NEW YORK STATE | Commission of Correction

Final Report of the New York State Commission of Correction:

In the Matter of the Death of

Luis Ramos, an incarcerated individual of the Westchester County Department of Correction

June 25, 2024

To: Commissioner Joseph Spano
Westchester Department of Correction
PO Box 389
Valhalla, New York 10595

Allen Riley
Chairman

Yolanda Canty
Commissioner

Elizabeth Gaynes
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 Luis Ramos, who died on March 17, 2023 , as a result of circumstances which occurred while an incarcerated individual in the custody of the Westchester County Department of Correction at the Westchester County Jail, the Commission has determined that the following final report be issued.

FINDINGS:

1. Luis Ramos was a 29-year-old male who died on 3/17/23 from a suicidal asphyxiation while in the custody of the Westchester County Department of Correction (WCDOC). The Medical Review Board has found that Ramos was discharged from mental health services after refusing prescribed medications without any clinical follow up. Additionally, the Board has found that Ramos was found with significant postmortem changes noted by the medical staff and ambulance personnel, indicating that his death had occurred hours before discovery.

2. [redacted] On November 1, 2021, a warrant was issued for Ramos for two counts of Murder. Ramos was accused of killing two women in Yonkers, NY [redacted]. Ramos then fled the area to Arizona. On December 16, 2021, Ramos was arrested by the U.S. Marshalls on a fugitive from justice warrant. On December 23, 2021, Ramos was returned to New York and arraigned on two counts of Murder 1st Degree Murder: Intentional, two counts of Robbery 1st Degree, Burglary, and Criminal Possession of a Weapon 4th Degree.

3. [redacted].

4. On 12/14/21, Ramos was received at the Westchester County DOC from Grady County Jail in Oklahoma. [redacted]

5. On 12/15/21, Ramos was removed from WCDOC by the U.S. Marshall's. On 12/16/21, Ramos was recommitted to the WCDOC after an appearance in Yonkers Court. The suicide screen was completed by an officer and Ramos answered 'no' to all questions. Ramos was seen for a medical screening. Ramos denied having any medical conditions or having any mental health concerns.

6. [redacted]

[redacted]

7. [redacted]

8. [redacted]

9. [redacted].

10. [redacted]

11. [redacted]

12. [redacted].

13. [redacted].

14. [redacted]

15. [redacted]

16. [redacted]e.

17. [redacted]

18. [redacted]

19. [redacted]

20. [redacted]

21. [redacted]

22. [redacted].

23. [redacted]

24. [redacted]

25. [redacted]

26. [redacted]

27. [redacted]H.

28. [redacted]

29. [redacted]

30. [redacted]

31. [redacted].

32. [redacted] The Medical Review Board opines that as Ramos was still symptomatic, further counseling, alternative therapy options, and follow-up should have been considered by the psychiatric provider prior to discontinuing Ramos from mental health services.

33. [redacted].

34. [redacted]

35. [redacted].

36. [redacted]

37. [redacted].

38. [redacted]

39. On 2/2/23, Ramos reported to the housing officer that he could not stay “there”. Ramos’s face was red and when asked if he had been hit Ramos stated, “I’m not saying that.” A review of the recorded camera footage of the housing area showed that Ramos had been assaulted by another incarcerated individual. Ramos refused medical attention and refused to make a statement to WDOC staff regarding who had assaulted him.

40. [redacted]

41. [redacted]

42. On 3/9/23, Ramos went to court and was to remain remanded to WDOC. Ramos was to reappear in court on 4/27/23. Ramos was seen by the officer on his court return for a re-book risk assessment and answered 'no' to all questions. Ramos denied having any suicidal intentions. Ramos responded "no" when asked if he had been sentenced.

43. On 3/17/23 at 7:00 a.m., Corrections Officer (CO) I.A. assumed the housing post on unit 2SE. CO I.A. completed a supervisory tour at 7:00 a.m. and 7:30 a.m. At approximately 7:45 a.m., CO I.A. unlocked the housing unit for breakfast. Incarcerated individual J.B. informed CO I.A. that he should check cell 28. CO I.A. went to cell 28 and found Ramos unresponsive with a blue sheet covering him. When the sheet was removed, CO I.A. noted that Ramos had the sheet tied tightly around his neck and a plastic bag over his head. At 7:46 a.m., CO I.A. called a signal three and a medical response. CO I.A. removed the bag and the sheet. At 7:47 a.m., NP arrived [redacted] At 7:51 a.m., Emergency Medical Services (EMS) was activated. [redacted] . At 8:09 a.m., EMS arrived [redacted]

44. The Medical Review Board finds that the postmortem changes documented by medical personnel and EMS, including lividity and rigor mortis to the jaw, indicate that Ramos had been deceased for more than two hours prior to being discovered by corrections officers. With a sheet reportedly covering Ramos' head and covering the ligature and asphyxiant, the Board finds that the individual's presence was not properly verified during supervisory visits in accordance with the requirements of 9 §7003.3(c) which states:

"*At a minimum, general supervision shall be maintained in all facility housing areas when all prisoners are secured in their individual housing units*."

and is further defined by 9 NYCRR §7003.2(a)(1) which states:

"*a personal visual observation of each individual prisoner by facility staff responsible for the care and custody of such prisoners to monitor their presence and proper conduct*"

ACTIONS REQUIRED:

TO THE COMMISSIONER OF WESTCHESTER COUNTY DEPARTMENT OF CORRECTION:

The Commissioner shall take notice of the Medical Review Boards finding of the presence of postmortem changes as observed by the nursing staff and Emergency Medical Services staff and initiate an investigation into the conduct of the officer who was assigned to supervise the housing area. Administrative action should be taken if the individual is found to be in violation of department directives.

In a response dated May 9, 2024 to the Commission's preliminary report, Westchester DOC indicated that the requested investigation was completed with findings that there were no violations department directives by staff.

TO THE DIRECTOR OF MENTAL HEALTH SERVICES AT WESTCHESTER COUNTY DEPARTMENT OF CORRECTION:

The Medical Review Board requests that a quality assurance review be completed regarding Ramos' mental health and psychiatric care with a focus on why alternative therapy options and further follow-up were not considered for a patient who was still presenting with symptoms.

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

In a response dated 5/9/2024 to the Commission's preliminary report, Wellpath Inc. indicated that the requested review was completed with quality improvement actions taken.

WITNESS, HONORABLE YOLANDA CANTY, 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 25th day of June 2024.

Yolanda Canty
Commissioner
Commission of Correction

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June 25, 2024