NEW YORK STATE | Commission of Correction

Final Report of the New York State Commission of Correction:

In the Matter of the Death of

Louis Rivera, 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 Louis Rivera who died on July 26, 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. Louis Arturo Rivera was a 65-year-old male who died at Westfield Memorial Hospital on 7/26/21 at 2:19 a.m. from Acute Gangrenous Cholecystitis, Perforation with localized Peritonitis and Sepsis while in the custody of the Chautauqua County Sheriff's Office at the Chautauqua County Jail. The Medical Review Board has found that there were failures by medical staff to properly assess and provide intervention for Rivera's complaints of abdominal distress heralding clinical deterioration that ultimately lead to his death. Rivera was never seen by a physician during his incarceration despite having significant medical history and unresolved complaints. Additionally, there was a substantial error by correction staff who administered an unauthorized medication to Rivera for gastro-intestinal complaints which delayed the access to a hospital and life-saving surgery Rivera was in need of. The Medical Review Board has found that had Rivera received adequate medical care, had been properly assessed, and had been timely referred to a hospital for treatment, his death could have been prevented.

2. Rivera was born in Chicago, Illinois. Rivera was divorced with no children. Both of Rivera's parents were deceased. A review of Rivera's records did not reveal any information pertaining to Rivera's childhood. Rivera dropped out of high school after completing the 11th grade. River a later obtained his GED in 1974. [redacted]. Rivera was unemployed and a review of his records indicated that Rivera made money from selling drugs. Rivera was survived by one brother and one sister.

3. [redacted]. In the instant offense, Rivera was arrested on 4/23/21 for Criminal Possession Controlled Substance 3rd Degree, Intent to Sell and Criminal Use Drug Paraphernalia 2nd Degree, Scales. Rivera's criminal record was characterized by repeat drug related offense. Rivera admitted guilt and reported that his motive for his crimes were financial gain and to support his own addiction.

4. [redacted]

[redacted].

5. [redacted].

6. On 4/23/21 at 7:27 p.m., Rivera was admitted to the Chautauqua CJ by Correction Officer (CO) K.D. On the medical questionnaire, Rivera answered "YES" to being on medication for [redacted]. Rivera denied having any current mental health treatment and denied ever considering committing suicide. Rivera answered "YES" to [redacted]. Rivera reported that his last [redacted]. The questionnaire value was zero. Rivera was listed as high risk by CO K.D. CO K.D. indicated on the form that medical was notified.

7. [redacted]. Rivera had been admitted to Chautauqua CJ having used heroin and methamphetamines within the last 48 hours and was not assessed for withdrawal or placed on a withdrawal protocol by RN [redacted]. in accordance with 9 NYCRR §7010.1 (b) which states that, *"Prompt screening is essential to identify serious or life-threatening medical conditions requiring immediate evaluation and treatment. Appropriate medical appraisal of inmates is necessary to reduce the risk that a serious physical deficiency or medical emergency will be obscured by drug or alcohol ingestion".* [redacted]. No refusal form was located within Rivera's chart. [redacted]

8. [redacted]. In an interview with Commission staff, RN [redacted]. reported that all mental health referrals made by medical get placed into a folder in the medical office and that mental health staff pick them up. [redacted]

[redacted].

9. [redacted].

10. [redacted].

11. [redacted]. The delayed health assessment and provider review are both a violation of 9 NYCRR §7010.2(b)(1) which

states:
"*Each prisoner shall be examined by a physician licensed to practice in the State of New York or by medical personnel legally authorized to perform such examinations at the time of admission or as soon thereafter as possible, but no later than 14 days after admission."*
Additionally, the Medical Review Board finds that the physical exam by RN A.M. was inadequate for documenting Rivera's findings as being "normal" despite the documented findings of an elevated pulse and blood pressure.

12. [redacted]. During an interview with Commission staff, RN [redacted]. reported that when lab work is completed, the results go directly to PA-C [redacted]. [redacted]. During an interview with Commission staff, PA-C [redacted] acknowledged that the lab work had been missed but could not provide an explanation as to why. [redacted]. The Medical Review Board opines that Rivera's continued complaints of gastrointestinal issues should have prompted a referral to the physician for assessment.

13. [redacted]. PA-C [redacted]. failed to refer Rivera to a physician for a GI consult based on

Rivera's continuous complaints of heartburn that were not improving with medication or diet intervention. [redacted] During an interview with Commission staff, RN [redacted]. and PA-C [redacted]. were asked about the lack of provider orders in Rivera's chart. RN [redacted]. and PA-C [redacted]. both indicated that at the time of Rivera's incarceration, there was not a place in the electronic record for orders to be documented. RN [redacted]. and PA-C [redacted] both reported that currently in the electronic record, there is a tab for physician orders. A printout of the computer orders tab was printed for Commission staff's review during the investigation. A review of the orders printout revealed that there was no indication as to which provider had prescribed the medications listed on Rivera's orders list. RN [redacted]., RN [redacted]. and PA-C [redacted] reported that there are currently two separate electronic medical records being used by medical and mental health. Communication between medical and mental health is challenging due to the two separate systems of communication. The Medical Review Board endorses the use of integrated electronic records for corrections-based patients to assure optimal continuity of care.

14. [redacted]

15. [redacted]

16. [redacted].

17. [redacted].

18. On 7/25/21 at 12:04 p.m., per the housing logbook, Rivera reported to CO A.K. that he felt nauseous and was sweating. CO A.K. notified medical. At 12:20 p.m., per the housing logbook, Rivera went to medical. At 12:32 p.m., Rivera's cell was search by CO A.K. No drugs or other contraband was found in Rivera's cell.

19. [redacted]. The Medical Review Board finds that there was a failure by RN [redacted]. to adequately assess Rivera's complaints of unresolved GI issues dismissingly attributing his signs and symptoms to substance use without any verified indictors of such and ignoring signs and symptoms of extensive peritonitis. The lack of adequate assessment and referral to a physician denied Rivera access to lifesaving surgery which was needed due to an undiagnosed cholecystitis.

20. Per a review of the logbook, at 5:08 p.m., Incarcerated Individual [redacted] reported to CO A.K. that Rivera was feeling nauseous. CO A.K. notified Sgt. F.F. At 5:17 p.m., Sgt. F.F. came on post for an inspection. There was no documentation in the logbook that Sgt. F.F interacted with Rivera. Nor was there any documentation indicating that medical staff were contacted regarding Rivera's continued complaints. At 7:44 p.m., CO A.K. documented that medications were passed. During an interview with Commission staff, CO A.K. reported that it is part of their duties as a unit CO to review the events of the previous shift in the logbook. CO A.K. did document that Rivera was feeling ill and stated to Commission staff if she documents issues in the logbook, she makes sure to report those issues to the oncoming CO at the end of her shift.

21. During an interview with Commission staff, CO A.K. was asked if nursing was on the unit at 7:44 p.m. to pass medications. CO A.K. answered that all medications are passed by

the officers on all shifts. Commission staff confirmed with medical that nursing does not pass any medication while on duty at the Chautauqua County Jail.

22. At 10:55 p.m., CO D.H. came on shift for the 11:00 p.m. to 7:00 a.m. tour. The off going evening shift officer, CO A.K., and the on-coming overnight shift officer, CO D.H., completed a count together. CO D.H. documented that he had reviewed the logbook from the previous shift. During an interview with Commission staff, CO D.H. stated that he did not receive any report from CO A.K. regarding Rivera feeling ill nor did he recalled if any entries were made in the logbook indicating Rivera was not feeling well. The Medical Review Board finds that there was a failure by CO D.H. to properly review the previous shift log information in accordance with the requirements of 9 NYCRR §7003.6(b) Upon assuming responsibilities in an assigned area and following the completion of duties set forth in section 7003.5, review the records maintained pursuant to section 7003.3(j) and subsequent to such review, initial such written records.

23. On 7/26/21 at 1:00 a.m., CO D.H. was making rounds. Rivera called out to CO D.H. and was complaining of heartburn. During an interview with Commission staff, CO D.H. reported that he went to Rivera's Medication Administration Record and saw that Rivera had an order for [redacted] to be given at 6:00 a.m. CO D.H. then reported that he decided to administer 2 [redacted] to Rivera at 1:00 a.m. CO D.H. gave an unauthorized dose of medication at an unauthorized time without any medical provider's order to do so. This was in direct violation of Chautauqua County Sheriff's Office Policy 700.20: Medication Administration and Training Policy. During an interview with Commission staff, CO D.H. reported that he was familiar with the [redacted] and had been taught by nursing that he could administer over the counter (OTC) medications at his discretion. During an interview with Commission staff, CO D.H. was asked where he would document on the Medication Administration Record that he had given a dose of over the counter medications. CO D.H. replied that if he had given a Tylenol, for example, that it would not be documented anywhere as it "was not necessary" to document the over the counter medications. CO D.H. explained that the officers would tell the oncoming shift they had given an over the counter medication and would sometimes email nursing staff to inform them. Commission staff were informed during the investigation that COs are trained to pass medication by nursing staff and other field training Cos, and they are trained to pass medication per the Chautauqua County Sheriff's Office Policy 700.20 Medication Administration and Training. All of the Chautauqua County Jail COs that were interviewed by Commission staff except for CO D.H. reported that a medication is never to be given to an incarcerated individual unless it is clearly stated on the individual's Medication Administration Record and it was at the correct scheduled time to be given. The Medical Review Board finds that CO D.H. acted carelessly, outside his scope of duty, and in direct violation of agency policy and procedure by administering a medication to Rivera that was outside of the prescribed time and that was not authorized by a medical provider. The Medical Review Board further finds that critical time needed to transport Rivera to a hospital for emergency surgery was lost while the officer awaited to see if the wrongfully administered medications would have effect on Rivera.

24. At 1:25 a.m., per CO D.H.'s statement, CO D.H. made it a point to check on Rivera when he made his next round. CO D.H. indicated that Rivera was sitting in a tripod position, struggling to breath. Rivera reported to CO D.H. that he was feeling "worse". CO D.H. saw that Rivera was having trouble breathing and called Sgt. E.C.

25. At 1:30 a.m., Sgt. E.C. went to A-Pod immediately and spoke with Rivera. During an interview with Commission staff, Sgt. E.C. stated that when Rivera was talking, he could hear that there was something in Rivera's lungs. Rivera's bunk mate, Incarcerated Individual S.T., did most of the talking for Rivera because Rivera was having difficulty breathing. Sgt E.C told Commission staff that he knew right away that Rivera was in trouble and called an ambulance.

26. At 1:40 a.m., Sgt. E.C. ordered CO M.C. to get a wheelchair so they could transport Rivera to booking in order to meet the ambulance crew as Sgt. E.C. did not want Rivera walking to booking. During an interview with Commission staff, CO M.C. indicated that he remembered Rivera had a gurgling wheeze with each breath.

27. At 1:45 a.m., Mayville Rescue EMS arrived and prepared Rivera for transport to Westfield Memorial Hospital. CO J.H. rode in the ambulance with Rivera and observed Rivera vomit two bags of black fluid on the way to the hospital.

28. [redacted].

29. [redacted]

30. [redacted]

[redacted]. The Medical Review Board has found that the post-

mortem findings Acute Gangrenous Cholecystitis with Perforation, Sepsis, and Acute Tubular Injury indicated that Rivera's condition had been developing into an acute state over the course of multiple days and was in need of emergency surgical intervention.

ACTIONS REQUIRED**:**

TO THE OFFICE OF THE CHAUTAUQUA COUNTY SHERIFF:

1. The Sheriff shall conduct a review and retraining with CO D.H. who failed to follow Chautauqua County Sheriff's Office Policy 700.20: Medication Administration and Training Policy by delivering unauthorized mediations. Administrative action should be taken if determined to be appropriate.

2. The Sheriff shall review and retrain staff on the importance of immediately alerting the supervisor on duty when an incarcerated individual is in need of medical care.

3. The Sheriff shall review with staff the procedures required to assure that officers who are assuming responsibilities in an assigned facility area are properly reviewing the previous shift's information as per 9 NYCRR §7003.6(b).

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

In a response dated 9/15/22 to the Commission's preliminary report, the Chautauqua County Sheriff indicated the requested reviews were completed with corrective actions taken including, in-service training for staff and issuing of special orders.

TO THE CHAUTAUQUA COUNTY JAIL PHYSICIAN:

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

2. The Jail Physician shall conduct an investigation and review pertaining to the reason Rivera's initial health exam by RN [redacted]. was not completed until 5/11/21 and not reviewed by PA-C A.S. until 7/2/21, a violation of 9 NYCRR §7010.2(b)..

3. The Jail Physician shall conduct an investigation and review regarding the reason Rivera was not assessed for withdrawal or placed on withdrawal protocol by RN [redacted]. after admitting using [redacted] within the last 48 hours prior to his admission, a violation of 9 NYCRR §7010.4(b). The Jail Physician shall conduct an investigation and review regarding the reason a refusal form could not be located in Rivera's records pertaining to Rivera's refusal on 4/24/21 to be monitored for withdraw symptoms.

4. The Jail Physician shall conduct an investigation and review regarding the reason Rivera's continued complaints of heart burn from 4/23/21 until his death were not adequately addressed by medical staff. RN [redacted].'s failure to adequately assess Rivera's

complaints of the unresolved GI issues by dismissingly attributing his signs and symptoms to substance use without any verification.

5. The Jail Physician shall conduct a quality assurance review pertaining to the adequacy of patient charting at the Chautauqua CJ to assure that clinical notes are properly made and maintained within the patient record. The Medical Review Board endorses the use of integrated electronic records for corrections-based patients to assure optimal continuity of care.

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

In a response dated 9/15/22 to the Commission's preliminary report, the Chautauqua County Sheriff indicated the requested reviews were completed with corrective actions taken including policy and procedure revisions and training on electronic health record documentation.

TO THE OFFICE OF THE CHAUTAUQUA COUNTY SHERIFF AND TO THE CHAUTAUQUA COUNTY JAIL PHYSICIAN:

Arrangements shall be made to obtain a third-party medical review regarding the healthcare provided to Rivera and the physician supervision of the physician assistant with focused reviews on:
• PA-C [redacted].'s failure to assure that the ordered lab work was completed and failure to submit a referral for a physician consult for Rivera's unresolved gastrointestinal complaints.
• The lack of a documented physical examination of Rivera by PA-C [redacted]. prior to 5/16/21 despite Rivera having a significant medical history.
•The overall supervision of the healthcare staff, physician assistants and nursing staff, by the appointed jail physician.

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

In a response dated 9/15/22 to the Commission's preliminary report, the Chautauqua County Sheriff indicated the requested reviews were completed with corrective actions taken including policy and procedure changes.

TO THE DIRECTOR OF CHAUTAUQUA COUNTY MENTAL HEALTH SERVICES:

1. The Director shall conduct a quality assurance review pertaining patient charting at the Chautauqua CJ to assure that clinical notes are properly made and maintained in the patient record. The Medical Review Board endorses the use of integrated electronic records for corrections-based patients to assure optimal continuity of care.

2. The Director shall conduct an investigation and review regarding the reason mental health staff on multiple occasions did not appropriately address sick calls slips submitted by Rivera, the reason that Rivera's suicidality was not addressed or followed up on, and the reason why Rivera was not seen by mental health staff from 4/23/21 until 6/2/21.

3. The Director shall conduct an investigation and review regarding mental health staff's

continued delay in addressing Rivera's continually requests for a drug treatment program.

4. The Director shall conduct an investigation and review pertaining to RN [redacted]. listing [redacted] on Rivera's medication list on 5/11/21 when Rivera was not prescribed these medications.

In a response dated 9/15/22 to the Commission's preliminary report, the Chautauqua County Sheriff indicated the requested reviews were completed with corrective actions taken including implementing a single electronic health record system, revision to standard operating procedures, and staff re-training.

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

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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