NEW YORK STATE | Commission of Correction

Final Report of the New York State Commission of Correction:

In the Matter of the Death of

Ricky Mack, an incarcerated individual of the Orange County Jail

December 20, 2023

To: Sheriff Paul Arteta
Orange County Sheriff's Office
110 Wells Farm Road
Goshen, New York 10924

Allen Riley
Chairman

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 Ricky Mack who died on January 16, 2022 , as a result of circumstances which occurred while an incarcerated individual in the custody of the Orange County Sheriff at the Orange County Jail, the Commission has determined that the following final report be issued.

FINDINGS:

1. Ricky Mack was a 65-year-old male who died on 1/16/22 due to hypernatremic dehydration, poor oral intake, chronic kidney disease complicating diabetes mellitus, hypertensive cardiovascular disease, esophagitis, and a contributory COVID-19 infection while in the custody of the Orange County Sheriff at the Orange County Jail (CJ). The Medical Review Board has found that there were gross failures in the medical assessments and treatment of Mack during his incarceration that were contributory to his death. The Board opines that had Mack been properly assessed and timely transferred to a hospital for diagnosis and treatment, his death could have been prevented.

2. Mack was born in Bunnell, Florida. He was survived by his four children and five siblings. Mack received his GED but was unemployed. There was no further demographic or social history available to the Commission regarding Mack.

3. [redacted]

4. [redacted]

5. [redacted]

6. On 12/17/21 at 1:11 p.m., Mack was admitted into the Orange County Jail from Orange County Court after being charged with Criminal Possession of a Controlled Substance 3rd Degree. Mack scored a three on the Suicide Screening Guidelines for answering "yes" to having a history of drug or alcohol abuse, having a history of mental health, and having a previous suicide attempt. [redacted]. Mack's next court date was scheduled for 2/14/22.

7. [redacted]

8. [redacted] During an interview with Commission staff, RN [redacted] reported that she could not recall what the length of time was for daily COVID-19 temperature checks on new admissions.

9. [redacted]

10. [redacted]

11. [redacted] After a review of Mack's medical records by the Commission staff, Mack was not seen for his admission medical history and physical assessment within the 14 days of his admission. This is a violation of 9 NYCRR §7010.2(b)(1) Health Services which states: *Each prisoner shall be examined by a physician licensed to practice in the State of New York or by a medical personnel legally authorized to perform such examination at the time of admission or as soon as thereafter, but no later than 14 days after admission.*

12. [redacted] There was no documentation in Mack's medical chart that Mack's prior medical history and physical that was completed on 10/6/21 was reviewed by a physician. This is a violation of 9 NYCRR §7010.2(b)(2) Health Services which states: *Documented evidence of an examination by a physician or other authorized medical personnel within the six-month period prior to admission shall satisfy the requirements of this subdivision. Such documentation shall be reviewed, and follow-up treatment initiated as necessary.*

13. [redacted]

14. [redacted]

15. [redacted] The Medical Review Board finds that there was no documentation that Dr. [redacted] was updated that Mack refused on two occasions to have his blood drawn for laboratory testing. The Medical Review Board also finds that Dr. [redacted] failed to follow-up with the laboratory testing that he ordered for

Mack.

16. [redacted] A review of Mack's medical chart by the Medical Review Board finds that there was no documentation that LPN [redacted] updated an RN or a Physician that Mack [redacted]. The Medical Review Board also finds that there was no documentation that LPN [redacted] had updated an RN or a physician that Mack reported not eating anything in three days, and that he was only taking in juice and minimal water. The Medical Review Board opines that Mack should have been seen by an RN for an assessment, and that the facility provider should have been notified for further orders that included neurological assessments with parameters, and for Mack to be placed on food consumption and fluid intake monitoring.

17. [redacted]

18. [redacted] A review of Mack's medical record by Commission staff indicated that there was no documentation by RN [redacted] as to why Mack was on a bland diet or who had ordered the bland diet.

19. [redacted] The Medical Review Board finds that the neurological assessment on Mack by RN [redacted] was incomplete for assessing him for a concussion, a brain contusion, a hematoma, or a skull fracture. Additionally, the Board finds that there was a failure by the nursing staff to accurately utilize the Glasgow Coma Scale to assess Mack's neurological functioning.

20. [redacted] The Medical Review Board finds that the neurological assessments were not performed for 48 hours as was indicated in the medical chart. The Medical Review Board also finds that there was no indication that the neurological assessments were reviewed by the jail physician.

21. [redacted] The Medical Review Board has found that based upon the postmortem autopsy findings, had Mack been tested for COVID-19, his PCR results would have been positive.

22. A review of Mack's medical chart by Commission staff revealed that there was no documentation of any assessment or vital signs being taken from 1/13/22 through 1/16/22 which is after Mack was placed on contact isolation precautions. The Medical Review Board opines that had Mack received a complete set of vital signs and an assessment at least daily, his medical deterioration would have been identified. The Medical Review Board opines that lack of documented assessments is indicative of inadequate supervision of the nursing staff by the jail physician.

23. On 1/16/22 at 9:25 a.m., Correction Officer (CO) R.M. documented in the Delta 4 Unit logbook that Mack refused his shower.

24. [redacted] The Medical Review Board finds that there were no Refusal of Clinical Services Forms for Mack after refusing his medications on 1/11/22, 1/14/22, and 1/15/22. The Medical Review Board also finds that on 1/16/22, after Mack had refused his medication for the third consecutive day, there was no documentation that LPN [redacted] notified a physician that Mack had refused his [redacted] and [redacted] for three consecutive days from 1/14/22to 1/16/22.

25. On 1/16/22 at 11:35 a.m., CO R.M. documented in the Delta 4-unit logbook that rounds were completed. During an interview with Commission staff, CO R.M. reported that during the round, when he was at Mack's cell, # 10, Mack was laying supine on his bed and asked CO R.M. for a cup of water. CO R.M. reported that he finished making the unit round and at 11:38 a.m., he brought a cup of water to Mack. When CO R.M. returned to Mack's cell, CO R.M. observed Mack laying supine on the floor between the bed and the toilet. CO R.M. asked Mack if he was okay, and Mack responded, "No". CO R.M. immediately made a radio transmission for a medical emergency to Delta 4 cell # 10.

26. [redacted]

27. On 1/16/22 at 12:03 p.m., documentation from the Goshen Volunteer Ambulance Corps indicated arriving at Mack's cell [redacted]

28. [redacted]

29. [redacted] The Medical Review Board opines that had Mack been properly assessed and timely transferred to a hospital for diagnosis and treatment, his death could have been prevented.

ACTIONS REQUIRED:

TO THE ORANGE COUNTY JAIL PHYSICIAN AND MEDICAL DIRECTOR OF WELLPATH MEDICAL:

1. The Jail Physician and Wellpath Medical Director shall conduct their own comprehensive quality assurance review plus arrange for an outside peer medical review regarding the following:

    a. Why Mack did not have admission daily temperatures taken on 12/25/21 or 12/26/21.
    b. Why there was a failure to comport with the requirements of 9 NYCRR §7010.2(b)(1) to have Mack's physical assessment completed within 14 days during his incarceration from 9/14/21 to 10/14/21.
    c. Why Mack's medical history and physical that was completed on 10/6/21 during his previous incarceration from 9/14/21 through 10/14/21 was not reviewed by the physician after his readmission to the jail on 12/17/21 in accordance with 9 NYCRR §7010.2(b)(2).
    d. Why Dr. [redacted] was not updated that Mack refused to have his blood drawn for laboratory testing on 1/4/22 and 1/5/22.
    e. Why Dr. [redacted] failed to follow-up with laboratory testing that he ordered for Mack.
    f. Why on 1/11/21 LPN [redacted] did not update an RN or the Jail Physician that Mack had fallen, passed out, and sustained a head injury.
    g. Why on 1/11/21 there was no physician order in Mack's medical chart for a neurological assessments to be done for 48 hours, along with how often the assessment should be completed.
    h. Why there was no documentation in the medical chart that the jail physician reviewed the neurological assessments.
    i. Why on 1/11/21 LPN [redacted] did not update an RN or a physician that Mack had not eaten in three days and was only drinking juice and minimal water.
    j. Why on 1/11/22 Mack was not placed on food consumption and fluid intake monitoring.
    k. Why on 1/11/22 there was no documentation by RN [redacted] as to why Mack was placed on a bland diet or who had ordered the bland diet.
    l. Why on 1/13/22 RN [redacted] did not document why Mack was placed on contact isolation precautions.
    m. Why on 1/13/22 RN [redacted] did not complete an assessment on Mack or take a set of baseline vital signs to monitor for any fluctuations while being on contact isolation precautions.
    n. Why Mack did not have any assessments or vital signs taken after being placed on contact isolation precautions.
    o. Why Mack did not have medication refusal forms filled out on 1/11/22, 1/14/22, and 1/15/22 after he refused his medications.
    p. Why on 1/16/22 LPN [redacted] did not update the physician that Mack had refused his medications for three consecutive days.

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

The Commission received a response dated 12/7/23 from Barclay Damon LLP representing New York Correct Care Solutions which indicated that the requested quality assurance review was completed. NYCCS indicated that the cited LPN was terminated from employment, medical staff received retraining on patient refusal policy and provider notification, the medical director will receive daily reports regarding unattended appointments, and implementation of a

continuous quality improvement process for ancillary services, nursing documentation, and patient refusals.

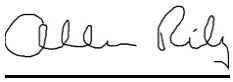
TO THE DEPARTMENT OF EDUCATION, OFFICE OF PROFESSIONAL DISCIPLINE:

The Medical Review Board requests that an investigation be conducted into the professional misconduct of Licensed Practical Nurse (LPN) [redacted] for failure to report a patient's unwitnessed fall from passing out and sustaining a head injury to a Registered Nurse or Physician and for failure to report critical findings of a patient who reportedly did not eat anything for three days with minimal fluid intake.

TO THE ORANGE COUNTY EXCUTIVE AND CHAIR OF THE ORANGE COUNTY LEGISLATURE :

As the appointing authority for the delivery of jail incarcerated individual health services pursuant to Correction Law section 501, the County Legislature shall review the above findings and conduct an inquiry into the fitness of the designated provider.

WITNESS, HONORABLE ALLEN RILEY, Chairman, 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 20h day of December, 2023.



Allen Riley
Chairman
Commission of Correction

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