



**Commission of  
Correction**

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

**In the Matter of the Death of**

**Edwin Manuel Ortiz,  
an incarcerated individual of the  
Sullivan County Jail**

**December 18, 2024**

**To: Sheriff Michael A. Schiff  
Sullivan County Sheriff's Office  
58 Old Route 17  
Monticello, New York 12701**

**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 Edwin Ortiz, who died on October 30, 2023 , as a result of circumstances which occurred while an incarcerated individual in the custody of the Sullivan County Sheriff at the Sullivan County Jail, the Commission has determined that the following final report be issued.

FINDINGS:

1. Edwin Ortiz was a 46-year-old man who died on 10/30/23 from an acute intoxication due to the combined effects of fentanyl, xylazine, promethazine and loperamide while in the custody of Sullivan County Sheriff at the Sullivan County Jail. The Medical Review Board has found that the health services staff failed to provide appropriate medical care to Ortiz and failed to identify and assess his worsening condition prior to his death.

2. [REDACTED]

On 10/25/23, Ortiz was arrested for Criminal Impersonation 2<sup>nd</sup> Degree, however these charges were abated by his death.

3. [REDACTED]

4. On 10/25/23, Ortiz was received at the Sullivan County Jail. Upon intake, it was noted that Ortiz [REDACTED], had a felony record and showed signs of intoxication. [REDACTED]

5. [REDACTED]

6. [REDACTED]

7. [REDACTED]

8. [REDACTED]

9. [REDACTED]

10. [REDACTED]

The Medical Review Board opines that Ortiz's highly elevated blood glucose levels should have been immediately addressed by the health services staff and not re-assessed two hours later before providing insulin coverage. Additionally, there was no indication that the elevated blood glucose levels were reported to a medical provider by the nursing staff.

11. [REDACTED].

12. On 10/28/23 at 1:45 p.m., Ortiz was heard yelling from his cell. Deputy (Dep.) J.G. responded to Ortiz's cell. Dep. J.G. noted that Ortiz appeared to be having a seizure. Dep J.G. called a "code white". Sergeant (Sgt) P.N. and additional security staff responded. Narcan was administered without the desired effect. A second dose of Narcan was administered. RN [REDACTED] arrived and [REDACTED].

[REDACTED]

While enroute to intake, Ortiz began to lose control of his bowels and requested to use a toilet. Under close supervision from Sgt. P.N. and Dep M., Ortiz used the toilet.

[REDACTED]

The cell Ortiz occupied was searched and a white substance was found which was noted to be 100% Fentanyl.

13.

[REDACTED]

A review of Ortiz's records by the Medical Review Board revealed that there were no orders from jail staff to place Ortiz on any type of contraband protocol. Although the order to place Ortiz on constant supervision after discharge from the hospital was appropriate, the Board opines that given that Ortiz had an overdose incident and had illicit substances found in his cell, a contraband watch protocol should have been initiated.

14.

[REDACTED]

15.

[REDACTED]

16.

[REDACTED]

17. On 10/29/23 at 8:15 a.m., Dep. J.G. documented in the constant supervision logbook that Ortiz was laying on his bunk, urinating on the floor.

18. On 10/29/23 at 8:20 a.m., Dep. J.G. documented in the constant supervision logbook that Ortiz threw his breakfast tray, a carton of milk, and a banana at his cell door.

19. On 10/29/23 at 8:37 a.m., Dep J.G. documented in the constant supervision logbook that Ortiz was vomiting on the floor of his cell.

20. On 10/29/23 at 10:00 a.m., Dep J.G. documented in the constant supervision logbook that Ortiz refused medications from LPN [REDACTED]

21. On 10/29/23 at 10:06 a.m., Dep J.G. documented in the constant supervision logbook that Ortiz was urinating on the floor.
22. On 10/29/23 at 10:43 a.m., Dep L. documented in the constant supervision logbook that he asked Ortiz if he wanted to go to medical and Ortiz just moaned, did not move, and did not give him an answer.
23. On 10/29/23 at 11:30 a.m. and 12:08 p.m., deputies documented in the constant supervision logbook that Ortiz was vomiting on the floor of his cell.
24. On 10/29/23 at 12:15 p.m., Sgt. G. documented in the constant supervision logbook that Ortiz was moved to cell C-39 by Sgt G. and Sgt P.N. after urinating and defecating on the cell floor. Dep J.G. documented in the constant supervision logbook that Ortiz refused a shower.
25. On 10/29/23 at 12:41 p.m., 12:50 p.m. and 1:07 p.m., Dep J.G. documented in the constant supervision logbook that Ortiz was vomiting on the floor of his cell.
26. On 10/29/23 at 1:12 p.m., Dep J.G. documented in the constant supervision logbook that Ortiz received his Medication-Assisted Treatment (MAT) medication from LPN [REDACTED]  
[REDACTED]
27. On 10/29/23 at 1:55 p.m., Dep J.G. documented in the constant supervision logbook that Ortiz vomited on the floor of his cell.
28. On 10/29/23 at 2:12 p.m., Dep O. documented in the constant supervision logbook that Ortiz refused Gatorade from RN [REDACTED]
29. On 10/29/23 at 2:35 p.m., 3:11 p.m. and 3:15 p.m., Dep L. documented in the constant supervision logbook that Ortiz vomited on the floor of his cell.
30. On 10/29/23 at 3:26 p.m., Dep L. documented in the constant supervision logbook that Ortiz refused to go to medical.
31. On 10/29/23 at 3:30 p.m., Dep L. documented in the constant supervision logbook that Ortiz was offered his diabetic snack. Ortiz was lying on his bunk and stated that he could not get up. [REDACTED]  
[REDACTED] There was no further documentation noted to indicate that a medical provider was notified of Ortiz's complaints and there was no further assessment completed. The Medical Review Board opines that Ortiz vomiting nine times, with urinary incontinence and failure to take meals should have been reported to the medical provider immediately for follow up and orders.
32. On 10/29/23 at 4:22 p.m., Dep C. documented in the constant supervision logbook that Ortiz refused his meal tray.
33. On 10/29/23 at 4:45 p.m., Sgt. P.N., Sgt G. and RN [REDACTED] responded to C39 cell with a diaper and medication. Ortiz was moved back to C41 cell after Dep L. reported that Ortiz

defecated in the cell, outside of the toilet. There was no other documentation provided related to the medication administered.

34. [REDACTED]  
[REDACTED] Although clinically acceptable, the Medical Review Board opines that Ortiz should have been seen for his complete physical intake exam prior to having his therapies adjusted by a mid-level provider.
35. On 10/29/23 at 5:28 p.m., Dep C. documented in the constant supervision logbook that Ortiz took his 2:00 p.m. diabetic snack.
36. On 10/29/23 at 5:31 p.m., Dep C. documented in the constant supervision logbook that Ortiz vomited on the floor of his cell.
37. On 10/29/23 at 7:46 p.m., Dep R. documented in the constant supervision logbook that Ortiz was offered his diabetic snack, but Ortiz refused.
38. On 10/29/23 at 8:02 p.m., Dep C. documented in the constant supervision logbook that Ortiz was given an apple, and that Ortiz was eating the apple.
39. [REDACTED]
40. On 10/30/23 at 6:53 a.m., Dep C.W., Dep L. and an incarcerated individual entered Ortiz's cell to clean it. During an interview with the Commission staff, Dep C.W. stated that Ortiz rolled over partially and looked to acknowledge the presence of the deputies and the incarcerated individual. Dep C.W. stated Ortiz would not get up to urinate, defecate or vomit, but did it from his bunk onto the floor. Dep C.W. stated during the interview that he had been asked by a supervisor to get the cell cleaned.
41. On 10/30/23 at 7:15 a.m., [REDACTED]  
[REDACTED] At 7:15 a.m., Dep C.W. noted in the constant supervision logbook that Ortiz refused medical after asking multiple times. Dep C.W. noted Ortiz's movement and his chest rise in the logbook. During an interview with the Commission staff, Dep C.W. stated that Ortiz groaned in response, as a "refusal". At 9:00 a.m., Ortiz refused his morning COWS assessment and medication, and [REDACTED]  
[REDACTED]
42. On 10/30/23 at 8:38 a.m., Dep. S.M. documented in the constant supervision logbook that Ortiz refused the meal tray. At 8:43 a.m., Dep S.M. documented in the constant supervision logbook that Ortiz refused medical. At 8:50 a.m., Dep S.M. documented in the constant supervision logbook that Ortiz refused to go to court. Ortiz had a 9:00 a.m. Order to Produce at Monticello Village Court. Dep. H.T. documented in an incident report that he gave Ortiz multiple orders to get up and to get ready for court, which were

- ignored. During an interview with the Commission staff, Dep. S.M. stated that Ortiz was breathing but no other movement was noticed. Dep. S.M. did not recall how Ortiz refused his meal tray, medical or orders to get ready for court.
43. On 10/30/23 at 10:10 a.m., Dep. H.T. documented in the constant supervision logbook that Ortiz refused medication from LPN [REDACTED]
44. On 10/30/23 at 11:00 a.m., Dep. S.S. documented in the constant supervision logbook that Ortiz refused his blood glucose testing. At 11:15 a.m., Dep. S.S. documented in the constant supervision logbook that Ortiz refused his lunch tray and that Ortiz stated that he did not want it. During an interview with the Commission staff, Dep. S.S. stated that there was no notable physical movement when Ortiz refused. Dep. S.S. said that after he asked Ortiz if he wanted his lunch tray, Ortiz's refusal was an audible "no". During an interview with the Commission staff, Dep. S.S. stated that he and Cpl. C. verified that Ortiz's chest was rising, but Ortiz had not changed his position.
45. On 10/30/23 at 12:02 p.m., Dep. H.T. documented in the constant supervision logbook that Ortiz refused to go to intake for court. Ortiz had a 2:00 p.m. Order to Produce for Sullivan County Court. At 12:04 p.m., Dep. H.T. documented in the constant supervision logbook that Ortiz refused a shower and the phone. During an interview with the Commission staff, Dep. H.T. said that he did not recall what Ortiz said but that Ortiz did verbally refuse.
46. [REDACTED]
47. On 10/30/23 at 1:15 p.m., Dep. S.M. noted that Ortiz refused his MAT medication and that he would not get out of bed. [REDACTED] A review of the recorded video footage from the housing area by the Commission revealed that there was no observable contact between LPN [REDACTED] and Ortiz, or between LPN [REDACTED] and any deputy in the immediate area to pass medication to Ortiz. There was no refusal form noted in the medical record. The Medical Review Board finds that LPN [REDACTED] falsified a patient record by documenting that Ortiz's medication was delivered when it was not.
48. On 10/30/23 at 3:10 p.m., Dep. H.T. documented in the constant supervision logbook that Ortiz refused a diabetic snack.
49. [REDACTED]
50. A review of the constant logbook entries by the Commission revealed that Ortiz was documented from approximately 11:30 p.m. on 10/29/23 through 10/30/23 at 4:00 p.m. as either laying on his stomach or right side. There was no documentation in this period of approximately 16 hours of Ortiz moving, getting up, using the bathroom, drinking fluids or consuming a meal. During interviews with Commission staff, jail deputies reported that Ortiz's refusals for medication and food, were either a grunt or groan in response to questions or no response at all. The Medical Review Board finds that there was a failure by health services staff to monitor the observations of Ortiz while on the ordered



ACTIONS REQUIRED:TO THE OFFICE OF THE SULLIVAN COUNTY SHERIFF AND JAIL ADMINISTRATION:

1. The Jail Administration shall conduct a comprehensive quality assurance review of the Sullivan County Sheriff's Office Jail Division Constant Supervision Policy to include why with multiple shift changes of staff, Ortiz's cell was never inspected and why any inspection results were not documented in the constant supervision logbook.
2. The Jail Administration shall conduct a comprehensive quality assurance review of Ortiz's constant supervision watches to include the contraband watch protocol given that Ortiz was found with contraband after a medical emergency and may have been secreting additional contraband.

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

*In a response dated 11/25/24 to the Commission's preliminary report, the Sullivan County Sheriff Office indicated that the requested reviews were completed with correction actions taken based on the Board and Commission's findings. The Commission will review the corrective actions taken at a later scheduled facility evaluation.*

TO THE JAIL PHYSICIAN FOR THE SULLIVAN COUNTY JAIL:

1. The Jail Physician shall conduct a comprehensive quality assurance review of the policy and procedures pertaining to the administration of MAT medications to include why the medical staff documented that a MAT medication was administered to Ortiz, however the video footage showed no physical contact between Ortiz and medical staff or security staff. If medical staff are found to have committed professional misconduct, appropriate referral to NYS Education Dept. Office of Professional Discipline should be made.

*In a response dated 11/13/24 to the Commission's preliminary report, PrimeCare Medical of NY indicated that a review was completed but that they could not determine with certainty [REDACTED]. The Medical Review Board does not accept this response as the video recording of Mr. Ortiz constant supervision cell was clear and there was no visible interaction between Mr. Ortiz and LPN [REDACTED]. Given that the proper protocol for administering buprenorphine to individuals requires significant interaction to assure all medication has been properly taken with no diversion being attempted, the Board opines that these interactions would have been clearly visible if completed properly.*

2. The Jail Physician shall conduct a comprehensive quality assurance review with health services staff regarding monitoring of staff observations of individuals who are placed on a medical constant supervision. This shall include a specific review as to why Ortiz's multiple refusals to check his blood glucose levels, to accept medications and to engage in activities of daily living were not further assessed by the attending medical staff.

3. The Jail Physician shall conduct a comprehensive quality assurance review of the medical care policies and procedures to include the assessments of individuals who have been placed on a medical constant watch and at what juncture, through assessments, those individuals must be maintained on or removed from a medical constant watch.

*In a response dated 11/13/24 to the Commission's preliminary report, PrimeCare Medical of NY indicated that a review was completed and found that Ortiz was properly assessed by medical and had a proper plan established for his medical constant supervision. The Medical Review Board does not accept this response as it does not address why Ortiz's documented lack of activities of daily living for over 16 hours was not addressed.*

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

TO THE CHAIR OF THE SULLIVAN COUNTY LEGISLATURE:

As the appointing authority(s) 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, 12<sup>th</sup> Floor, in the City of Albany, New York 12210 on this 18<sup>th</sup> day of December 2024.



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Yolanda Canty  
Commissioner  
Commission of Correction

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December 18, 2024