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

Sean Riordan, an incarcerated individual of the Erie County Holding Center

September 25, 2024

To: Sheriff John C. Garcia
Erie County Sheriff's Office
10 Delaware Avenue
Buffalo, New York 14202

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)(e), regarding the care and treatment provided to Sean Riordan, which occurred while an incarcerated individual in the custody of the Erie County Sheriff at the Erie County Holding Center, the Commission has determined that the following final report be issued.

FINDINGS:

1. Sean Riordan was a 30-year-old male who died at Buffalo General Hospital on 6/14/22 from complications of chronic Ethanolism after being released from the custody of the Erie County Sheriff. Riordan began showing symptoms of alcohol withdrawal after being remanded on 6/2/22 to the custody of the Erie County Sheriff at the Erie County Holding Center (ECHC). The Medical Review Board has found that there were serious deficiencies and absences in Riordan's medical care during his incarceration that may have contributed to his death. The Medical Review Board opines that had established medical policy and procedures been properly followed and had Riordan been promptly sent to a hospital for treatment, his death may have been preventable.

2. Riordan was born in Buffalo, NY. Riordan was survived by his mother and three siblings. Riordan received his high school diploma and had worked for Northeast Builders. There was no further demographic or social history available to the Commission for Riordan.

3. [redacted]

4. [redacted].

5. [redacted]

6. On 6/2/22, Riordan was arrested by the Town of Tonawanda Police for having two outstanding warrants from the Town of Tonawanda. Riordan was arraigned in the Town of Tonawanda Court and remanded to the Erie County Holding Center with a bail amount of $5,000 on one case and a $1.00 on the second case. Riordan also had active warrants in Amherst, NY and the City of Buffalo.

7. On 6/2/22 at 6:12 p.m., Riordan was admitted to the Erie County Holding Center (ECHC)

by Deputy G.S. for the charges of Aggravated Unlicensed Operation of a Motor Vehicle 1st Degree and Criminal Impersonation 2nd Degree. Riordan was housed in Bravo Reception for processing, classification, and his medical examination.

8. [redacted].

9. On 6/2/22 at 9:09 p.m., Riordan was transferred from the Bravo Reception area to the Bravo Long Housing Unit, cell # 05.

10. [redacted] A review of the ECHC's facility policy for Chronic Care Management Detoxification Management by Commission staff found that it stated the following:
Procedure: Medical Intake: C: *The registered nurse will contact the on-call provider to initiate treatment protocols.*

A review of the ECHC's facility policy for Chronic Care Management Detoxification Management by Commission staff found it stated the following: Detoxification: Stabilization: *All inmates that are identified as requiring evaluation for withdrawal have education provided regarding substance abuse and withdrawal. Inmates are referred to forensic mental health for identification of mental health needs.*

A review of the ECHC's facility policy for Chronic Care Management Detoxification Management by Commission staff found it stated the following: Detoxification: Alcohol Withdrawal: Screening: *All inmates will be screened at INTAKE for active alcohol use disorder with the AUDIT-C questionnaire.*

The Medical Review Board finds that even though Riordan did not report his alcohol consumption upon his admission to the ECHC for approximately 14-hours, the detoxification management policy should have been initiated by RN K.B. A review of Riordan's medical records by Commission staff found that RN K.B. scored Riordan's complaints of nausea and vomiting as a "2". A review of the ECHC's facility policy for Chronic Care Management CIWA (Alcohol and Benzodiazepine Detoxification Evaluation) by Commission staff found that Riordan should have received a score of 7 and not a 2 for reporting having Nausea/emesis during this assessment. Appropriate scoring of Riordan's symptoms would have scored Riordan as a total score of 11 and not a total score of 6 on the CIWA. A review of the ECHC's facility policy for Chronic Care Management Detoxification Management by Commission staff found it stated the following:
Detoxification: Alcohol Withdrawal: Treatment Protocol: *Moderate to High severity (CIWA > 10): Transferred to ECMC for emergent evaluation.*

RN [redacted] was not available for an interview by Commission staff during the investigation.

The Medical Review Board finds that accurate scoring on the CIWA would have warranted Riordan's transfer to the Erie County Medical Center (ECMC) per ECHC's facility policy for Chronic Care Management Detoxification Management for an evaluation of alcohol withdrawal. The Medical Review Board opines that had Riordan been properly scored on the CIWA and sent out for hospital treatment at this time, his death may have been prevented.

11. On 6/3/22 at 8:50 a.m., Riordan was transferred from Bravo Long to ECHO Dorm 3 for detox purposes. During this time, ECHO Dorm was being used as detoxification housing.

12. [redacted] RN [redacted] was not available for an interview by Commission staff during the investigation.

13. [redacted] The Medical Review Board finds that accurate scoring on the CIWA would have warranted Riordan's transfer to a hospital for an evaluation of alcohol withdrawal. The Medical Review Board opines that had Riordan been properly scored on the CIWA and sent out for hospital treatment at this time, his death may have been prevented.

14. On 6/3/22 from 3:00 p.m. until 11:00 p.m., Deputy A.W. was assigned to Echo Dorm. During an interview with Commission staff, Deputy A.W. reported that Echo Dorm at that time was being used as a detox reception. Deputy A.W. reported that where Riordan's bunk was, he could see him at all times. Deputy A.W. reported that he could hear Riordan in the bathroom throwing up. Deputy A.W. reported that Riordan was very agitated pretty much the entire shift and moving around. Deputy A.W. reported that

towards the end of the shift, Riordan reported that he was throwing up blood. Deputy A.W. notified his sergeant and medical immediately. Deputy A.W. reported that Riordan was brought to medical, and then he was brought back. Deputy A.W. reported that Riordan walked to and from medical independently. Deputy A.W. reported that shortly after Riordan was brought back from medical, Riordan reported that he was still throwing up blood. Deputy A.W. reported that he called medical again and the nurse came down, looked at Riordan, and reported to him that Riordan was fine. Deputy A.W. reported that when he left at the end of his shift, he thought that Riordan was laying on his bunk.

15. On 6/3/22 at 11:00 p.m. through 6/4/22 at 7:00 a.m., Deputy J.Y. was assigned to ECHO Dorm. During an interview with Commission staff, Deputy J.Y. reported that when he arrived on the unit for his shift, he completed his first round of the dorm. Deputy J.Y reported that Riordan was assigned the first bunk that was to his left side of his desk, and when he was doing the first round of the dorm, Riordan was sitting on the bunk. Deputy J.Y. reported that soon, after RN [redacted]. came into the dorm to do CIWA checks. Deputy J.Y. reported that after one of his unit rounds, he was sitting at his desk, and he heard one of the showers go off. Deputy J.Y. walked over to the shower area and observed Riordan in the shower. Deputy J.Y. explained to Riordan that the dorm was on lockdown and that he could not be in the shower. Riordan came out of the shower and sat on his bunk. Deputy J.Y. reported that none of the other incarcerated individuals (II) were complaining that Riordan was awake.

16. [redacted]

17. On 6/3/22 at 11:00 p.m. through 6/4/22 at 7:00 a.m., Deputy S.M. was assigned to the Echo Dorm. During an interview with Commission staff, Deputy S.M. reported working on ECHO Dorm and that she had been stationed in the back of the dorm to watch over the unit. Deputy S.M. reported that during the shift, Riordan was not sleeping, would get up every 15-to-20 minutes to go the bathroom and that he was going through his property bin that was by his bed. Deputy S.M. reported that Riordan was disrupting the other incarcerated individuals that were trying to sleep. Deputy S.M. reported that she went to the housing unit Deputy and reported that the Sergeant should be called. Deputy S.M. reported that the Sergeant came up and told Riordan to gather his stuff and that Riordan was moved off of the unit.

18. A review of Riordan's medical records by Commission staff did not find that medical was called to assess Riordan for having disruptive behavior on the dorm prior to him being moved off of ECHO Dorm by security. A review of the ECHC's facility policy for Chronic Care Management Detoxification Management by Commission staff found that it stated the following:
Discharge From Detoxification Housing: Inmates identified as undergoing acute withdrawal syndrome, or at risk for developing Alcohol Withdrawal Syndrome (AWS), will be maintained in detoxification housing until medically cleared by the MD/NP/PA. Once medically cleared, provider will fax a list of cleared individuals to classification. Classification will then coordinate with records for appropriate placement considering

any forensic alerts. Minimum Duration of Treatment in Detox housing: Opiates: 72 hr. Alcohol: 96 hr. Benzodiazepine: 96 hr.

The Medical Review Board opines that removing Riordan from the ECHO Dorm, the detoxification housing unit was detrimental in the continuity of care for Riordan who was experiencing signs and symptoms of alcohol withdrawal.

19. On 6/4/22 at 12:04 a.m., Deputy K.S. documented in the Bravo Long logbook that Riordan was received and assigned to cell # 1. Deputy K.S. documented that Riordan would be on 15-minute general supervisory tours due to detox.

20. [redacted] The Medical Review Board finds that NP [redacted]. was not aware that Riordan was removed off of the detox housing unit and placed on Bravo Long. [redacted] The Medical Review Board opines that Riordan's documented acuity of withdrawal symptoms should have prompted consideration of short term benzodiazepine therapy.

21. [redacted]. During an interview with Commission staff, NP [redacted]. reported that co-signing RN [redacted]s note meant that the RN ordered a medication and that she co-signed for the medication. NP [redacted] reported that the electronic signature did not mean that she agreed with the note, or that she put in a plan of action based on the RN's note. [redacted]

[redacted]. When NP [redacted]. was asked if she had known about the vomit, would she have done anything different with the assessment that she did, NP [redacted]. reported that typically when a nurse writes that it was unwitnessed, “no”.

22. [redacted]. From a review of the video recording of elevator # 5, and the Delta medical treatment hallway by Commission staff, the following was observed:
Riordan walked independently onto elevator # 5. Riordan walked independently off of elevator # 5 and down the hallway to the treatment room where he sat on the examination table. When Riordan’s CIWA was completed, he walked independently back to elevator # 5. Once Riordan was inside elevator # 5, he stood facing the back wall of the elevator and rested against the wall. When the elevator door opened, Riordan began to turn around to face the door and he hesitated, and it appeared that he knelt down on the floor. Riordan was able to independently stand back up, and he walked off of the elevator out of the recording view.

23. On 6/4/22 at 4:09 p.m., from a review of the video recording of elevator # 5, and the Delta medical treatment hallway by Commission staff, the following was observed: Riordan was observed being pushed in a wheelchair onto elevator # 5 by security staff. Riordan appeared to be alert and was communicating with security staff. Riordan was wheeled off of elevator # 5 and he was taken to the Delta medical treatment room.

24. [redacted]. RN [redacted]. was not available for an interview with Commission staff.

25. [redacted]

[redacted] A review of Riordan's medical records by Commission staff found that RN [redacted]. did not notify the on-call medical provider that Riordan had fallen, that he had complaints of dizziness and dehydration, that he was nauseous, that he had complaints that his stomach continued to hurt, and that Riordan needed a wheelchair and was not able to ambulate independently. A review of the ECHC's facility policy for Chronic Care Management Detoxification Management by Commission staff found it states the following: Alcohol Withdrawal: Screening: *Patients that are intoxicated during intake will be monitored in alcohol detoxification program until clinically sober and able to reliably complete full screening process. Inmates experiencing severe, life-threatening intoxication (overdose) or withdrawal (e.g., the inability to ambulate or speak without assistance) should be transferred to emergency department for further evaluation.* The Medical Review Board opines that nursing staff failed to appropriately respond and manage Riordan's obviously worsening symptoms and immediately make notification to the jail physician and or have him sent out to the hospital after having a syncopal episode. The Medical Review Board opines that had Riordan been properly assessed and sent out for hospital treatment at this time, his death may have been prevented.

26. On 6/4/22 at 11:00 p.m., Deputy K.S. documented in the Bravo Long logbook assuming the duties of the unit and completing a general supervisory tour with a head count of 11 IIs.

27. On 6/5/22 at 12:34 a.m., Deputy K.S. documented in the Bravo Long logbook that Riordan refused correctional health for CIWA. A [redacted] Deputy K.S. and RN [redacted]. were not available for an interview by Commission staff during the investigation.

28. [redacted].

29. A review of the Bravo Long logbook by Commission staff found that between the hours of 12:34 a.m. on 6/5/22 through 4:45 a.m. on 6/5/22, Deputy K.S. documented completing 15-minute tours on the unit with no specific logbook entries made for Riordan.

30. On 6/5/22 at 5:00 a.m., Deputy K.S. documented in the Bravo Long logbook that a general supervisory tour (GST) "was completed. GST's end. Active supervision begins. Trays offered # 15 refused. All others accepted." Deputy K.S. continued to make 15-

minute unit tours until 6:45 a.m., with no specific logbook entries made for Riordan.

31. On 6/5/22 at 7:00 a.m., Deputy S.S. documented in the Bravo Long logbook assuming the duties of the unit and completing a general supervisory tour.

32. On 6/5/22 at 8:40 a.m., Deputy S.S. documented in the Bravo Long logbook that Riordan refused medical. Deputy S.S. documented that medical and the sergeant were notified.

33. [redacted] RN [redacted]. was not available for an interview by Commission staff during the investigation.

34. On 6/5/22 at 9:03 a.m., Deputy K.B. documented in the Bravo Long logbook, “Eyes on Riordan BL # 1 due to refusal”.

35. On 6/5/22 at 9:40 a.m., Deputy M.C. documented in the Bravo Long logbook, “Med Pass”.

36. During an interview with Commission staff, Deputy S.S. reported that he was standing at the gate working the control box with the nurse standing to his right side. The nurse would tell him who he needs for medication pass. Deputy S.S. reported that he would “call out ‘medication’, and most people know that they are coming up for medication. If they don’t come up, I would call out their names individually or their cell number”. Deputy S.S. did not recall if he called Riordan out individually or if Riordan came up on his own. Deputy S.S. reported that Riordan walked up to the gate of his cell, and he believed that Riordan had fallen backwards, but that he could not see Riordan because Riordan was still in his cell. Deputy S.S. reported that he went over to the side and observed Riordan in his cell on the floor, and he called for a 10-62 (Medical Emergency).

37. [redacted]

[redacted] The Medical Review Board opines that Riordan was hypotensive and medically unstable and should have had EMS called for him immediately by attending nursing staff.

38. On 6/5/22, from a review of the video recording of Bravo Long by Commission staff, the following was observed. It is noted that the time stamp of the recording was not visible on the video recording.

Sergeant T.M. entered Riordan's cell and asked Riordan, "are you okay?" Riordan replied, "Yeah I'm fine". RN [redacted] entered Riordan's cell and assessed Riordan with a set of vital signs. Riordan was asked what happened and Riordan replied, "I don't know. I was talking to the nurse and all of the sudden I passed out". RN [redacted]. asked Riordan to sit up and Riordan was able to independently sit up on his bed.

A few seconds later Riordan began to fall sideways to the left. Staff assisted Riordan back to the upright sitting position. Riordan was visibly sweating, and security staff dried Riordan's face off with a towel.

The decision was made by medical staff to take Riordan up to the medical unit via a wheelchair. Riordan began to fall sideways on his right side while on his bed. Security staff assisted Riordan to the sitting position and assisted him with dressing. Riordan's body began to stiffen, and he was assisted by security staff out to the hallway and placed in the wheelchair. Riordan's body remained stiff while he was in the wheelchair, and his neck was hyperextended over the back of the wheelchair. Security staff did assist with holding Riordan's head up.

Medical staff requested Emergency Medical Services (EMS) and Sergeant T.M. told staff to get a mattress. Riordan was transferred by staff from the wheelchair to a mattress that was placed on the floor. RN [redacted]. continued to monitor Riordan and RN [redacted] applied oxygen via a nasal canula (NC). Shortly after, the NC was changed to a mask. Riordan was observed briefly on the video recording laying on the mattress. Riordan was in the supine position with his head turned towards the left. Riordan had a blank stare, and he was not responding to staff, or a sternal rub. [redacted] Staff continued to monitor Riordan until EMS responded and assumed the care of Riordan. Riordan was again observed briefly on the video recording laying on the mattress unresponsive with a blank stare and what appeared to be agonal breathing.

The Medical Review Board finds that at this time, Riordan should have been assisted with his respirations via the Bag Valve Mask (BVM) and the Automated External Defibrillator (AED) should have been applied on Riordan.

EMS arrived and RN [redacted]. and RN [redacted]. gave EMS a report on Riordan. [redacted]

[redacted]. Riordan was transferred from the mattress to the EMS gurney by EMS staff and security staff. EMS applied cardiac leads to Riordan's chest. Riordan's oxygen was switched from the facility oxygen to EMS's oxygen via a mask, [redacted] Riordan was transported off of Bravo Long to the EMS ambulance. [redacted].

39. [redacted].

40. [redacted] On 6/10/22 at 2:00 p.m., Riordan was released from the custody of the Erie County Sheriff's Office. [redacted]

ACTIONS REQUIRED:

TO THE OFFICE OF ERIE COUNTY SHERIFF:

The Sheriff shall conduct an inquiry into the conduct of the security staff that moved Riordan off of the detoxification housing on 6/4/22 without being cleared by the MD/NP/PA. Administrative

action should be taken if staff are found to be in violation of facility policy and procedures.

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

In a response dated 8/12/24 to the Commission's preliminary report, the Erie County Attorney indicated that Riordan was not removed from detoxification housing on 6/4/22 as the unit he was re-assigned to, Bravo Long, was also used as detoxification housing at that time. The Medical Review Board found this response unacceptable noting that Riordan was originally housed in Bravo Long on 6/2/22, then relocated to Echo Dorm on 6/3/22 for the purposes of detoxification housing before being returned to Bravo Long on 6/4/22.

TO THE ERIE COUNTY JAIL PHYSICIAN:

The Jail Physician shall conduct a comprehensive quality assurance review regarding the following:

1. Why, on 6/3/22, RN [redacted]. did not notify the on-call medical provider that Riordan reported drinking a quart of vodka daily.
2. Why, on 6/3/22, RN [redacted]. did not notify the on-call medical provider that Riordan was experiencing alcohol withdrawal symptoms.
3. Why, on 6/3/22, RN [redacted]. did not score Riordan on the CIWA as a "7" for experiencing nausea and vomiting for the past 24 hours.
4. Why, on 6/3/22, RN [redacted]. did not refer Riordan to mental health.
5. Why, on 6/3/22, RN [redacted]. did not complete an Audit-C questionnaire on Riordan.
6. Why, on 6/3/22, RN [redacted]. did not score Riordan on the CIWA as a "7" after visualizing Riordan's emesis.
7. Why, on 6/3/22, RN [redacted]. did not document on the CIWA that Riordan was sweating.
8. Why, on 6/4/22, Deputy S.M. did not notify medical that Riordan was being disruptive.
9. Why, on 6/4/22, NP [redacted]. did not prescribe Riordan a Benzodiazepine or Barbiturate to reduce the risk of seizures or Delirium Tremens.
10. Why, on 6/4/22, RN [redacted]. did not notify the on-call medical provider that Riordan had fallen with complaints of dizziness, dehydration, nausea, and that his stomach hurt.
11. Why, on 6/4/22, RN [redacted]. did not notify the on-call medical provider that Riordan was not able to ambulate without assistance and he was placed in a wheelchair.
12. Why, on 6/5/22, medical staff did not apply the BVM and the AED on Riordan.
13. Why EMS was not called immediately for Riordan after a witnessed fall and showing signs of a deteriorating medical condition.

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

In a response dated 8/12/24 to the Commission's preliminary report, the Erie County Attorney refuted some of the report's findings and stated that the Sheriff's Office conducted an in-depth investigation into Riordan's death and found no violations of policy by security or correctional health staff. The Medical Review Board found that there was no specific response to the enumerated quality of care issues raised about Riordan's care. The Board did not accept the response and remains affirmed in its findings and actions required.

TO THE CHAIR OF THE ERIE 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 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 September 2024.

Yolanda Canty
Commissioner
Commission of Correction

YC:BB:vc
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