anatomical findings on Fernandez as a patient who was three days post-surgery but had no detailed description of his surgical site in the autopsy report.

TO THE CHIEF MEDICAL OFFICER AT SUNY UPSTATE MEDICAL CENTER:

The Medical Review Board requests that the Chief Medical Officer conduct a quality assurance review regarding the surgical procedure and care of Jose Fernandez who died of a small bowel perforation due to a small bowel obstruction three days after surgical repair of inguinal and umbilical hernias.

WITNESS, HONORABLE THOMAS J. LOUGHREN, Commissioner, NYS Commission of Correction, Alfred E. Smith State Office Building, 80 South Swan Street, 12th Floor, in the City of Albany, New York 12210 on this 29th day of March, 2022.

A handwritten signature in cursive script, reading "Thomas J. Loughren", written over a horizontal line.

Thomas J. Loughren
Commissioner & Chair
Medical Review Board

TJL:ET:jdb
2019-M-0132
March 2022

cc: Dr. Carol Moores, Acting Deputy Commissioner, Chief Medical Officer
Bryan Hilton, Assistant Commissioner for Mental Health
Superintendent Elizabeth O'Meara, Cape Vincent CF