NEW YORK STATE | Commission of Correction

Final Report of the New York State Commission of Correction:

In the Matter of the Death of

Niki Capaci
an incarcerated individual of the
Orange County Jail

September 25, 2024

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

Allen Riley
Chairman

Yolanda Canty
Commissioner

Elizabeth Gaynes
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 Niki Capaci, who died on May 6, 2023 , 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. Capaci was a 40-year-old female who died on 5/6/23 from acute drug intoxication of fentanyl, xylazine, chlordiazepoxide, and diazepam while in the custody of the Orange County Sheriff at the Orange County Jail (CJ). The Medical Review Board has found that there were failures to maintain proper supervision in accordance with minimum standards and failures to meet acceptable standards of medical care while Capaci was in custody.

2. [redacted]. On 4/4/23, in the instant offense, Capaci was charged with Criminal Possession of a Controlled Substance 3rd Degree.

3. [redacted]

4. On 5/3/23, Capaci was admitted into the Orange CJ on charges of Criminal Possession of a Controlled Substance 3rd Degree. Correction Officer (CO) R. completed Capaci's suicide prevention screening with Capaci scoring a '3'. CO R. documented that Capaci was worried about medical problems, [redacted] and had a [redacted]. Capaci was referred to medical and mental health. [redacted]. The Medical Review Board finds that there was an inadequate medical assessment of Capaci. Capaci's histories of Asthma, Lupus, and Lyme disease were not reviewed nor assessed. Additionally, there was no urinalysis or lab work ordered to screen for recent drug use.

5. [redacted]

6. [redacted]

7. [redacted] The Medical Review Board opines that this is not in comportment with the requirements of 9 NYCRR §7010.2(j) which states:
(j) Adequate health service and medical records shall be maintained which shall include but shall not necessarily be limited to such data as: date, name(s) of inmate(s) concerned, diagnosis of complaint, medication and/or treatment prescribed. A record shall also be maintained of medication prescribed by the physician and dispensed to a prisoner by a staff person.

8. [redacted]

9. [redacted]

[redacted]. During an interview with Commission staff, RN [redacted] stated that a medication ordered at that time of the day, would be started at the 9:00 a.m. medication pass and would be documented in the medication administration record upon administration. RN [redacted] continued by saying that Buprenorphine was administered on the day shift and would not have been administered at the time of day it was ordered.

10. [redacted]

11. [redacted] The Medical Review Board opines that Capaci should have received Buprenorphine as ordered.

12. [redacted]

13. [redacted]

14. [redacted]

15. On 5/5/23 at 8:03 p.m., CO L.D. documented that Capaci complained of chest pain and notified medical. At 8:10 p.m., Capaci was documented in the housing area logbook as going to main medical. [redacted] the Medical Review Board did not find any recorded vital signs for the 5/5/23 8:30 p.m. clinical encounter. During an interview with Commission staff, RN [redacted]. stated that documentation of vital signs were in a different field within the electronic medical records and should have been attached. [redacted]

[redacted]

16. On 5/5/23 at 10:45 p.m., CO C.D. assumed control of the housing unit from CO L.D. In an interview with Commission staff, CO C.D. stated that he could not recall any discussion with CO L.D. pertaining specifically to Capaci. CO C.D. stated that he knew that Capaci was on 15-minute supervision. CO C.D. continued by saying that he witnessed Capaci dry heaving throughout the night but did not witness her vomiting. CO C.D. stated that he informed medical of Capaci's need to be seen by medical due to her dry heaving.

17. [redacted] The Medical Review Board opines that Capaci's acute withdrawal symptoms and unresolved vomiting should have prompted an evaluation by a medical provider if not a transfer to an emergency room for evaluation. The Medical Review Board finds the lack of a physician exam of Capaci, who had a significant medical history and acute withdrawal symptoms, plus multiple sick call encounters with orders given without an examination was not within the acceptable standards of medical care and does not meet the intent of 9 NYCRR 7010.2(b)(1) which states:
Each prisoner shall be examined by a physician licensed to practice in the State of New York or by medical personnel legally authorized to perform such examination at the time of admission or as soon thereafter as possible, but no later than 14 days after admission.

18. Between 2:00 a.m. and 6:00 a.m., Capaci was documented by the officer as laying on her bunk during general supervision tours and 15-minute supervision tours. During an interview with Commission staff, CO C.D. stated that during the night, Capaci was upset with his stopping at her cell for rounds throughout the night. CO C.D. stated that throughout the night, Capaci was observed dry heaving, washing her hands or wetting herself to stay cool. CO C.D. stated that at 5:00 a.m., Capaci was observed laying on her bunk.

19. On 5/6/23 at approximately 6:03 a.m., while conducting a supervisory tour of the housing area, CO C.D. observed Capaci lying on the floor of her cell on her back with her head tilted to the side. During an interview with Commission staff, CO C.D. stated that on this watch tour, he did not observe Capaci's on her bed where she had previously been. This prompted CO C.D. to inspect her cell further and notice that Capaci was unresponsive on the cell floor. CO C.D. stated that he did not enter Capaci's cell or make physical contact with her. CO C.D. attempted to get a verbal response from Capaci twice to which she did not respond. CO C.D. called via the facility radio a medical emergency for an

unresponsive incarcerated individual. At 6:05 a.m., responding staff arrived including Sergeant A.C. who immediately entered Capaci's cell and found her in cardiac arrest. Sergeant A.C. began chest compressions and called for medical. Medical staff responded, [redacted]. At 6:08 a.m., emergency medical services were activated. [redacted] At 6:20 a.m., Goshen Volunteer EMTs arrived on the unit and assumed care of Capaci. At 6:25 a.m., Mobile Life EMS arrived on the housing unit to assist with life saving measures. [redacted]

20. During the investigation, Commission staff reviewed the recorded housing unit video footage and toured the housing area. In order to check on Capaci, the officers had to physically walk up to the cell that Capaci was housed in due to not having a complete view of an individual in the cell from the officer's post. While comparing the recorded housing unit video with the written logbook, the following was noticed pertaining to the 15-minute supervision of Capaci:

a. On 5/4/23, the following additional supervisory visits were not made at the as documented in the housing area logbook:

6:13 a.m. by CO C.
7:30 a.m.by CO C.
9:00 a.m. by CO C.
9:15 a.m. by CO C.
10:15 a.m. by CO C.
10:45 a.m. by CO C.
11:00 a.m. by CO C.
11:15 a.m. by CO C.
11:45 a.m. by CO C.
1:19 p.m. CO C. made a supervisory visit, however this visit was not documented in the logbooks.
5:45 p.m. by CO Q.
9:15 p.m. by CO Q.
10:15 p.m. by CO Q.
11:05 p.m. by CO L.P.

b. On 5/5/23, the following additional supervisory visits were not made as documented in the housing area logbook:

12:00 a.m. by CO L.P.
1:30 a.m. by CO F.
2:50 a.m. CO F. made a visit however this visit was not documented in the logbook
3:15 a.m. by CO F.
3:30 a.m. by CO F.
3:45 a.m. by CO F.
4:00 a.m. by CO F.
4:15 a.m. by CO F.
4:30 a.m. by CO F.

5:15 a.m. by CO F.
5:30 a.m. by CO F.
5:45 a.m. by CO F.
6:00 a.m. by CO F. made a visit however this visit was not documented in the logbook.
6:45 a.m. by CO F.
7:00 a.m. by CO W.
7:15 a.m. by CO W.
8:15 a.m. by CO W.
8:45 a.m. by CO W.
10:15 a.m. by CO W.
10:45 a.m. by CO W.
1:06 p.m. by CO W.
1:15 p.m. by CO W.
1:45 p.m. by CO W.
2:15 p.m. by CO W.
11:30 p.m. by CO C.D.
11:45 p.m. by CO C.D.

c. On 5/6/23, the following physical rounds were not made as documented in the housing area logbook:

12:15 a.m. by CO C.D.
12:45 a.m. by CO C.D.
1:15 a.m. by CO C.D.
1:45 a.m. by CO C.D.
2:15 a.m. by CO C.D.
2:45 a.m. by CO C.D.
3:15 a.m. by CO C.D.
3:45 a.m. by CO C.D.
4:15 a.m. by CO C.D.
4:45 a.m. by CO C.D.
5:15 a.m. by CO C.D.
5:30 a.m. CO C.D. made a visit however this visit was not documented in the logbook.
5:45 a.m. by CO C.D.

The Medical Review Board finds that there was a substantial failure to complete supervisory visits in comportment with the requirements of 9 NYCRR §7003.2(a) Supervisory visit and §7003.3(h) General supervision, which state:

7003.2(a)(1)Supervisory visit shall mean a personal visual observation of each individual prisoner by facility staff responsible for the care and custody of such prisoners to monitor their presence and proper conduct; and (2) a personal visual inspection of each occupied individual prisoner housing unit and the area immediately surrounding such housing unit by facility staff responsible for the care and custody of prisoners to ensure safety, security and good working order of the facility.

7003.3(h)(1) The chief administrative officer and/or the facility physician shall determine whether a prisoner requires additional supervision based on the prisoner's

condition, illness or injury, and the chief administrative officer shall order such supervision if warranted. Additional supervision may include more frequent supervisory visits;

During the investigation, Orange County Jail Administration informed the Commission that administrative action had been taken against CO C.D. for failure to follow Orange CJ policy regarding supervision in this incident.

ACTIONS REQUIRED:

TO THE OFFICE OF THE ORANGE COUNTY SHERIFF:

The Commission acknowledges the administrative action previously taken by the Sheriff's Office in this matter. The Commission requests that a review be conducted regarding the other identified staff who failed to comport with the requirements of 9 NYCRR §*7003.3(h)(1).* Administrative action should be taken if they are found to be in violation of agency's policy and procedures.

TO THE ORANGE COUNTY JAIL PHYSICIAN:
The Jail Physician shall arrange for an independent peer led quality assurance review regarding the care provided to Capaci to include the following:

1. Why on 5/5/23 at 2:04 a.m., a medical provider was not contacted regarding Capaci's elevated COWS and CIWA scores.

2. Why was there a delay in the administration of Buprenorphine 4mg when it was ordered at 5:17 a.m. and administered at 4:05 p.m.

3. Why Capaci was not seen by a medical provider for an evaluation due to her complaints of irretractable nausea and vomiting.

4. Why Capaci's histories of Asthma, Lupus, and Lyme disease were not reviewed nor assessed during her intake exam.

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

A response dated 9/4/24 to the Commission's preliminary report from the attorney representing New York Correct Care Solutions, LLC, indicated that the requested reviews were completed however the findings of the Board were refuted with explanation that the cited deficiencies had no causal relationship to Capaci's cause and manner of death. The response indicated that retraining of staff regarding procedures was completed however, there was no indication that a review was completed by an independent medical peer as requested by the Board. The Medical Review Board did not find this acceptable and remains affirmed in its findings and actions required.

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

As the appointing authority(s) 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 currently designated provider.

WITNESS, HONORABLE YOLANDA CANTY, 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 25th day of September 2024.

Yolanda Canty
Commissioner
Commission of Correction

YC:MB:vc
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September 25, 2024