NEW YORK STATE COMMISSION OF CORRECTION

In the Matter of the Death of Joaquin Rodriguez, an inmate of the Monroe County Jail	: : : : :	FINAL REPORT OF THE NEW YORK STATE COMMISSION OF CORRECTION

TO: Sheriff Patrick O'Flynn
Monroe County Sheriff's Office
130 Plymouth Avenue South
Rochester, NY 14614

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 Joaquin Rodriguez who died on October 18, 2009 while an inmate in the custody of the Monroe County Sheriff at the Monroe County Jail, the Commission has determined that the following final report be issued.

FINDINGS:

1. Joaquin Rodriguez was a 60 year old male who died on 10/18/09 from undiagnosed and untreated Diabetic Ketoacidosis and associated undiagnosed and untreated left lower lobe pneumonia while in the custody of the Monroe County Sheriff at the Monroe County Jail. Rodriguez' death may have been prevented had he received timely medical care and received proper supervision. At the time of his death, Rodriguez was under the care of Correctional Medical Care, Inc. (CMC, Inc.), a business corporation holding itself out as a medical care provider. The care provided by CMC, Inc. in this case was characterized by gross negligence and gross incompetence and should be the basis of termination of its contract with Monroe County for cause.

   ADDENDUM: In a meeting with the assembled Medical Review Board, Dr. Todd Wilcox, a paid medical consultant to Correctional Medical Care, Inc., asserted that Joaquin Rodriguez died from a condition he referred to as "ketosis-prone diabetes," intimating that Rodriguez' ketoacidosis was sudden, unforeseen and so rapidly overwhelming that effective diagnosis and treatment was improbable. The Medical Review Board rejected this argument. Ketosis-prone diabetes is not markedly clinically different from diabetic ketoacidosis, rather a syndrome variant. The fact remains that Joaquin Rodriguez was seriously ill for five days and critically ill for at least 36 hours without medical care.

2. Joaquin Rodriguez was born and raised in Lagunas, Cuba. He legally immigrated to the United States in 1995 after the death of his wife. Rodriguez had a high school diploma and would work as a truck driver. Rodriguez had been on disability since March 2009 due to physical illness and mental health problems.

3. [redacted]

4. [redacted]

5. Rodriguez was discharged from the drug court program due to continued drug use. He was re-incarcerated at the Monroe County Jail on 7/14/09 and on

9/15/09 he was sentenced to one year. With time served and good time allowance, he was due to be released on 1/19/10.

6. Joaquin Rodriguez was admitted to the Monroe County Jail on 7/14/09. [redacted]

7. [redacted] This represents inadequate medical care by CMC, Inc.

8. [redacted]

9. Pursuant to Correctional Medical Care's policy entitled, "Chronic Disease Program," patients who are identified for chronic care are placed on a master list for chronic care appointments and have a Chronic Care Treatment form and treatment plan filled out by the "doctor" (PA, NP). [redacted] This represents inadequate medical care by CMC, Inc.

10. [redacted] This represents inadequate medical care by CMC, Inc.

11. [redacted] No effort was made to resolve these discrepancies, a lapse in continuity and quality of care by CMC, Inc.

12. [redacted]

[redacted]

13. [redacted]

14. [redacted] According to CMC's Director of Nursing C.R., a note was attached with specific instructions to LabCorp as to the numbers to call at the Monroe County Jail with the results of the STAT analysis.

15. Pursuant to an investigation completed by the NYS Department of Health, Laboratory Investigative Unit of the Wadsworth Center, as requested by the Medical Review Board, the following information was obtained regarding Rodriguez' lab sample. On 10/15/09 a courier made a pickup pursuant to a request at the Monroe County Jail. Two samples were picked up but neither belonged to Rodriquez. On 10/16/09 another pickup was made pursuant to a call. Two samples were picked up, one belonging to Rodriguez and one belonging to another patient. Pursuant LabCorp procedures, all STAT samples were to be sent to the Erie County Medical Center (ECMC) in Buffalo, NY for analysis while routine samples were sent to the LabCorp facility in Raritan, NJ. The sample from the other patient was sent to ECMC under the STAT order most likely with the STAT test-specific reporting telephone numbers. Rodriguez' sample was sent to the Raritan, NJ facility and run as routine. The Raritan facility was in possession of and employed different telephone and fax numbers than those that CMC, Inc. staff claimed to have sent with the STAT specimen, according to the Wadsworth investigation.

16. The date and time reported on the lab report for Rodriguez' specimen collected was 10/16/09 a.m. The sample was received by LabCorp on 10/17/09. The lab report for the BMP was prepared on 10/17/09 at 9:15 a.m. [redacted] The lab results were faxed to the Monroe County Jail medical office, however, 10/17/09 was a Saturday and there were no clerical staff assigned to receive it. The procedure according to CMC was that LabCorp was to contact the booking nurse by phone with any critical results. No phone call was reportedly received by nursing staff at the jail from LabCorp. LabCorp reported making a call to the jail with the number they had on file but received no answer. Pursuant to an investigation by the Laboratory Investigative Unit of the Wadsworth Center, LabCorp was unable to locate written contract language or specific written instructions from the Monroe County Jail outlining protocols for calling critical results to the Monroe County Jail or CMC, Inc. According to LabCorp, absent such specific instructions, LabCorp's policy on "panic

level" results is to call the client multiple times and if unable to make notification, fax the results to the number on file and make a call on the next business day to confirm receipt. Absent specific instructions or contract language for LabCorp to contact the Monroe County Jail for "panic level" laboratory results, LabCorp should reasonably have attempted to find a number to contact the jail as it is a 24 hour a day operation that is continuously staffed. Similarly, it is inexcusable that CMC medical staff would not be able to receive a fax of the critical lab results due to the day falling on a weekend and the receiving office not being staffed. With a lab sample being sent out for "STAT" analysis, medical staff should have been expectant to receive such results (by phone or fax) and should have contacted the lab directly if such results had not been received in a timely manner. CMC, Inc. and their physician, Dr. A.D., had an absolute, non-delegatable duty to follow-up the STAT laboratory results on their patient. They did not do so.

ADDENDUM: During a meeting with the assembled Medical Review Board on March 3, 2011, both CMC, Inc. President Emre Umar and Dr. A.D. acknowledged the absolute duty to following the missing laboratory results in this case to a complete resolution as a required element of the community standard of care and of the duty of care owed to Rodriguez, as well as a lapse in that regard in this case. Corporation President Emre Umar stated to the assembled Medical Review Board on March 3, 2011 that CMC, Inc. has either altered or reinforced existing policy and procedure to prevent future similar lapses in managing laboratory reporting. President Umar agreed to provide an existing or amended policy and procedure to that effect to the Medical Review Board. However, as of March 15, 2011, no such documents have been received.

17. On 10/17/09, Rodriguez was housed in 4MS-15. At approximately 5:46 p.m., Deputy M.G. observed a sheet tied around Rodriguez' cell bars going into his cell and under his blanket. Rodriguez was laying in his bed with his blanket half covering his read. Deputy M.G. and Corporal D. entered Rodriguez' cell to remove the sheet. The sheet was not tied around Rodriguez. Rodriguez stated he had only done it to draw attention to his stomach problems.

18. [redacted] Rodriguez should have been provided with a physician consultation or sent out to a hospital for assessment. Failure to do so represents a departure from the community standard of care and from the duty of care owed to Rodriguez.

19. Deputy S.C. received Rodriguez in his area, 4 West cell 10, for constant supervision at approximately 6:00 p.m. Deputy S.C. was advised that Rodriguez was having problems with abdominal pain and needed to drink lots of fluids. Deputy S.C. stated that Rodriguez slept most of his remaining

shift, occasionally getting up to have a drink. Deputy S.C. had an inmate porter deliver three cups of juice for Rodriguez to drink.

20. Deputy R.F. took over the constant supervision post on 4 West at 11:00 p.m. Deputy R.F. observed that Rodriguez was restless and snoring loudly. He stated he did not hear any moaning from Rodriguez or observe any signs of distress.

21. Corporal I. was assigned constant supervision and Corporal G.G. was assigned supervision of 4 West for the 7:00 a.m. to 3:00 p.m. shift on 10/18/09. At approximately 7:14 a.m., inmate porter A.T. was delivering the breakfast meal trays to the constant supervision inmates in 4 West. When inmate A.T. approached 10 cell, he observed that Rodriguez was not responding. Inmate A.T. alerted his escorting officer who notified Corporal G.G.

22. Corporal G.G. responded and entered Rodriguez' cell. Corporal G.G. found Rodriguez in a fetal position on his right side facing the wall. Rodriguez was unresponsive and not breathing. He was found with his eyes open and was cold to the touch. A copious amount of bodily fluid and emesis was observed around and underneath Rodriguez.

23. Corporal G.G. called for a "code blue" medical emergency on the unit. Deputies M.C., M.G., V.B., and RN M.B. responded to the code blue call. Deputy M.G. arrived first and helped Corporal G.G. remove Rodriguez from his cell and place him on the floor in the day space. [redacted]

24. [redacted]

ADDENDUM: In their written response and again in person during the Medical Review Board meeting March 3, 2011, Monroe County Jail officials denied that Rodriguez suffered extensive vomiting in his cell before the terminal event as evidenced by the scene photos provided by the Monroe County Sheriff's Office. However, photos examined by Commission investigators during the original investigation and re-examined in their entirety by the Medical Review Board members and staff unequivocally confirm the presence of copious amounts of coffee ground emesis on the person of Rodriguez and on the floor, wall and bed in Rodriguez' cell, filling the mattress support tray and overflowing the mattress onto the floor. Rodriguez was undoubtedly violently ill during his terminal event as evidenced both by the death scene and the nature of his critical illness.

25. [redacted]

26. Deputy R.F. and Corporal I. Failed to provide constant supervision on Rodriguez as defined in 9 NYCRR §7003.2(d)(1)(2) which states:

"Constant supervision shall mean the uninterrupted personal visual observation of prisoners by facility staff responsible for the care and custody of such prisoners without the aid of any electrical or mechanical surveillance devices. Facility staff shall provide continuous and direct supervision by permanently occupying an established post in close proximity to the prisoners under supervision which shall provide staff with:

1. *a continuous clear view of all prisoners under supervision; and*
2. *the ability to immediately and directly intervene in response to situations or behavior observed which threaten the health or safety of prisoners or the good order of the facility."*

Rodriguez was found unresponsive, asystolic, without respirations, and with a frank amount of emesis around him indicating he had been experiencing undetected significant distress prior to his death.

ADDENDUM: During a meeting of the assembled Medical Review Board on March 3, 2011, Monroe County Sheriff's Department officials asserted that Rodriguez had been ordered placed on constant supervision because he had made a suicidal gesture and that therefore his supervision would be expected to be focused exclusively on suicide attempt, not violent illness. The Board rejected this argument as invalid. Effective constant supervision in accordance with the requirements of 9 NYCRR §§7003.2(d)(1)(2) and 7003.3(h) was not maintained.

27. Based upon the medical record and the laboratory evidence, the Board finds abundant and convincing proof that Rodriguez was seriously ill for five days and critically ill for at least 36 hours prior to his death without medical care.

RECOMMENDATIONS:

TO THE SHERIFF OF MONROE COUNTY:

1. The Sheriff of Monroe County shall immediately seek to terminate Monroe County's contract with Correctional Medical Care, Inc., for cause.

2. The Sheriff shall conduct a review of the conduct of the deputy(s) assigned to provide constant supervision for Rodriguez in 4 West on 10/18/09. Administrative action should be taken if such conduct is found to be in violation of department policy.

3. The Sheriff shall require uniformed staff to conduct constant supervision when ordered in full compliance with 9 NYCRR §7003.2(d)(1)(2)

TO THE PRESIDENT OF CORRECTIONAL MEDICAL CARE, INC.:

1. CMC, Inc. shall conduct a quality improvement review with the PA [redacted]

Evidence that such review was conducted shall be submitted to the Medical Review Board by April 15, 2011.

2. CMC, Inc. shall conduct a quality improvement colloquium with all clinical and support staff to assure proper procedures are followed to obtain, process, and receive and act upon all ordered lab tests. The written policy and procedure on which the colloquium is predicated shall be forwarded to the Medical Review Board by April 15, 2011.

3. CMC, Inc. shall conduct a quality improvement review with clinical staff and support staff [redacted] Evidence that such review was conducted shall be forwarded to the Medical Review Board by April 15, 2011.

4. CMC, Inc. shall take administrative action against the nurse [redacted]

TO THE NYS EDUCATION DEPARTMENT, OFFICE OF THE PROFESSIONS:

That the Office of the Professions undertake an inquiry into the status of Correctional Medical Care, Inc., a Pennsylvania corporation, as a lawful medical practitioner in New York State, operating in accordance with Education Law, Title 9, Article 130, §6507 and Business Corporations Law, Articles 4, 15 and 15A.

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 18th day of March, 2011.

Phyllis Harrison-Ross, M.D.
Commissioner

PHR:mj
09-M-137
12/10

cc: Emre Umar, President, Correctional Medical Care, Inc.
Deirdre Astin, Program Director, Regulatory Affairs Laboratory Investigative Unit, NYS Department of Health