Commission of Correction

Final Report of the New York State Commission of Correction:

In the Matter of the Death of

Oscar Ortez (17R0915), an incarcerated individual of the Clinton Correctional Facility

September 24, 2025

To: Honorable Daniel F. Martuscello, III
Commissioner
NYS Department of Corrections
And Community Supervision
The Harriman State Campus
1220 Washington Avenue
Albany, New York 12226

Allen Riley
Chairman

Yolanda Canty
Commissioner

Elizabeth Gaynes
Commissioner

80 South Swan Street, 12th Floor, Albany, New York 12210 | 518-485-2346 – phone | 518-485-2467 – fax | www.scoc.ny.gov

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 Oscar Ortez, who died on February 8, 2018, while an incarcerated individual in the custody of the NYS Department of Corrections and Community Supervision at the Clinton Correctional Facility, the Commission has determined that the following final report be issued.

FINDINGS:

1. Oscar Ortez was a 23-year-old Hispanic male who died on 2/8/18 from a cardiac arrest that occurred during a use of force restraint with officers while in the custody of New York State Department of Corrections and Community Supervision (NYS DOCCS) at the Clinton Correctional Facility (CF). The Medical Review Board opines that absent any pathological indicators of a medical condition that would cause death, Ortez's manner of death could only be attributed to the use of force and therefore should be ruled as a homicide. The Medical Review Board has found that there were failures to recognize Ortez's progressively deteriorating mental health status, failures to properly diagnose his symptoms of delirium, and failures to obtain proper psychiatric assessment and intervention. The Board opines that had Ortez received proper intervention his may have been prevented.

2. Ortiz was born in West Islip, N.Y. Ortez was survived by his parents and two siblings. Ortez was single and had no children. Ortez had a 10th grade education and did not peruse his GED. Ortez was not employed.

3.

4.

5.

6. On 4/10/17, Ortez was admitted into NYS DOCCS at Ulster CF Reception On 4/27/17, Ortez was transferred from Ulster CF Reception to Lakeview Shock Incarceration CF for program purposes. On 5/23/17, Ortez was transferred from Lakeview Shock Incarceration CF to Gowanda CF due to being disqualified for the shock incarceration program for medical reasons. On 2/2/18, Ortez was transferred from Gowanda CF Special Housing Unit (SHU) to Upstate CF SHU for

poor custodial adjustment. At the time of Ortez's transfer to Upstate CF, Ortez was being housed in Elmira CF [redacted]. On 2/8/18, Ortez was transferred from Upstate CF to Clinton CF [redacted] This is where the terminal event occurred.

7. On 4/10/17, Ortez was received at Ulster CF Reception [redacted]

8. [redacted]

9. [redacted] The Medical Review Board questions how Ortez was approved for a shock incarceration program, a program with significant physical training components, with a known orthopedic injury.

10. [redacted]

11. [redacted]

12. On 4/27/17, Ortez was transferred from Ulster CF Reception to Lakeview Shock Incarceration CF for program purposes.

13. [redacted]

14. [redacted]

15. [redacted]

16. On 5/23/17, Ortez was transferred from Lakeview Shock Incarceration CF to Gowanda CF due to his medical disqualification from the shock incarceration program.

17.

18.

19. On 1/9/18 at 4:05 a.m., Correction Officer (CO) F.L. was assigned to infirmary isolation room # 4 for the one-to-one watch of Ortez. Ortez took his smock off and began displaying self-sexual acts. CO F.L. gave Ortez a direct order to stop at which Ortez did not comply. At 4:10 a.m., Ortez smeared body fluids on the mattress and continued with self-sexual acts. CO F.L. continued to give Ortez direct orders to stop and to put his smock back on, but Ortez did not comply. CO F.L. documented that it took Ortez approximately two and a half hours to comply with the direct orders, and that Ortez did comply with the order to put his smock back on. Ortez then began jumping on the infirmary bed while yelling, causing a disturbance.

20.

21. On 1/9/18, Ortez received a Tier 3 infraction for having two episodes of Unhygienic Act, creating a Disturbance, Lewd Conduct, two episodes of Failure to Follow a Direct Order, and Violent Conduct. Ortez's hearing was held at Elmira CF on 1/31/18 and he received 90 days in the Special Housing Unit (SHU) with 90 days loss of packages, commissary, and phone use.

22.

23.

24.

25.

26. On 1/11/18, Ortez transferred from Gowanda CF to Elmira CF.

27.

28. Incarcerated individuals in correctional facilities without Satellite Units who require emergency psychiatric services beyond the capacity of the facility in which the inmate resides will be transferred to a Satellite Unit under DOCS Directive 4301 and will be admitted to the Residential Crisis Treatment Program (RCTP) for evaluation and treatment.

29.

30.

The Medical Review Board opines that Ortez's sudden onset of altered mental status and bizarre behaviors should have prompted an immediate psychiatric referral and evaluation.

31.

32.

33. The Medical Review Board opines that Ortez was in need of a medical evaluation at a hospital, and notes that ultimately Ortez would have a use of force 27 days later during a transfer into Clinton CF RCTP

34.

35.

36.

37. [redacted]

38. [redacted]

39. [redacted] The Medical Review Board notes that this was the first attempt to psychiatrically evaluate Ortez after the onset of his behaviors and opines that a referral and evaluation should have occurred immediately. Additionally, the Board opines that a patient refusal to be seen does not preclude the ability of a psychiatric provider to make observations of a patient and formulate a diagnosis based off them.

40. [redacted]

41. [redacted]

42. [redacted]

43.

44.

45.

46.

47.

48. The Medical Review Board notes that Ortez was both admitted and discharged from RCTP status without psychiatric assessment. This issue was identified by OMH in their Incident Report dated 10/21/19 and was addressed with Elmira CF OMH staff at that time.

49.

50.

51.

52.

M.

53. On 2/1/18, Ortez was transferred from Elmira CF SHU to Upstate CF SHU as a result of disciplinary sanctions.

54.

55.

56.

57.

58.

59.

60.

61.

62.

63.

64.

65.

66.

67.

68.

69.

70.

71.

72.

73.

74.

75.

76.

77.

78.

79.

80.

81.

82.

83.

84. [redacted]

85. [redacted]

86. [redacted] The Medical Review Board opines that there was a failure to recognize progressive deterioration of Ortez's mental health over a 30-day period that required immediate psychiatric intervention and possible removal for emergency psychiatric hospitalization per Criminal Procedure Law §402. The Board finds that there was a failure to recognize signs and symptoms of delirium in Ortez, which are often hallmarked with waxing and waning symptoms. The Board opines that had Ortez been emergently hospitalized and treated his death may have been prevented.

87. On 2/8/18 at 11:00 a.m., per the Unusual Incident Report from Upstate CF, Ortez, who was housed in the Upstate CF Infirmary cell # 10, was scheduled to be transported via the State van to Clinton CF [redacted] Ortez refused staff direction to submit to a strip frisk prior to the trip. The area Supervisor Sergeant T.S. was notified and force was authorized by the Acting Superintendent D.Q. (The use of chemical agents is not authorized for use in the infirmary). The facility Chaplin W.S., the Offender Rehabilitation Counselors (ORC) [redacted] and [redacted], Lieutenant S.S, and acting Captain Lieutenant M.E. all made verbal attempts to gain compliance from Ortez which failed. Force was used to complete the strip frisk with no contraband found and Ortez became compliant. [redacted] At 12:35 p.m. Ortez was transported in the state van to Clinton CF. At 1:00 p.m., during the transport to Clinton CF, Ortez began to spit towards CO R. and Sergeant S. authorized CO B. to apply a spit net on Ortez. Sergeant S. immediately called Lieutenant K.G. on his cell phone to report the use of the spit net.

88. Per the Unusual Incident Report from Upstate CF, upon arrival to Clinton CF Ortez was escorted to the hospital on the third floor at approximately 1:30 p.m. As the security staff and Ortez exited the elevator on the third floor, Ortez became violent and combative, and force became necessary to gain control.

89. [redacted]

90.

91.

92. On 2/8/18, per documentation from the Clinton CF Use of Force Report, Sergeant M.P. documented being on the third floor of the facility hospital when four officers and a Sergeant arrived on the floor with Ortez. As soon as Ortez exited the elevator, he was combative and struggling with the staff and he was able to get his spit net off. A use of force became necessary at that time. Ortez was forced to the floor of the entrance of the hospital third floor by the escorting officers using body holds. Once Ortez was on the ground, CO P.F. assisted the escorting staff by using a body hold on Ortez's left foot to keep him from kicking. Once the new spit net was back on Ortez, he was immediately assisted to his feet and the spit net was adjusted and secured. Ortez was then escorted to the OMH Interview Room, and he was secured into the restraint chair. Ortez began to resist, and he attempted to get up and he ripped the spit net off rendering it unusable. Sergeant M.P. used his state issued Oleoresin Capsicum (OC) spray and administered two applications (four one second bursts) to Ortez's face without the desired effect. Staff then forced Ortez to the floor, and he continued to violently struggle with the officers by thrashing violently. RN entered the room Ortez was rolled to his left side and another spit net was applied and adjusted Ortez then appeared to begin to deescalate, and he was again assisted to his feet and placed in the restraint chair. As soon as Ortez was placed back in the restraint chair he reached for his face and started pulling off the spit net and he attempted to spit at the staff. Ortez was then forced to the floor and the spit net was adjusted, and Ortez continued to struggle violently until the staff were able to get him on his left side. After a brief moment, Ortez became unresponsive, and all force was ended. Ortez was placed back in the restraint chair and remained unresponsive. Sergeant M.P. immediately directed staff to obtain the Automated External Defibrillator and the first aid kit. Ortez was carried from the restraint chair to a gurney, he was rushed to the elevator and the AED was opened and applied. The elevator opened on the first floor and Ortez was rushed to the facility Emergency Room

93. During an interview with Commission staff, RN reported

that after giving an IM injection the facility policy requires 15-minute checks by the RN for the first hour after administering the medication.

94.

95. On 2/8/18 at 2:11 p.m., Champlain Valley Physicians Hospital EMS arrived at the facility, and they were taken to Ortez.

96.

97. Per documentation from the Office of Special Investigations (OSI), Based upon the review of the facility records, OMH records, interviews, interrogations and review of video in this matter, the investigation did not identify any malfeasance on the part of OMH staff, Upstate Correctional Facility security staff, Clinton Correctional Facility security staff, or Clinton Correctional Facility medical staff for this incident. The entire event was on video except for the time Inmate Ortez was in the restart room. Each event

on the video was corroborated by the interviews and interrogations of involved security and medical staff. Staff involved with the use of force and witnessing the use of force in the restart room provided consistent statements as to what occurred in the room. Multiple staff members involved in the use of force in the restart room and those who witnessed events in the room, provided testimony that Ortez was placed on his side both times he was taken to the floor. Staff were cognizant of the possible effects of positional asphyxia. Ortez was placed on his stomach during the first take down to the floor in the restart room in order that [redacted] Ortez was rolled back on his side. DOCCS staff have received training in the hazards of positional asphyxia and are cognizant of the dangers. Staff involved in the use of force reiterated their awareness of positional asphyxia in their statements regarding the use of force and multiple staff stated that during the time the inmate was on the floor and not resisting, he was rolled onto his side. The Clinton County District Attorney's Office appointed a Special Prosecutor (Franklin County District Attorney's Office) to present the matter to a Grand Jury based upon the majority of security staff who refused to be interviewed by the New York State Police. Multiple conferences were conducted with the Franklin County DA's Office. As of November 2024, OSI was advised that the investigation would not be presented to a grand jury, and that the case would be closed, and no criminal action will be taken. OSI closed the case as unsubstantiated.

98. [redacted] The Medical Review Board disagrees with the medical examiner's findings in this case. Neither pathology findings nor toxicology results indicated any acute or chronic medical condition that would lead to Ortez's death and Ortez did not have a toxic level of any substance in his system. Ortez did not have any documented injuries in the morning prior to his death. Therefore, the Medical Review Board has opined that Ortez's death was attributed to asphyxia that occurred during the restraint with officers and should be ruled as a homicide.

ACTIONS REQUIRED:

TO THE DEPARTMENT OF CORRECTIONS AND COMMUNITY SUPERVISION:

The Department shall conduct a review of training for correction officers regarding risks during use of force restraints to assure that staff are educated in the known risks and have been provided procedures and techniques to minimize them.

In a response dated 8/6/25 to the Commission's preliminary report, the Deputy Commissioner

indicated that DOCCS directives define positional asphyxia and directs all staff to be aware of the changing conditions of an incarcerated individual who may be restrained behind their back in a prone position. In-person training on positional asphyxia is provided to staff annually.

TO THE OFFICE OF MENTAL HEALTH DIVISION OF FORENSIC SERVICES:

The Medical Review Board, in furtherance of its mission to determine the circumstances of an incarcerated individual's death and to prevent recurrence, requests that the Division of Forensic Services conduct reviews of this matter regarding:

1. Why Ortez's sudden onset of altered mental status on 1/12/18 did not prompt an immediate referral to psychiatry?
2. Why did the first attempt of a psychiatric evaluation not occur until five days into his first admission to RCTP?
3. Why was Ortez given a suicide risk of substance use but had no documented indication of what substances he had or allegedly used?
4. Why after 30 days of documented unresolved deterioration of Ortez's mental health emergent psychiatric hospitalization was not considered?

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

In a response dated 7/31/25 to the Commission's preliminary report, the Office of Mental Health indicated that the requested reviews were completed. OMH indicated that as Ortez's case occurred seven years ago, their review was limited as numerous clinical staff were no longer available.

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 24th day of September 2025.

Yolanda Canty
Commissioner
Commission of Correction

YC:BB:vc
2018-M-0022
September 24, 2025

cc: Dr. Carol Moores, Chief Medical Officer
James Donahue, Associate Commissioner of Mental Health
Superintendent Mariejosee King, Clinton CF
Dr. Li-Wen Lee, Associate Commissioner
Division of Forensic Services, NYS Office of Mental Health

Danielle Dill, Executive Director, CNYPC
William Vertoske, Deputy Director of CBO, CNYPC
Meaghan Bernstein, Advocacy Letter Coordinator, CNYPC