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State report blames private medical firm for two Niagara County inmate deaths

State cites new hire by Niagara County

By Thomas Prohaska | *News Niagara Reporter* | *@ThomasProhaska* | *Google+*
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LOCKPORT – A state investigation concludes that two inmates died four days apart in the Niagara County Jail in 2012, victims of "grossly inadequate" medical care and "patient abandonment."

Both inmates died two weeks after a Miami-based medical company took over medical care at the jail. The Niagara County Legislature hired Armor Correctional Health Services in hopes of saving money.

Daniel Pantera's death on Christmas morning 2012 was preventable, the state Commission of Correction's Medical Review Board concluded, citing "grossly inadequate medical and mental health care,"

Additionally, Tommie Lee Jones was the victim of "patient abandonment" and an erroneous prescription by the jail's medical director, the board concluded.

Although the report referred to that physician as "Dr. S.G.," an Armor spokeswoman identified him as Dr. Steven C. Gasiewicz, a local physician hired by Armor. Armor remains the medical provider at the jail and Gasiewicz is the medical director.

The report, though, said that Gasiewicz ought to be investigated by the State Health Department's Office of Professional Medical Conduct for "grossly incompetent and inadequate care." The report also called on the Niagara County Legislature to consider whether Armor "is fit to provide medical and mental health care at the Niagara County Jail, or should be terminated for cause."

The Buffalo News obtained a heavily redacted copy of the report through the Freedom of Information Law, but the conclusions and recommendations were not blacked out.

Sheriff James R. Voutour responded: “I did review the conduct of my CO’s and I didn’t find anything that departed from best practices.”

Armor, through a spokeswoman, said it “disagrees with all of the written findings. Due to patient privacy, Armor declines to comment further.”

The News tried to reach. Gasiewicz through Team Health, which he is connected with, but the group would not provide contact information for him. A message left for him at the jail was not returned, and an attempt to reach him via Facebook also drew no response.

The families of Jones and Pantera have filed lawsuits against the county and Armor over the deaths. Those cases, filed last December, have languished while waiting for the state report, according to Gregory P. Krull of the Lipsitz Green law firm, the attorney for Jones’ estate.

The County Legislature hired Armor in October 2012 to provide medical and nursing services at the jail. At the time, it was estimated that hiring the company would save the county about $800,000 a year, as compared to the cost of the county providing the care itself. Armor took over on Dec. 15, 2012.

Staffers told the investigating physician that the transition was “a disaster and complete and mass chaos,” according to the state report, signed by Dr. Phyllis Harrison-Ross, a member of the Commission of Correction.

“There was inadequate nursing staff present during the transitional period,” former county nurses and former Armor nurses told the state investigators. “They related that there was no one there to provide any guidance. Medications were not available and laboratory tests and other testing were not completed, and reportedly (there was) a significant backlog for the M.D. sick call.”

Pantera’s death

Pantera, 46, suffered from severe mental illness. He was arrested in North Tonawanda on Dec. 10, 2012, after leaving a 7-Eleven store without paying for a cup of coffee. The arresting officer reported that he had dealt with Pantera before and knew he had mental health problems.

Pantera “appeared to be incoherent,” resisted arrest and was zapped with a Taser twice before being subdued.

The state report says it is “unclear why Pantera was not transported to the hospital as he had been in the past when he was described as appearing highly mentally unstable.”

Instead, he was taken to the County Jail.

Pantera started kicking and screaming when he was let out of the patrol car. He was bound with two restraint belts and carried into the jail. His mental condition deteriorated rapidly.

On Dec. 22, a corrections officer reported seeing Pantera run from one side of his cell to the other, crashing into the wall at full speed and knocking himself out.

When revived, Pantera said he had been "trying to get out."

On Christmas Eve afternoon, Pantera was seen in his cell "walking like he was walking downhill with his hand on the floor." He took off all his clothes and remained naked in the chilly cell for hours, could not communicate understandably with officers, ate a little but mostly pushed his food around on the floor and seemed "in a perpetual state of confusion," the report said,

By 11 p.m., Pantera, still naked, was under the bed talking to the wall, the report said. He remained naked all night.

At 7:50 a.m., there was no response when an officer opened the food slot. Pantera was found on the floor with his arms crossed over his face, and his arms were cold and rigid.

The ambulance was called, but it was too late.

The report also says that the Special Housing Unit, the solitary confinement area where Pantera died, was so cold that the main cause of his death was **hypothermia**.

The medical examiner was told the temperature in the cell was 72 to 74 degrees, but the commission staff visited Jan. 8 of this year and found it between 60 and 62 degrees.

A nurse said it was typical for space heaters to operate under desks and for blankets to be draped over the staff's shoulders at night. The cold temperatures violate state building codes, which require a minimum temperature of 68 degrees.

The report also said that the official jail account about the medical response to Pantera being found unresponsive is contradicted by a report from Rural Metro Medical Services, the private ambulance company that came to the jail that morning. However, the details of the contradiction are blacked out.

"In the case of Pantera, without any doubt, that was a subject that belonged in a mental health institution," the sheriff said.

The sheriff said that a female inmate was placed in a mental facility last week after three months in jail.

“It probably cost me $25,000 (in overtime) to watch an inmate who should be in a mental institution,” Voutour said. “It’s easy to say, ‘Why wasn’t (Pantera) placed?’ It’s harder to do.”

Jones’ death

Jones, who had a long history of heart disease, was a parole violator.

The 51-year-old man died of “acute untreated pulmonary edema, secondary to congestive heart failure,” the state report said.

He told jail staffers on his admission Nov. 29, 2012, that he had heart disease, emphysema and gout, and was addicted to crack cocaine.

Jones, too, was put in the Special Housing Unit so he could be watched more closely.

On Dec. 27 and 28, Jones complained of shortness of breath. What the medical staff did for him is blacked out in the report, Jones was found unresponsive in his cell shortly before noon Dec. 29, with a bloody liquid coming out of his mouth and nose.

The report also said Jones during his month in jail filled out numerous sick call slips but received no response. The state report cites “documentation of refusal of essential cardiac medications.” The documentation appears blacked out.

Responses

While Voutour responded to News questions about the state report and its recommendations, other county officials said little.

“It hasn’t been brought to my attention,” County Manager Jeffrey M. Glatz said.

County Legislature Chairman William L. Ross, C-Wheatfield, said he presumed the County Attorney’s Office was handling the reports.

Will the county end its contract with Armor?

“I know there’s a problem, and I know there’s not too many in the business Armor’s in,” Ross said.

James A. Vandette, the attorney for Pantera’s widow, said the state report “validates the claims we’re making” against the against the county.

“Our claim is not only limited to the treatment the decedent received, but to the overall operation of the jail,” Vandette said.

email: tprohaska@buffnews.com