NEW YORK STATE COMMISSION OF CORRECTION

In the Matter of the Death of Jesse Ramirez, an inmate of the Anna M. Kross Center	: : : : :	FINAL REPORT OF THE NEW YORK STATE COMMISSION OF CORRECTION

TO: Commissioner Dora Schriro
NYC Department of Correction
75-20 Astoria Blvd, Ste. 100
East Elmhurst, NY 11370

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 Jesse Ramirez who died on August 5, 2009 while an inmate in the custody of the NYC Department of Correction at the Anna M. Kross Center, the Commission has determined that the following final report be issued.

FINDINGS:

1. Jesse Ramirez was a 34 year old male inmate who died on 8/5/09 from a suicidal hanging while in the custody of the NYC Department of Correction (NYCDOC) at the Anna M. Kross Center. Ramirez was under the mental health care of Prison Health Services, Inc. (PHS, Inc.), a business corporation holding itself out as a medical care provider. Ramirez received inadequate mental health care, without continuity of care characterized by nine (9) conflicting diagnoses, none of which [redacted] were supported by clinical evidence. Additionally, Ramirez did not receive an adequate suicide risk assessment from a mental health clinician after being referred by correction staff on the date of his death.

2. Jesse Ramirez was born and raised in the Brooklyn, NY area. He completed the 10th grade but obtained his GED during a prior incarceration. Ramirez was engaged to be married and had one child. [redacted] He had a recent family loss when his father died on 1/18/09.

3. [redacted]

4. Jesse Ramirez was admitted into NYCDOC custody at AMKC on 2/8/09. He was initially housed on 2/10/09 in Dorm 4 Main for new admissions. On 2/17/09, he was reassigned to Quad 6 Upper, general population. His last move was to Quad 15 Upper cell #3 on 4/29/09. Ramirez had an uneventful incarceration with no unusual incidents or disciplinary infractions.

5. [redacted]

6. [redacted]

7. [redacted]

8. [redacted]

9. [redacted]

10. [redacted]

11. [redacted]

[redacted]

12. [redacted] This represents an inadequate and inappropriate approach to the patient.

13. [redacted]

14. [redacted]

15. [redacted]

16. [redacted] As noted elsewhere herein, this represents a reckless and cavalier diagnostic approach to this patient.

17. [redacted]

18. [redacted]

19. [redacted]

20. On 8/5/09, Correction Officer G.C. was assigned the A post on Quad Upper 13/15 for the 11:00 p.m. to 7:00 a.m. tour. At approximately 5:00 a.m., Officer G.C. observed Ramirez pacing back and forth in the tier. Officer G.C. called Ramirez over and asked him what was going on. Ramirez stated that he was upset due to family problems, was not sleeping well, and was being seen by mental health for depression. Ramirez began crying and said that his girlfriend didn't want to be with him anymore. Officer G.C. talked with Ramirez and assured him that she would get him sent down to the mental health clinic as soon as she could.

21. Officer G.C. filed a Referral of Inmates to Mental Health Services form on Ramirez noting "unable to sleep," "being depressed" and documenting "inmate is crying profusely and is continuously stating he needs to speak to a psych." Officer G.C. was relieved by Officer L.R. at 7:00 a.m. Officer G.C. debriefed Officer L.R. and informed her of the need to have Ramirez sent to the mental health clinic. Officer L.R. made notification to area Captain A. who took responsibility for processing the referral.

22. Ramirez was observed by Officer L.R. to follow his usual housing unit routine for the rest of the morning. After the count, Ramirez went to the dayroom to use the phone. At approximately 9:30 a.m., he went out to the recreation yard.

23. [redacted]

24. [redacted]

25. [redacted] This represents flagrantly inadequate mental health evaluation and treatment by PHS, Inc. staff.

26. Officer K.P. was assigned supervision of the B post on 8/5/09 for the 3:00 p.m. to 11:00 p.m. tour. Officer L.R. remained the A post officer for overtime. Officer K.P. conducted the count at approximately 3:20 p.m. and had all inmates accounted for. Officer K.P. then conducted a supervisory tour at 3:45 p.m. with all appearing secure.

27. Officer K.P. proceeded to hand out soap supplies to the inmates and began on the 15 side of the unit. At approximately 4:10 p.m., he approached Ramirez' cell (#3) and observed that a sheet was covering the bars on the cell door. Officer K.P. pulled the sheet away and observed Ramirez on the floor with a ligature around his neck and affixed to the cell door. Officer K.P. called to Officer L.R. and ordered cell #3 opened.

28. Officer K.P. had difficulty opening the cell door as the sheet was jammed in the door mechanism. Officer K.P. ordered Officer L.R. to release a nearby inmate to assist him. Officer K.P. and an inmate finally forced the door open and were able to enter the cell. Ramirez was found seated on the cell floor with his back against the cell door. Officer K.P. utilized his cut down tool to remove the ligature from Ramirez' neck. Ramirez was checked for a pulse and breathing, found none, and started CPR.

29. [redacted]

[redacted]

RECOMMENDATIONS:

TO THE DEPUTY COMMISSIONER, DIVISION OF HEALTH CARE ACCESS AND IMPROVEMENT, NYC DEPARTMENT OF HEALTH AND MENTAL HYGIENE:

1. The Division shall require PHS, Inc. to conduct a comprehensive quality improvement review of the psychiatric care provided to Ramirez by PHS, Inc. while in the custody of the NYC Department of Correction. Specifically, the review shall focus on:

   a. [redacted]

   b. [redacted]

   c. [redacted]

2. The Division shall require PHS, Inc. to conduct a comprehensive quality improvement review of the mental health care provided to Ramirez by the mental health clinicians while in the custody of the NYC Department of Correction. Specifically, the review shall focus on:

   a. Verification of continuity for patients who are recommended for group therapy as part of their treatment plan have been afforded the opportunity to attend such programs;

   b. [redacted]

3. The Division shall require PHS, Inc. to conduct training for all clinical staff on suicide risk assessment, as approved by the State Commission of Correction.

4. The Deputy Commissioner, in consultation with the Health Commissioner, should ask the NYC Corporation Counsel's Office to inquire into the status of PHS, Inc. to lawfully hold itself out as a medical care provider in New York State.

WITNESS, HONORABLE PHYLLIS HARRISON-ROSS, M.D., Commissioner, NYS Commission of Correction, 80 Wolf Road, 4th Floor, in the City of Albany, New York 12205 this 24th day of December, 2010.

Phyllis Harrison-Ross, M.D.
Commissioner

PH-R:mj
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8/10

cc: Eric Berliner, Executive Director
of Health Services
Lewis Finkelman, General Counsel
Archana Jayaram, Chief of Staff
Louise Cohen, Deputy Commissioner
Correctional Health Services, NYC
Department of Health & Mental Hygiene
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