NEW YORK STATE | Commission of Correction

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

## In the Matter of the Death of

## Jose Rivera-Perez, an incarcerated individual of the Chautauqua County Jail

## November 15, 2022

**To: Sheriff James Quattrone**
**Chautauqua County Sheriff's Office**
**15 E. Chautauqua Street**
**P.O. Box 128**
**Mayville, New York 14757**


**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 Rivera-Perez who died on September 7, 2021 , as a result of circumstances which occurred while an incarcerated individual in the custody of the Chautauqua County Sheriff at the Chautauqua County Jail, the Commission has determined that the following final report be issued.

FINDINGS:

1. Jose Louis Rivera-Perez was a 31-year-old Hispanic male who died on 9/7/21 at 4:22 a.m. from a suicidal hanging while in the custody of the Chautauqua County Sheriff at the Chautauqua County Jail. The Medical Review Board has found that there were failures to meet standards of care regarding Rivera-Perez's mental health and psychiatric treatment during his incarceration.

2. Rivera-Perez was born in Ponce, Puerto Rico. Rivera-Perez was raised by his mother and was one of four children in his family. [redacted]. Rivera-Perez was single and had a 12-year-old daughter that he had never met. Rivera-Perez graduated from high school in Puerto Rico and worked as a welder before he came to the United States in 2021. Prior to his incarceration, Rivera-Perez was unemployed and lived with his girlfriend. Rivera-Perez was able to speak both English and Spanish. Rivera-Perez was selective with who he would speak to in English to while incarcerated and at times would claim that he did not speak English at all.

3. Rivera- Perez's criminal history before coming to New York from Puerto-Rico in 2021 is unknown. [redacted]. Rivera spent 36 days in ECP before he was extradited to New York and admitted to Chautauqua County Jail on 4/15/21.

4. On 3/11/21 at 7:30 p.m., Rivera-Perez, while in Dunkirk, NY, stabbed his mother's boyfriend, causing serious physical injury. Rivera-Perez's victim sustained multiple stab wounds to his colon, abdomen, pectoral area, lung, neck and face. These injuries caused the victim to be transported by helicopter to Hamot Medical Center in Pennsylvania for medical treatment. Rivera-Perez fled the scene after stabbing the victim. When police entered the apartment of Rivera-Perez's mother, they noted blood spatter and blood in every room except one bedroom. Rivera-Perez's mother reported that Rivera-Perez was a getting a drink in the kitchen and her boyfriend, who was laying on the couch in the other room, called Rivera-Perez a "dumbass". Rivera- Perez got a knife and stabbed the victim multiple times. The victim went outside after having been stabbed by Rivera-Perez. Rivera-Perez then went to the kitchen and got another knife and self-inflicted a deep laceration cut to his left hand and then went outside. Rivera-Perez did not say why he cut himself but did state that he needed to go outside after the victim because Rivera-Perez "needed to kill him".

5. At 8:10 p.m., police responded to the Chautauqua County Airport in Dunkirk to meet with the EMS crew. [redacted]. When police asked Rivera-Perez why he stabbed his mother's boyfriend, Rivera-Perez said. "He called me dumbass, I'm not a fucking dumbass, I'll kill him, I stabbed with a knife and I'll kill him". [redacted].

6. On 3/12/21 at 10:19 a.m., Rivera-Perez was taken into custody by Pennsylvania's Erie Police Department (EPD) while at Hamot Medical Center as a fugitive from justice. Rivera-Perez had an active warrant from Dunkirk Police in NY for Aggravated Assault.

7. At 7:58 p.m., Rivera-Perez was brought to Erie County Prison in Pennsylvania by the Erie County Police (ECP). Rivera-Perez was uncooperative and EPD needed help from ECP Officers in order to get Rivera-Perez into the prison. Rivera-Perez was pulling at bandages on both his left and right wrists, intentionally hitting his head on the wall and being defiant with instruction and orders. Rivera-Perez was restrained and calmed down.

8. At 8:11 p.m., Rivera-Perez was admitted to Erie County Prison by Correction Officer (CO) D.N. At 8:20 p.m., CO J.W. informed Lieutenant (Lt.) B.D that Rivera-Perez was in his cell sitting on his bunk bleeding. Rivera-Perez was restrained and placed in a chair so that Licensed Practical Nurse (LPN) [redacted] could assess him. [redacted].

9. [redacted].

10. [redacted].

11. [redacted].

12. [redacted], Rivera-Perez was to be on administrative segregation in a single cell with two officers present due to aggressive behavior.

13. At 3:05 p.m., [redacted], Rivera-Perez began removing his bandages to his right arm. CO Z.W. advised Rivera-Perez to stop multiple times. Rivera-Perez continued to remove the bandage and stiches even after being sprayed with chemical agents by CO Z.W. two times. Rivera-Perez sat on his bed and was losing blood through the wound. [redacted]

14. [redacted].

15. [redacted]

[redacted]

16. On 4/15/21 at 3:09 p.m., Rivera-Perez [redacted] and was released from Erie County Prison's custody to Dunkirk Police Department and was extradited back to New York.

17. On 4/15/21 at 6:15 p.m., Rivera-Perez was admitted to the Chautauqua County Jail by CO L.H. Rivera-Perez scored a 1 for a "YES" answer to having a history of counseling or mental health evaluation and treatment for [redacted] CO L.H. indicated that a supervisor was notified, and a non-emergency mental health referral was made. CO L.H. completed Rivera-Perez's medical questionnaire indicating that Rivera-Perez was alert and oriented and reported a medical history of [redacted]. Rivera-Perez indicated that he was receiving medication for his [redacted]. Rivera-Perez also reported that he was hospitalized the month before in Pennsylvania for a cut on his wrist. Rivera-Perez claimed the cut was not a suicide attempt. Rivera-Perez reported that he did not have a history of suicide attempts. CO L.H. indicated that Rivera-Perez was a medical high risk and had medical special conditions. CO L.H. made a note in Rivera-Perez's floor file that Rivera-Perez had been cooperative with the admission process and that Rivera-Perez was referred to medical and mental health. During an interview with Commission staff, CO L.H. stated that nursing would not typically come down to assess incarcerated individuals (I.I.) in booking unless an I.I. had wounds that needed to be cleaned or some other acute issue that needed to be addressed. CO L.H. told Commission staff that medical and mental health referrals that the officers make when performing their initial medical questionnaire are given to medical or emailed for them to review the next morning. CO L.H. indicated that often nursing was not available due to a lack of coverage on all shifts.

18. [redacted].

19. From 4/18/21 through 6/3/21 per Rivera-Perez's floor file, the officers documented that Rivera-Perez was moved to Pod A cell 9 and then requested a move to cell 11. Rivera-Perez was noted as not standing for count and having towels over his cell window on a

few occasions. On 7/8/21, Rivera-Perez told the CO that he wanted to be placed in protective custody (PC). Rivera-Perez was moved to cell 00 in PC. On 7/9/21, Rivera-Perez refused PC and asked to be sent to B Pod. On 7/19/21 per Rivera-Perez's floor file, he was moved from B pod to BB block on administrative-segregation (Ad-Seg) protective custody. Rivera-Perez requested to stay in Ad-Seg PC when his one-month review came because he said it was safe there. Rivera-Perez remained in Ad-Seg-PC until his death on 9/7/21.

20. [redacted]. A review of Rivera-Perez's chart showed that there were no provider orders section located within the chart. When RN [redacted] was asked by Commission staff where the specific orders could be found in the chart, RN [redacted] stated that they did not have a section at the time the chart was created. RN [redacted] reported to Commission staff that the facility's medical computer system had since been updated and there is currently a tab where the provider orders would be found. [redacted]). During an interview with Commission staff, RN [redacted] was asked if she ever reviewed any of Rivera-Perez's chart from Erie County Prison to which RN [redacted] stated "no". RN [redacted] failed to review Rivera-Perez's clinical history.

21. [redacted] The lack of the documentation of the provider name in the note is a violation of 9 NYCRR §7010.2(j*).*

22. [redacted]ys.

23. [redacted]

24. [redacted]

25. [redacted]. This note was lacking a provider identification, signature or the time Rivera-Perez was seen. It was

unclear who completed the suicide risk assessment on Rivera-Perez. This is the first time Rivera- Perez had a suicide assessment by medical staff since arriving to Chautauqua County jail on 4/15/21.

26 [redacted].

27. [redacted]

28. [redacted]

[redacted]. . The Medical Review Board opines that Rivera-Perez's mental health history and current symptoms should have been referred to Dr. [redacted] urgently for a review after Rivera-Perez was admitted to Chautauqua County Jail.

29. [redacted]

30. [redacted].

31. [redacted].

32. [redacted].

33. [redacted]. The

Medical Review Board finds that standard of psychiatric care was not adequately met with Rivera-Perez. Although the medication change from [redacted] was made to address his urinary retention complaints, there was a failure to schedule a follow up assessment of his psychiatric symptoms and review the medication efficacy. The Medical Review Board also opines that Rivera-Perez's increasing mental health symptoms should have been immediately referred to the psychiatrist for review and consultation.

34. [redacted]

35. [redacted]

[redacted]. The Medical Review Board opines that Rivera-Perez's psychiatric assessment was inadequate and opines that the psychiatric diagnosis made was incorrect due to the failure to properly review the records and account for his history . [redacted]. The Medical Review Board has found that there were significant lapses in the continuity of care pertaining to Rivera-Perez's mental health and psychiatric care and a lack of collaboration of care between the medical and mental health staff. In a matter of approximately five months, Rivera-Perez was diagnosed with Schizoaffective Disorder, Schizophrenia Unspecified, PTSD, and Sleep Disorder Unspecified. Rivera-Perez also had multiple psychiatric medication changes which were all ordered by PA-C [redacted] without any consultation or any assessment by a psychiatrist.

36. [redacted].

37. [redacted]

38. [redacted].

39. [redacted].

40. [redacted]. During an interview with Commission staff, LCSW [redacted] stated that she did not make any chart notes documenting her encounters with Rivera-Perez at the time of their visits on 6/16/21 and 7/14/21. LCSW [redacted] reported to Commission staff that the notes included in Rivera-Perez's chart for 6/16/21 and 7/14/21 were memos that she had typed up recently from memory in response to the Commission's request for mental health documentation. LCSW [redacted] was asked if she ever reviewed any of Rivera-Perez's chart from Erie County Prison to which LCSW [redacted] stated "no". The Medical Review Board has found that LCSW [redacted] failed to properly chart the clinical encounters that occurred with Rivera-Perez in accordance with 9 NYCRR §7010.2(j) and failed to review Rivera-Perez's clinical history. Additionally, the Medical Review Board opines that proper standard of psychiatric care would have had Rivera-Perez scheduled for a psychiatric follow-up between his initial encounter of 6/16/21 and his terminal event on 9/7/21.

41. On 9/7/21 at 3:52 a.m., Sgt. E.C. was working the 11 p.m. to 7:00 a.m. shift and making rounds in the jail. Sgt. E.C. was checking B Block. Sgt. E.C. went by cell 5 which housed Rivera-Perez. Rivera-Perez appeared to be sitting on the floor of his cell with his back against the bars. As Sgt. E.C. moved closer to the cell, he saw that there was a bed sheet tied around Rivera-Perez's neck with the other end tied approximately three to 4 bars up from the floor. Sgt E.C. radioed for assistance and within 10-15 seconds CO D.V. arrived. Rivera-Perez's butt was off the floor a few inches. CO D.V. assisted Sgt. E.C. to lift Rivera-Perez while CO M.F. untied the sheet from the bars. The sheet was untied from River-Perez's neck by CO D.V. Rivera-Perez was lowered to the cell floor. CO D.V. performed a sternal rub with no response and noticed Rivera-Perez did not have a pulse and was not breathing. Sgt. E.C. and CO D.V. immediately started CPR.

CO D.V. did compressions while Sgt. E.C. ran to his office to get oxygen and the first aid kit. CO B.B. and CO K.D. retrieved the AED. Sgt. E.C. arrived back to Rivera-Perez and began using a CPR face mask to give Rivera-Perez breaths while CO D.V. was doing compressions. CO M.F. assisted with CPR. CO M.C., CO A.D. and CO K.D arrived and assisted with chest compressions. The AED was placed on Rivera-Perez by CO D.V. and CO M.C. which advised no shocks to be given. At 3:54 a.m., CO B.B. called Mayville EMS.

42. At 4:10 a.m., EMT [redacted]. arrived and assumed care of Rivera-Perez. [redacted]

ACTIONS REQUIRED:

TO THE CHAUTAUQUA COUNTY JAIL PHYSICIAN:

1. The Jail Physician shall conduct a quality assurance review to ensure that all medical staff complete all medical documentation with the full date and time as well as initials and/or signatures of attending staff in accordance with 9 NYCRR §7010.2(j).

2. The Jail Physician shall conduct a quality assurance review into PA-C [redacted]. the multiple mental health diagnoses and medications prescribed to Rivera-Perez without any consultation with the jail's coordinating Psychiatrist, Dr. [redacted], and why changes to prescribed psychotropics were not reassessed.

3. The Jail Physician shall conduct an investigation into why Rivera-Perez was not immediately referred to psychiatry on 5/5/21 despite having a history of and presenting acute psychiatric symptoms.

4. The Jail Physician shall conduct an investigation into why PA-C [redacted]. did not place Rivera-Perez's on a constant watch on 6/16/21 as opposed to requesting the officer not to leave Rivera-Perez alone until a suicide assessment could be obtained.

5. The Jail Physician shall conduct a quality assurance review with medical and mental health staff to ensure that medical and mental health charts are reviewed, and adequate psychiatric consultations are made for patients with extensive psychiatric histories and high suicidal risk factors when entering the jail.

A report of findings and corrective actions taken shall be provided to the Board upon completion.

*In a response dated 9/15/22 to the Commission's preliminary report, the Chautauqua County Sheriff indicated that all requested reviews were conducted with corrective actions taken.*

TO THE DIRECTOR OF CHAUTAUQUA COUNTY MENTAL HEALTH SERVICES:

1. The Director shall conduct a review regarding patient charting at the Chautauqua CJ to assure compliance with 9 NYCRR §7010.2(j) in that clinical notes are properly made and maintained in the patient record. The Medical Review Board endorses the use of integrated records for corrections-based patients to assure optimal continuity of care.

2. The Director shall conduct a review of the psychiatric evaluations provided to Rivera-Perez with a focus as to why critical clinical information regarding suicide risk was not provided to the psychiatrist to review prior to assessment.

A report of findings and corrective actions taken shall be provided to the Board upon completion.

*In a response dated 9/15/22 to the Commission's preliminary report, the Chautauqua County Sheriff indicated that all requested reviews were conducted with corrective actions taken. Additionally, it was noted that the mental health and medical departments implemented a single electronic health record system as of 9/14/22.*

TO THE CHAIR OF THE CHAUTAUQUA 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 15th day of November, 2022

Thomas J. Loughren
Commissioner & Chair
Medical Review Board

TJL:JW:jdb
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