NEW YORK STATE | Commission of Correction

Final Report of the New York State Commission of Correction:

In the Matter of the Special Investigation into the Care and Treatment Provided to

Ferdy Jacinto-Martinez, an incarcerated individual of the Rockland County Jail

April 26, 2022

To: Sheriff Louis Falco III
Rockland County Sheriff's Office
55 New Hempstead Road
New City, New York 10956

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)(e), regarding the care and treatment provided to Ferdy Jacinto-Martinez which occurred while an incarcerated individual in the custody of the Rockland County Sheriff at the Rockland County Jail, the Commission has determined that the following final report be issued.

FINDINGS:

1. Ferdy Jacinto-Martinez was a 36-year-old male who died on 7/25/19 while hospitalized at Englewood Hospital, NJ after being released from the custody of the Rockland County Sheriff at the Rockland County Jail. Jacinto-Martinez died after a physical restraint incident that occurred on 7/23/19 with correction officers who were attempting to move him from a restrain chair to an ambulance gurney. Jacinto-Martinez was hospitalized and on life support after the incident and was released from custody by court order on 7/25/19, prior to his death. The Medical Review Board has found that there was an improper use of force on Jacinto-Martinez whereas he was improperly placed on the ambulance gurney during the restraint with his head pushed forward and compression on his neck that obstructed his circulation and breathing causing a respiratory and then subsequent cardiac arrest. The Medical Review Board also found deficiencies in Jacinto-Martinez's medical care at the jail marked by failures to send him to a hospital when clinically indicated as being needed. The Medical Review Board opines that Jacinto-Martinez's death was a homicide that could have been prevented with proper intervention.

2. Jacinto-Martinez was born in Guatemala. Jacinto-Martinez resided in New York and was single. Jacinto-Martinez's education and employment history were unknown. [redacted].

3. [redacted].

4. [redacted]

5. [redacted].

6. In the instant offense on 7/20/19 at 8:40 p.m., in the Village of Spring Valley, Rockland County, NY, Jacinto-Martinez was arrested by the Spring Valley Village Police Department and was charged with Sexual Abuse 1st Degree: Sexual Contact with Individual Less Than 11 Years Old.

7. Jacinto-Martinez was held in a cell at the Spring Valley Police Department until the evening of 7/21/19 at which point Jacinto-Martinez was escorted to court for arraignment. Jacinto-Martinez was ordered held on bail and was returned to the cell of the police department. Rockland County Sheriff's Office arrived at the Spring Valley Police Department at 7:45 p.m. to transport Jacinto-Martinez to the Rockland County Jail.

8. On 7/21/19 at 8:10 p.m., Jacinto-Martinez entered the Rockland County Jail [redacted] After a review of the Correctional Health Services Triage Screening Form, the Medical Review Board opines that the Rockland County Jail Correctional Health Services Triage Screening Form should include a section for obtaining vital signs.

9. On 7/21/19 at 10:01 p.m., Officer J.P. along with Officer S.V (Spanish translator) saw Jacinto-Martinez in the intake area for the admission process into the Rockland County Jail. Officers J.P. and S.V. completed the initial classification, mental health screening, and suicide prevention screening. Jacinto-Martinez scored a "0" in the initial classification, a "0" in the mental health screening, and a "1" in the suicide prevention screening after answering "yes" to being worried about major problems. Jacinto-Martinez voiced having problems in Guatemala but was not specific as to what the problems were. After Jacinto-Martinez finished the admission process with Officers J.P. and S.V., Jacinto-Martinez went to the intake showers to change into the jail uniform. After showering, Jacinto-Martinez went to the court holding area to wait for the nurse for the initial nursing assessment. During an interview with Commission staff, Officer J.P. reported that Jacinto-Martinez had a Spanish translator due to speaking little to no English. Jacinto-Martinez understood the questions asked by Officer S.V. and answered them appropriately. Jacinto-Martinez did not seem to be under the influence of any drugs or alcohol. Officer J.P. reported that during the admission process, there is three to four feet between himself and the incarcerated individual with a partition that is about three feet high. There was no glass barrier between the upper torso and head of Officer J.P. and Jacinto-Martinez. Officer J.P. reported not smelling any alcohol on Jacinto-Martinez's breath during the admission process. Officer J.P. stated that Jacinto-Martinez was cooperative through the entire admission process.

10. [redacted]

[redacted]. The Medical Review Board opines that RN [redacted] should have updated the facility's Physician regarding Jacinto-Martinez's increased blood pressure and history of drinking on the weekends and Jacinto-Martinez should have been started on the Clinical Institute Withdrawal Assessment (CIWA) protocol.

11. [redacted] The Medical Review Board opines that if an incarcerated individual (II) refuses to sign the refusal of treatment form, it should be documented on the form that the II refused to sign the form. The form should then be signed by the staff that witnessed the incarcerated individual's refusal to sign the form and the refusal of treatment.

12. [redacted]. The Medical Review Board opines that Jacinto-Martinez should have been sent out to the hospital for an evaluation of hypertensive crisis at that time. Along with the dangerously elevated blood pressure, Jacinto-Martinez had a new complaint of anxiety. A hospital evaluation at this time may have prevented the death of Jacinto-Martinez.

13. [redacted]

14. [redacted]

[redacted]. The Medical Review Board opines that the failure of the first-line interventions for hypertension should have indicated that Jacinto-Martinez needed to be evaluated at a hospital. Along with the dangerously elevated blood pressure, Jacinto-Martinez was described as being very anxious.

15. [redacted] The Medical Review Board opines that RN [redacted]. should have gone to Jacinto-Martinez's cell to check on the status of Jacinto-Martinez, who was in a hypertensive crisis and refusing to go to medical.

16. On 7/23/19 at 12:11 a.m., video recording of the intake housing area showed Officer R.N. getting up from the desk and walking over to cell #5 that housed Jacinto-Martinez. During an interview with Commission staff, Officer R.N. reported hearing Jacinto-Martinez making sounds that prompted Officer R.N. to go to Jacinto-Martinez's cell. Officer R.N. stated knowing a few words in Spanish and asked Jacinto-Martinez "are you ok"? Officer R.N. stated that Jacinto-Martinez placed his hand over his chest area. Officer R.N. tried asking Jacinto-Martinez what was going on, but Jacinto-Martinez did not understand. Officer R.N. asked Officer F.C. to call medical to evaluate Jacinto-Martinez.

17. On 7/23/19 at 12:14 a.m., Officers M.S. and B.S. entered intake housing to escort Jacinto-Martinez to medical. Control opened Jacinto-Martinez's cell door and Jacinto-Martinez came out of the cell. Officers M.S. and B.S. motioned to Jacinto-Martinez to walk towards the back-hallway door that led to medical. Jacinto-Martinez ignored the officers' gestures and walked directly across the hall to the opposite side of cell # 5 and stood with his back against the wall. Officers M.S. and B.S. were trying to explain to Jacinto-Martinez that they were there to escort him to medical, but Jacinto-Martinez did not seem to understand them. Sergeant (Sgt.). W.C. entered the intake housing to assist with Jacinto-Martinez and called for Officer M.M. to report to intake housing to translate in Spanish for Jacinto-Martinez. During an interview with Commission staff, Officer M.M. stated that upon arriving to the intake housing, Jacinto-Martinez's behavior was frantic and very erratic. Officer M.M. asked Jacinto-Martinez in Spanish what the problem was, and Jacinto-Martinez responded not feeling good in the chest. Officer M.M. relayed to Sgt. W.C. that Jacinto-Martinez did not feel well in the chest. Sgt. W.C. told the officers to take Jacinto-Martinez to medical. Officer M.M. explained to Jacinto-Martinez that the officers were going to take Jacinto-Martinez to medical. Jacinto-Martinez told Officer M.M. that he did not want to go to medical and then started talking in Spanish and not making any sense. Additional officers entered the intake housing through the back door and Officer M.M. told Jacinto-Martinez to follow them to medical. Jacinto-Martinez responded, "no, no, no, no". Officer M.M. pointed to the front door for Jacinto-Martinez to go to medical and Jacinto-Martinez responded, "no, no. no. no", and began to run away from the officers. The housing area video recording showed Martinez walking back towards cell #5 and grabbing the cell door and crouching down. At that time, officers were approaching Jacinto-Martinez to secure him. Sgt W.C. and another officer struggled to put Martinez on the floor and force was used to contain Jacinto-Martinez on the floor to apply the handcuffs. The officers escorted Jacinto-Martinez from the intake housing to court holding with resistance and spitting from Jacinto-Martinez. Once in court holding, Sgt. W.C. applied a spit mask on Jacinto-Martinez and Jacinto-Martinez

was secured in the restraint chair at 12:30 a.m. and medical was notified.

18. [redacted] The Medical Review Board opines that the on-call jail physician, after receiving multiple reports on Jacinto-Martinez's condition should have responded to the jail to assess the patient or ordered that he be taken to a hospital for an examination by a physician.

19. On 7/23/19 at 1:11a.m., video recording of court holding showed RN [redacted] returning to intake. RN [redacted] did not enter court holding to check Jacinto-Martinez's circulation while in the restraint chair. RN [redacted] remained in the intake hallway and looked at Jacinto-Martinez through the court holding window. RN [redacted] appeared to attempt to communicate with Jacinto-Martinez through the window with hand gestures. RN [redacted] left the intake area at 1:12 a.m. [redacted] The Medical Review Board has found that RN [redacted] falsified a nursing progress note indicating that an assessment of circulation was completed at both 1:00 a.m. and 1:15 a.m.

20. [redacted] Video recording showed Jacinto-Martinez occasionally making head, wrist, and leg movements. Jacinto-Martinez appeared calm at that time.

21. On 7/23/19 at 1:47 a.m., video recording showed Jacinto-Martinez exhibiting increased hand, leg, and head movements with increased restlessness. A review of the video recording did not show medical returning to court holding to check Jacinto-Martinez's circulation. [redacted] The Medical Review Board has found that RN [redacted] falsified a nursing progress note indicating that an assessment of circulation was completed at 1:45 a.m.

22. On 7/23/19 at 2:00 a.m., video recording showed RN [redacted] returning to intake. RN [redacted] did not enter court holding to check Jacinto-Martinez's circulation while he was in the restraint chair. RN [redacted] remained in the intake hallway and looked at Jacinto-Martinez through the court holding window. RN [redacted] made a hand gesture to Jacinto-Martinez and then left court holding at 2:01 a.m. Video recording showed Jacinto-Martinez making increased wrists movements forward, backward, and side to side in the restraints along with head and shoulder movements from side to side. Jacinto-Martinez appeared to have increased restlessness during this time that went overlooked due to RN [redacted].'s failure to enter the court holding room and assess Jacinto-Martinez's restraints and

condition at that time.

23. On 7/23/19, video recording from 2:01 a.m. through 2:34 a.m. did not show medical entering court holding to assess the restraints on Jacinto-Martinez for circulation. A review of the medical documentation does not indicate that a 15-minute restraint check was done at 2:15 a.m.

In a response dated 3/21/22 to the Commission's preliminary report, the Rockland CJ Administration indicated that the facility nursing staff was in compliance with policy 1600-012-00 Prisoner Restraint Chair which states "Medical staff will review the continued retention of the inmate in the restraint chair and will physically check the restraints a minimum of every hour or upon the request of correctional staff". The Commission acknowledges this but notes that during the investigation, Commission staff was provided with Correctional Health Services Policy J-G-01 Restrain and Seclusion which states: "12. Health staff will initiate health monitoring of the restrained inmate every 15 minutes for as long as the inmate is restrained. If the health of the inmate is at risk, it is immediately communicated to the appropriate custody staff."

24. On 7/23/19 at 2:25 a.m., Sgt. W.C., Officer M.M., and two other officers enter court holding. During an interview with Commission staff, Officer M.M. stated that they entered court holding to take Jacinto-Martinez out of the restraint chair to change him into a suicide prevention suit. Officer M.M. stated that Jacinto-Martinez began to flail forcefully once the restraints were released and Jacinto-Martinez was talking about his brother and then began speaking "gibberish" and not making any sense. Jacinto-Martinez was secured back in the restraint chair and was not changed into a suicide prevention suit. Medical was called to court holding to check on Jacinto-Martinez.

25. On 7/23/19 at 2:35 a.m., RN [redacted] and RN [redacted] entered court holding and checked the left and right wrist restraints on Jacinto-Martinez. Video recording showed Sgt. W.C. and Sgt. J.A. loosening the wrist restraints. The bilateral lower restraints were not checked by medical. [redacted] Officer M.M. told Jacinto-Martinez about the trip to the hospital and Jacinto-Martinez replied "no, I don't want to go" and then started talking about his brother and then started speaking "gibberish" again. Video recording showed that Jacinto-Martinez seemed calmer once being secured back in the restraint chair.

26. A review of the video recording from the court holding area by the Commission revealed the following:
3:01 a.m., Rockland Paramedics arrived at intake.
3:02 a.m., RN [redacted] and RN [redacted] arrived at intake and gave the paramedics a report [redacted]
3:03 a.m., Sgt. W.C. and the two paramedics enter court holding. The paramedics assess Jacinto-Martinez. [redacted] Officer J.L. told Jacinto-Martinez in Spanish that he

would be going to the hospital.

3:08 a.m., two Emergency Medical Technicians (EMTs) from New City Volunteer Ambulance Corps arrived in intake.

3:09 a.m., one paramedic exits court holding.

3:10 a.m., the EMTs enter court holding with a gurney and lower the gurney. Sgt. W.C. has all non-security staff exit court holding and wait in the intake hallway while security transferred Jacinto-Martinez from the restraint chair to the gurney.

3:11 a.m., Sgt W.C. placed ankle shackles on Jacinto-Martinez and Jacinto-Martinez exhibited increased agitation with moving both legs and attempting to kick.

3:12 a.m., Officer J.L. placed two hands on Jacinto-Martinez's forehead and applied pressure to hold Jacinto-Martinez's head back securely against the headrest of the restraint chair. Once the leg shackles were applied, Sgt. W.C., with much resistance from Jacinto-Martinez, removed the right wrist restraint. Officer J.L. removed both hands from Jacinto-Martinez's forehead and positioned himself directly behind Jacinto-Martinez in the restraint chair and applied a hypoglossal hold for 45 seconds that appeared to stop Jacinto-Martinez from resisting.

3:13 a.m., Jacinto-Martinez's right hand was released from the wrist restraint and Sgt. C.W. attempted to place the right arm behind Jacinto-Martinez while releasing the shoulder straps. Sgt. W.C. releases the shoulder restraint from Jacinto-Martinez and Officer J.L. released the hypoglossal hold on Jacinto-Martinez.

3:14 a.m. With much resistance, Jacinto-Martinez's wrists were secured behind his back in the handcuffs. Officer J.L. explained to Jacinto-Martinez in Spanish that he would be moving from the chair to the gurney and Jacinto-Martinez replied that he understood.

3:16 a.m. Jacinto-Martinez was lifted out of the restraint chair to a standing position and walked to the gurney by six officers. Jacinto-Martinez lunged forward and began to resist the officers and Jacinto-Martinez was lifted by the six officers and was forcefully put on the gurney. A seventh officer joined to help restrain Jacinto-Martinez's legs to the gurney.

After reviewing the video recording of the transfer of Jacinto-Martinez from the restraint chair to the gurney, the Medical Review Board opines that the head of the gurney was placed in a high fowlers position that caused an obstruction of Jacinto-Martinez's airway as he was held down by seven security staff during the struggle to secure him to the gurney. Jacinto-Martinez was supine on the gurney that was in high fowler's position with both legs hanging down from the knee off of the foot of the gurney, while Jacinto-Martinez's head was awkwardly positioned on the gurney being pushed forward to his chest while being held down where the bottom and the back support of the gurney meet. During an interview with Commission staff, Officer C.M. stated that the spit mask was falling off and Jacinto-Martinez attempted to bite Sgt. W.C. Officer C.M. then stated that he restrained Jacinto-Martinez's head down on the stretcher by using a mandibular angle pressure. Video recording showed Jacinto-Martinez's head was turned to the right side and held down on the mattress of the gurney by Officer C.M. for 22 seconds. Officer C.M. stated that he gained control of Jacinto-Martinez and that Jacinto-Martinez was not able to bite Sgt. W.C. before being lifted by the seven officers onto the gurney that was still in the high fowler's position. Officer C.M. continued to hold Jacinto-Martinez's head down on the mattress with force for 25 seconds until he was secured onto the gurney with the straps applied and fastened.

3:17 a.m. Jacinto-Martinez was secured on the gurney and six of the officers back away from the gurney. Officer C.M. continues to hold Jacinto-Martinez's head down

even though Jacinto-Martinez was no longer struggling at that time.

3:18 a.m. Jacinto-Martinez's feet began to twitch, his eyes opened, and he began moving his head and torso. Three officers went to the gurney and held Jacinto-Martinez's legs. Officer C.M. applied the mandibular angle to gain control of Jacinto-Martinez. Jacinto-Martinez began to struggle by moving his torso and feet, and then he stopped moving completely. Officer C.M. released the head hold and mandibular angle as Sgt. W.C. applied a spit mask.

3:19 a.m. Sgt. W.C. opened the court holding door and the EMT entered and checked Jacinto-Martinez's carotid for a pulse. The paramedics enter court holding and the EMT removed a bag from behind the head of the gurney and the head of the gurney was lowered.

3:20 a.m. The paramedic was standing over Jacinto-Martinez and due to the angle of the video recording, it was not clear as to what the paramedic was doing. [redacted]

3:21 a.m. The EMT placed an oxygen mask on Jacinto-Martinez over the spit mask that had a plastic film across the mouthpiece of the spit mask. The paramedic checked for a carotid pulse and the straps were removed from around Jacinto-Martinez and he was moved up on the gurney.

3:22 a.m. The paramedic removed the oxygen and spit masks from Jacinto-Martinez and a bag valve mask was applied. Electrocardiogram leads were applied.

3:23 a.m. The paramedic initiated Cardiopulmonary Resuscitation (CPR).

3:24 a.m. The paramedics and EMTs exit court holding with CPR in progress [redacted].

27. Jacinto-Martinez died on July 25, 2019, in Englewood Hospital, NJ, hours after a Judge ordered his release from the custody of the Rockland County Sheriff.

28. A review of the incident, medical information, and local EMS protocols by the Medical Review Board revealed that Jacinto-Martinez's use of force and restraint that was used to place him on the ambulance gurney could have been avoided. The 2017 NYS EMS Collaborative Protocols #2-4 Agitated Patients, allows on standing order for paramedics to administer from 2.5 mg to 10 mg of Midazolam for agitated and potentially violent patients. There was no documentation from Rockland Paramedics that this protocol was considered or consulted on with a medical control physician. Jacinto-Martinez, who was securely placed in a restraint chair at the time of EMS's arrival, could have safely been administered the sedating medication intramuscularly prior to being released and moved to the gurney and could have possibly lessened the need for any use of force. Additionally, the Medical Review Board has found that the transporting EMS agency, New City Volunteer Ambulance Corps, had a responsibility to inform and advise the Rockland CJ officers of how Jacinto-Martinez needed to be safely placed on their gurney for transport to the hospital.

ACTIONS REQUIRED:

TO THE OFFICE OF SHERIFF OF ROCKLAND COUNTY:

The Sheriff shall conduct a review of use of force policies and techniques to assure that restraint positions involving compression of the neck and chest are avoided so as to prevent any interference with a subject's breathing.

In a response dated March 21, 2022 to the Commission's preliminary report Rockland County Jail administration indicated that a review of the policies and procedures would be conducted. The Jail Administration indicated that all use of force policies and techniques taught and used were previously submitted and approved by the Commission. The Commission notes however that all responsibility for training and review of training curriculum was removed from the Commission's purview in October 2009 and was placed under the NYS Division of Criminal Justice Services, Office of Public Safety.

TO THE MEDICAL DIRECTOR OF WELLPATH MEDICAL:

1. The Medical Director shall arrange for a peer review of the medical care provided to Jacinto-Martinez at the Rockland CJ with a focus on why Jacinto-Martinez's history of drinking alcohol, repeated elevated blood pressures, increasing anxiety, hallucinations, agitation, and aggression went unrecognized and unevaluated as a sign of underlying alcohol withdrawal.

2. The Medical Director shall conduct an investigation into why RN [redacted] failed to update the facility Physician as to Jacinto-Martinez's increased blood pressure and history of drinking on the weekends and why Jacinto-Martinez was not started on the Clinical Institute Withdrawal Assessment protocol.

3. The Medical Director shall conduct an investigation into why RN [redacted] did not go to Jacinto-Martinez's cell to check on the status of Jacinto-Martinez, who was in a hypertensive crisis and refusing to go to medical.

4. The Medical Director shall conduct an investigation into why the refusal of treatment forms for Jacinto-Martinez were not filled out and signed appropriately by the staff that witnessed the refusals.

5. The Medical Director shall conduct an investigation into why RN [redacted] falsified documentation pertaining to the monitoring of Jacinto-Martinez's blood circulation while in the restraint chair when video recording does not support the documented observation.

6. The Medical Director shall conduct a peer review with the jail physician regarding why after multiple reports of hypertension crisis on Jacinto-Martinez, the jail physician did not respond to the facility to exam him or order Jacinto-Martinez to have a physician's examination at a hospital.

A report of the findings and any actions taken shall be provided to the Medical Review Board when completed.

In a response to the Commission's preliminary report, the Executive Medical Director of Wellpath indicated review and response was completed regarding actions required 1 & 6. The

response indicated that there was no initial indication that Jacinto-Martinez was at elevated risk for alcohol withdrawal, that there is no information in the record which indicated that the jail physician knew Jacinto-Martinez was suffering from symptoms of alcohol withdrawal until just prior to the order to transfer him to the hospital, and that the actions of the jail physician were appropriate and within the standard of care, based on the information he received. The Medical Review Board remains affirmed in its opinion of Jacinto-Martinez's medical care and that there were multiple indicators, not limited to unresolved hypertension, that indicated a referral to a hospital was necessary. The Medical Director is also reminded that a jail physician, duly appointed by the county legislature in accordance with Correction Law §501, is the responsible authority over all the incarcerated population healthcare.

In a response dated March 21, 2022 to the Commission's preliminary report Rockland County Jail administration indicated that investigations were being conducted per the actions required in 3, 4, and 5. Rockland County Jail administration indicated that an investigation was being conducted on Action Required 2 but disagreed with the Medical Review Board's findings that the jail physician was not properly notified of clinical findings and that there was no indication that Jacinto-Martinez needed to be placed on alcohol withdrawal monitoring. The Board remains affirmed in its opinion that without a definitive clinical reason for Jacinto-Martinez's elevated blood pressure, a withdrawal monitoring would have been an appropriate preventive measure.

TO THE EXECUTIVE DIRECTOR OF ROCKLAND PARAMEDICS:

The executive director shall conduct a review with the Rockland Paramedics who responded to Jacinto-Martinez on 7/23/19 to ascertain why potentially lifesaving agitated patient treatment protocols were not considered nor consulted on with medical control.

TO THE NYS DEPT. OF HEALTH BUREAU OF EMS:

The Medical Review Board requests that the Bureau of EMS conduct an investigation into the New City Volunteer Ambulance Corps regarding a patient who was improperly placed on their transportation gurney by law enforcement, which was not corrected by the attending EMT's, and to which the patient went into cardiac arrest.

TO THE DEPARTMENT OF EDUCATION, OFFICE OF PROFESSIONAL DISCIPLINE:

The Medical Review Board requests that an investigation be conducted into the professional misconduct of Registered Nurse [redacted] for falsely documenting that assessments of restraints were performed on Jacinto-Martinez when video recording indicates that the nurse did not enter the patient's room.

TO THE CHAIR OF THE ROCKLAND 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 currently designated provider.

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 26th day of April, 2022.

Thomas J. Loughren
Commissioner & Chair
Medical Review Board

TJL:BB:jdb
Special Investigation
April 2022

Cc: Owen Heimer, Chief
NYS Attorney General, Office of Special Investigation