NEW YORK STATE COMMISSION OF CORRECTION

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

TO: Commissioner Martin Horn
NYC Department of Correction
33 Beaver Street
New York, New York 10004

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 Ruiz who died on November 6, 2007 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. Edwin Ruiz was a 44 year old Hispanic male who died on 11/6/07 at the Elmhurst Hospital from sepsis secondary to untreated necrotizing cellulitis while in the custody of the NYC Department of Correction (NYCDOC) housed at the Anna M. Kross Center (AMKC). The medical evaluation and treatment afforded Ruiz by Prison Health Services, Inc. (PHS, Inc.), a business corporation holding itself out as a medical care provider, was grossly inadequate and caused his death. [redacted]

2. [redacted]

[redacted]

3. [redacted] Suicide Prevention Screening indicated Ruiz scored a one for giving an affirmative answer to the question "Inmate has history of drug or alcohol abuse" with heroin noted in the comment section. [redacted]

4. [redacted]

5. [redacted] On 10/12/07 at 4:37 a.m., Ruiz was transported to a court appearance and returned to AMKC at

7:02 p.m. On 10/19/07 at 3:53 a.m., Ruiz was transported out of AMKC for a court appearance and was returned at 6:56 p.m.

6. [redacted]

On 190/20/07 at 12:30 a.m., per housing log, it is noted Ruiz was returned to his AMKC housing, Quad Lower, 1/3 from the clinic.

7. On 10/21/07 at 9:50 a.m., Officer S.S. documented Ruiz was summoned to the AMKC main medical clinic for a dressing change. Also written in the housing log was "waiting for escort, no pass on the post." In interview, Officer S.S. stated she informed the captain and the AMKC medical clinic of such, and later in the shift, Ruiz was taken down to the clinic for a dressing change. [redacted]

8. [redacted] In interview, Dr. S.S. did not recall the conversation.

9. On 10/21/07 at 11:31 p.m., Officer N.W. documented Ruiz was still in the AMKC clinic when she assumed duty on the night shift on Quad L 1/3. Officer J.W., the medical transport officer, stated when she assumed her post at the AMKC clinic she was told Ruiz would be transferring to the NIC. Officer

J.W. stated she went to Quad L 1/3 to pick up Ruiz' belongings and floor location card. She came back to the AMKC clinic and pushed Ruiz in a wheelchair to the AMKC receiving area where she dropped him off. In interview, Officer E.B., the AMKC intake officer, who was on duty that night, stated he did not remember Ruiz. On 10/22/07 at 4:50 a.m., per security log, Ruiz was returned to his original housing unit, Quad L 1/3. Officer N.W., Ruiz' housing officer, stated she does not remember why Ruiz was returned to the housing unit.

10. On 10/22/07 at 1:00 p.m., Officer S.S. documented Ruiz was out to the AMKC clinic for a dressing change. [redacted]

11. [redacted] At 1:00 p.m. per security log, Ruiz was called to the clinic. [redacted]

12. [redacted] Commission staff interviewed RN M.M., who at the time of this incident was the AMKC Clinic's evening charge nurse, and is presently the AMKC Director of Nursing. In interview RN M.M. stated she was unable to provide nor had the knowledge of the nurses' names who worked or the nursing assignments from 10/10/07 to 10/25/07. RN M.M. stated that the physician orders on admission generate a blood pressure monitoring flow sheet only in the incidents that the physician makes a definite diagnosis of hypertension. RN M.M. stated there was no computer system in place for transcription of orders for blood pressure monitoring of suspected hypertensive cases, [redacted]

13. On 10/26/07 at 4:00 a.m., Ruiz was transported to a court appearance and returned to AMKC at 6:57 p.m. [redacted]

[redacted]

14. On 10/30/07 at 2:00 a.m., Captain R.F. stated he requested medical staff to see Ruiz for pain in his legs. At 2:05 a.m., the medical staff was on the post and at 2:08 a.m., they had left with Ruiz in a wheelchair. In interview, Captain R.F. stated he believed that Ruiz was seen by the medical staff at the AMKC clinic, [redacted]

15. On 10/31/07 at 4:30 a.m., Ruiz was transported to a court appearance and returned to AMKC at 7:51 p.m. On 10/31/07 at 9:35 p.m., per housing log, Ruiz was transported to the clinic [redacted]

16. On 11/4/07 per security log at 10:00 p.m., Officer N.M. called Officer E. in the AMKC main clinic area regarding Ruiz. Officer N.M. stated she had been informed by Officer L.W., who was the "B" officer that evening, that Ruiz was sick, not looking well, and appeared to be in pain. Officer N.M. stated she was told Ruiz would not be able to be seen that evening at the AMKC medical clinic due to the amount of emergencies there. Officer N.M. also notified Captain L.S. of Ruiz' condition. Upon interview, Captain L.S. stated he did not recall Ruiz or his condition on 11/4/07. Officer E. was unable to be interviewed due to being out of work on Workers Compensation.

17. On 11/5/07 at 9:14 a.m., Officer J.B. notified the AMKC main clinic that she had a medical emergency on her assigned housing unit, Quad L 1/3. The officer reported Ruiz was "going in and out of consciousness." [redacted]

18. [redacted]

19. [redacted]

RECOMMENDATIONS:

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

1. An inquiry should be conducted into and address the failure to complete an infirmary admission for Ruiz [redacted] A written report shall be forwarded to the Board for review.

2. An inquiry should examine the nurses' responsibilities for compliance with a physician order [redacted] A written report of findings shall be forwarded to the State Commission of Correction's Medical Review Board for review.

3. An inquiry should be conducted into and address PHS, Inc. nurses' responsibilities for and compliance with the physician order on 10/10/08 [redacted] In addition, an inquiry should be made as to why the PHS, Inc. Blood Pressure Monitoring Sheet is not introduced when a physician orders a blood pressure measurements [redacted]

4. An quality assurance review should be conducted into and should address PHS, Inc. nurses' current practice of transcribing physician orders.

5. The Division should require PHS, Inc. to inquire into and report to the Division on the absence of medical progress notes for Ruiz on 10/20/07, in which a medical consult was generated, and on 10/30/07 at 2:00 a.m.

6. The Division should require PHS, Inc. to review and address why Ruiz was not seen by the AMKC medical staff on 11/4/07 at 10:00 p.m. when requested by AMKC security staff. This should generate a written report that shall be forwarded to the State Commission of Correction's Medical Review Board for their review.

7. The Division should use this case to re-evaluate the overall quality of medical care provided by PHS, Inc. Attention should be focused on the quality and continuity of care given

to Ruiz [redacted]

8. As recommended by the Board in previous cases, the Deputy Commissioner should require that PHS, Inc.'s mental health staff be trained in the Local Forensic Crisis Service Model - Suicide Prevention and Crisis Intervention Program.

9. The Deputy Commissioner, in consultation with the Commissioner of Health, should ask the New York City 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.

TO THE NYS DEPARTMENT OF HEALTH, OFFICE OF PROFESSIONAL MEDICAL CONDUCT:

That the Office of Professional Medical Conduct investigate the physician assistant for gross incompetence in his 10/31/07 evaluation [redacted] and failure to appropriately treat while Ruiz was an inmate at the Anna M. Kross Center, NYC Department of Correction.

TO THE NYS EDUCATION DEPARTMENT, OFFICE OF PROFESSIONAL DISCIPLINE:

That the Office of Professional Discipline investigate the professional conduct of the nurses who failed to execute the physician orders [redacted]

WITNESS, HONORABLE DANIEL L. STEWART, Commissioner, NYS Commission of Correction, 80 Wolf Road, 4th Floor, in the City of Albany, New York 12205 this 19th day of December, 2008.

Daniel L. Stewart
Commissioner

DLS:mj
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9/08

cc: Carolyn Thomas, Chief of Department
Roger Parris, Deputy Commissioner
of Strategic Planning and Programs
Eric Berliner, Executive Director
of Health Services
Florence A. Hutner, General Counsel
Mark Cranston, Deputy Chief of Staff
Louise Cohen, Deputy Commissioner
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