Final Report of the
New York State Commission of Correction:

In the Matter of the Death of

Xavier Moxley (93B3097),
an incarcerated individual of the
Woodbourne Correctional Facility

December 21, 2021

To: Honorable Anthony Annucci
   Acting Commissioner
   NYS Department of Corrections
   And Community Supervision
   The Harriman State Campus
   1220 Washington Avenue
   Albany, New York 12226

   Allen Riley
   Chairman

   Thomas J. Loughren
   Commissioner

   Yolanda Canty
   Commissioner
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 Xavier Moxley who died on December 14, 2018, while an incarcerated individual in the custody of the NYS Department of Corrections and Community Supervision at the Woodbourne Correctional Facility, the Commission has determined that the following final report be issued.

FINDINGS:

1. Xavier Moxley was a 48-year-old male who died on 12/14/18 due to bilateral pulmonary emboli while in the custody of the New York State Department of Corrections and Community Supervision (NYS DOCCS) at the Woodbourne Correctional Facility (CF). The Medical Review Board has found that there were serious issues with Moxley’s healthcare prior to and during the terminal event with a shockingly ignorance of knowledge for the proper management of a patient with symptoms of cardiogenic shock.

2. On 8/18/91, Moxley and three accomplices while armed entered an apartment in Rochester, NY occupied by a woman and two young children. Moxley and one accomplice reportedly stabbed and cut the woman several times fatally in the presence of the children and a 10-year-old nephew. There was also an adult male occupant at the residence whose throat was slashed but survived. Moxley claimed that the trio were at the apartment because one of the accomplices wanted to talk to the male occupant and when the discussion became heated, Moxley left the residence. Moxley was found guilty of Murder 2nd Degree and on 12/7/1993, Moxley was sentenced to 25 years to life.

3. 

4. On 12/23/93, Moxley was received at Elmira CF. In June 2009, Moxley was transferred to Eastern CF. In February 2015, Moxley was transferred to Woodbourne CF. In July 2015, Moxley was transferred to the Sing Sing CF.

5. In July 2016, Moxley was transferred to Woodbourne CF.

6. 

7.
An investigation completed by the NYS Office of Special Investigations revealed that Dr. [redacted] stated that Moxley was examined by the medical provider on 12/3/18 however, the provider failed to document that visit in the medical record.
On 12/14/18 at approximately 9:50 p.m., CO R.S. was making security rounds when Moxley called out to the officer. CO R.S. responded to cell A2-21 and found Moxley lying on the cell floor complaining of shortness of breath. Moxley had vomited and defecated. A green dot medical emergency was called.

A review of the medical record indicated that there was no provider order for the nitroglycerine and that the nurses were administering it under a “standing order.”

Per the Mobile Medic EMS report, activation of EMS was at 10:12 p.m. The Medical Review Board finds that RN [redacted] committed a critical error and gross negligence by administering a vasodilator without an assessment of the patient’s blood pressure and without a proper physician’s order.
The Medical Review Board finds that there was another critical error and gross negligence committed by RN [redacted] for administering a vasodilator without a physician’s order, without a measured patient blood pressure, and for a possible cardiac condition of inferior wall myocardial infarction of which vasodilators are contradicted. Additionally, the Medical Review Board finds that the recorded value of respirations at 60 highly suspect of being inaccurate given that such a rate would be unsustainable by a person for the recorded duration.

22. Per an investigation completed by the Office of Special Investigations, the nursing staff reported that they were following the standing order when administering Nitroglycerin and Aspirin to Moxley. The facility medical director stated that this was not a standing order for nurse’s use but rather a guide for medical providers. There was no documentation in the ambulatory health record from a medical provider to give addition doses of Nitroglycerine or Aspirin.

ACTIONS REQUIRED:

TO THE DEPUTY COMMISSIONER OF THE NYS DEPARTMENT OF CORRECTIONS AND COMMUNITY SUPERVISION, DIVISION OF HEALTH SERVICES:

The Deputy Commissioner shall convene a comprehensive quality assurance review on the health care provided to Moxley at Woodbourne CF with a focus on:

a. Why Moxley was given Nitroglycerine with an unobtainable blood pressure and no subsequent blood pressure readings?

b. Why Moxley was given doses of Nitroglycerine and Aspirin without a medical provider order?

c. Why Moxley was not given addition oxygen when the saturation did not improve with the initial amount?

d. Why Moxley was not seen by medical staff for five days following a request by the medical provider when prescribed antibiotics?

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

In a response to the Commission’s preliminary report dated 11/1/21, DOCCS Deputy Commissioner of Health Services indicated that the requested reviews were completed with corrective action(s) taken.
WITNESS, HONORABLE THOMAS J. LOUGHREN, 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 21st day of December, 2021.

Thomas J. Loughren
Commissioner & Chair
Medical Review Board

TJL:DC:jdb
2018-M-0166
December 2021

cc: Dr. John Morley, Deputy Commissioner Chief Medical Officer
    Bryan Hilton, Assistant Commissioner for Mental Health
    Superintendent David Howard, Woodbourne CF