



**Commission of
Correction**

**Final Report of the
New York State Commission of Correction:**

In the Matter of the Death of

**Michael Stevenson,
an incarcerated individual of the
Orange County Jail**

December 18, 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

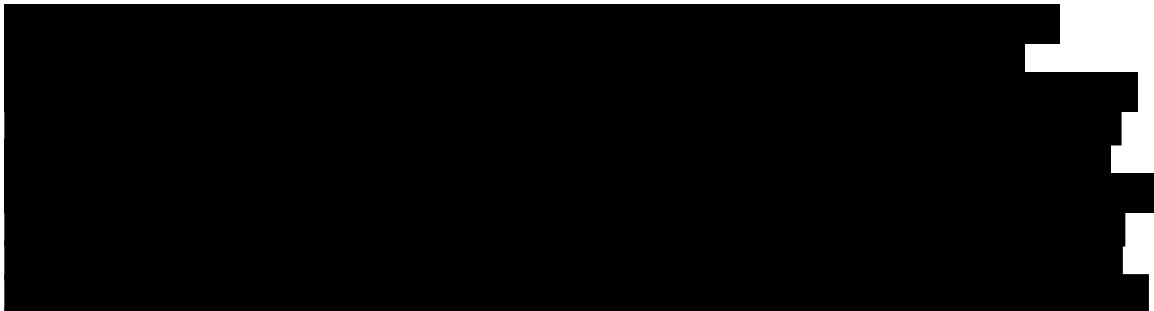
GREETINGS:

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 Michael Stevenson, who died on September 8, 2021, 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:

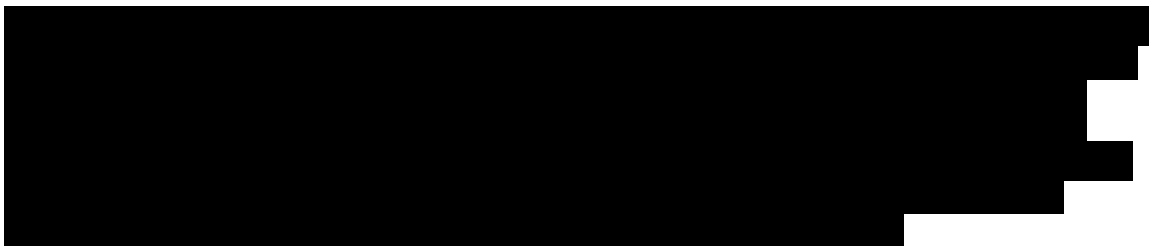
1. Michael Stevenson was a 41-year-old male who died on 9/8/21 from Coronary Artery Disease that resulted in an acute cardiac arrest while in the custody of the Orange County Sheriff at the Orange County Jail (CJ). Stevenson was found alone and unresponsive in his cell by a Correction Officer (CO). The Medical Review Board has found that during his approximately six months of incarceration, Stevenson had numerous complaints of cardiac related symptoms and chest pains that the contracted medical providers at Orange CJ, Wellpath Inc., failed to properly address. The Board has found that there was a lack of oversight and coordination with the jail's health services as evidenced by multiple instances of failing to conduct patient assessments, failing to properly document in the medical record, and failing to make referrals to outside medical specialists. The Medical Review Board opines that had Stevenson been properly referred to a cardiologist, had the proper diagnostic testing been completed, and had interventional procedures been completed, his death could have been prevented.


2.



On 3/21/21, Stevenson was arrested for the instant offenses and charged with Robbery 2nd Degree, Burglary 2nd Degree and Criminal Mischief, all of which were abated by his death.

3.



4. On 3/22/21 at 5:34 p.m., Stevenson was admitted into the Orange CJ charged with Burglary 2nd Degree, Robbery 2nd Degree and Criminal Mischief: Intent to damage property. At 9:14 p.m., CO D.P. completed Stevenson's suicide prevention screening. Stevenson scored a '3'. Stevenson was documented as having had a history of 



[REDACTED]

During Stevenson's initial risk assessment, it was documented that he had no injuries but did have an ongoing medical condition of swollen feet. Stevenson was documented as appearing with mental or physical handicaps with noted mental health issues but appeared normal for him. [REDACTED]

Stevenson confirmed that he had previously been incarcerated at Orange CJ. Stevenson was referred to Registered Nurse (RN) [REDACTED] Stevenson was referred to the Mental Health Department [REDACTED]

5.

[REDACTED]

6.

[REDACTED]

7.

On 3/24/21 at 1:55 a.m., Stevenson complained of having chest pain and was taken to medical. [REDACTED]

[REDACTED]

[REDACTED]

8.

[REDACTED]

9.

[REDACTED]

10.

[REDACTED]

11.

[REDACTED]

The Medical Review Board finds that Stevenson was admitted to GHMC at the time that the COWS assessment on 3/29/21 was documented as being completed, therefore the COWS assessment could not have been completed as documented. RN [REDACTED] is no longer employed by Wellpath at the Orange CJ and was not available to be interviewed.

Further review by the Commission after issuing the preliminary report revealed that the documented date could be interpreted as (3/27/21) or (3/29/21). As the RN who documented the note was not available to Commission to review, the finding regarding the record entry is inconclusive.

12.

[REDACTED]

[REDACTED]

13.

[REDACTED]

14.

[REDACTED]

15.

[REDACTED] The
Medical Review Board finds that Stevenson did not receive COWS assessments as per
the doctor's order that they occur once every eight hours.

16.

[REDACTED]

17.

[REDACTED]

18.

[REDACTED]

19.

[REDACTED]

20.

[REDACTED]

21.

[REDACTED]

22.

[REDACTED]

23. There was no documentation provided to the Commission that indicated when Stevenson returned to the facility or if Stevenson was seen by a medical provider as a follow-up to his hospitalization. This is a violation of 9 NYCRR §7010.2(j).

24. [REDACTED]

25. [REDACTED]

26. [REDACTED]

27. [REDACTED]

28. [REDACTED]

29. [REDACTED]

30. [REDACTED]

31. The Medical Review Board opines that with multiple hospital admissions, continued complaints of chest pain, and a known high risk of coronary artery disease that was

documented in the hospital discharge information on 3/30/21, the facility medical director should have been prompted to immediately refer Stevenson to a cardiologist for an evaluation. There was no documentation provided to the Commission that indicated that the cardiology appointments that were made by GHMC were offered to, attended or declined by Stevenson. During an interview with Commission staff, Dr. [REDACTED] stated that when an incarcerated individual is referred to a specialist, the referral is reviewed by medical personnel from Wellpath and the decision is made by Wellpath as to the continuation of care. This decision is not made at the facility level. [REDACTED]

32.

[REDACTED]

33.

[REDACTED]

34.

[REDACTED]

35.

[REDACTED]

36.

[REDACTED]

37.

[REDACTED]

38.

[REDACTED]

39.

[REDACTED] This clinical encounter was not documented in the medical progress notes. [REDACTED] The Medical Review Board finds that Stevenson was not properly assessed for his complaints by RN [REDACTED] which should have included a physical exam with vitals and consultation with an on-call medical provider.

40.

[REDACTED] This clinical encounter was not documented in the medical progress notes.

41.

[REDACTED]

42.

[REDACTED]

43.

[REDACTED]

[REDACTED] Stevenson's vital signs were not documented, and this clinical encounter was not documented in the medical progress notes. The Medical Review Board finds that there was a failure by RN [REDACTED] to properly assess Stevenson.

44. [REDACTED]

45. [REDACTED]

46. [REDACTED]

47. [REDACTED]

48. [REDACTED]

[REDACTED]
This clinical encounter was not documented in the medical progress notes.

49.

[REDACTED]

50.

[REDACTED] This clinical encounter was not documented in the medical progress notes.
[REDACTED] The Medical Review Board finds that RN [REDACTED] failed to properly conduct a hospital return assessment on Stevenson.

51.

[REDACTED] The Medical Review Board finds that Dr. [REDACTED] failed to recognize and address that Stevenson had breakthrough hypertension with his current medication therapies. The Medical Review Board opines that with Stevenson having made 23 complaints of chest pain to facility medical staff since his admission, four of which resulted in being sent to GHMC with three hospital admissions, Dr. [REDACTED], as the Orange CJ physician, should have referred Stevenson to a Cardiologist for further diagnostic studies and management in a chronic care setting for hypertensive cardiovascular disease.

52.

[REDACTED] These clinical encounters were not documented in the medical progress notes. The Medical Review Board finds that both RN [REDACTED] and RN [REDACTED] failed to conduct a proper assessment of Stevenson.

53.

[REDACTED]

[REDACTED]

54.

[REDACTED]

[REDACTED] This clinical encounter was not documented in the medical progress notes.

55.

[REDACTED]

56.

[REDACTED]

57.

[REDACTED]

58.

[REDACTED]

[REDACTED] This clinical encounter was not documented in the medical progress notes.

59.

[REDACTED]

[REDACTED] This clinical encounter was not documented in the medical progress notes.

60. [REDACTED]

61. [REDACTED]

62. [REDACTED] This clinical encounter was not documented in the medical progress notes.

63. [REDACTED]

64. [REDACTED] The Medical Review Board finds that RN [REDACTED] failed to complete a proper assessment of Stevenson for his complaint of chest pain.

65. [REDACTED]

[REDACTED]

66. On 7/27/21 at 10:10 p.m., a medical emergency was called for Stevenson on the housing unit. RN [REDACTED] responded to the housing unit. [REDACTED]

[REDACTED]

This clinical encounter was not documented in the medical progress notes. This was a failure to properly assess Stevenson. The Medical Review Board finds that RN [REDACTED] failed to complete a proper assessment of Stevenson for his emergency sick call.

67. [REDACTED]

68. [REDACTED]

69. [REDACTED]

70. [REDACTED]

71. [REDACTED]

The Paramedic documented this encounter on a medical incident report but not in the medical progress notes. The Medical Review Board questions the scope and use of paramedics by the facility's health services where they administered medication outside of the EMS protocol formulary and not subsequent to a physician's order.

72. [REDACTED] RN [REDACTED] documented this encounter on a medical incident report but not in the medical progress notes. The Medical Review Board finds that RN [REDACTED] failed to properly assess Stevenson and failed to notify the facility medical provider of Stevenson's complaint.

73. [REDACTED] During an interview with Commission staff, RN [REDACTED] stated that if there were any changes to an EKG, it would be left for the medical provider to review the following day. RN [REDACTED] also indicated that if there had been any changes, the medical provider would have been notified at that time. [REDACTED] There was no documentation of a Cardiology appointment or a refusal of an appointment in the records that were provided to the Medical Review Board for review.

74. [REDACTED] The Medical Review Board finds that there was no continuation of care provided by Dr. [REDACTED], as there was no follow up regarding Stevenson presenting to medical at 3:13 a.m. that morning with complaints of chest pain. There was also a failure to properly assess Stevenson and to properly maintain a medical record.

75. [REDACTED]

76. [REDACTED] There was no documentation of an assessment or what the specific orders were. RN [REDACTED] documented this encounter on a medical incident report but not in the medical progress notes. During an interview with Commission staff, Dr. [REDACTED] stated that the medical incident report was completed by the nurse and any encounter notes would be placed in the medical chart. A review of Stevenson's medical chart by Commission staff did not reveal any progress notes on 8/18/21 from a physician.

77. [REDACTED]

[REDACTED]

78. On 8/31/21, Stevenson was involved in an altercation on the housing unit. Medical responded

[REDACTED] RN [REDACTED] documented this encounter on a medical incident report but not in the medical progress notes.

79.

[REDACTED] RN [REDACTED] documented this encounter on a medical incident report but not in the medical progress notes.

80.

[REDACTED] RN [REDACTED] documented this encounter on a medical incident report but not in the medical progress notes.

81.

[REDACTED] RN [REDACTED] documented this encounter on a medical incident report but not in the medical progress notes. The Medical Review Board finds that RN [REDACTED], failed to properly assess Stevenson and document in the medical record.

82.

[REDACTED] RN [REDACTED] documented this encounter on a medical incident report but not in the medical progress notes.

83. On 9/7/21 at 3:45 p.m., Stevenson was documented in the housing unit logbook as being out to recreation.

84. On 9/7/21 at 6:00 p.m., a telephone mental health referral was made. The CO stated that Stevenson was in his cell having anxiety and freaking out. The CO stated that Stevenson was not suicidal or homicidal.

[REDACTED] CO B.

contacted medical.

85. On 9/7/21 at 7:16 p.m., Stevenson was documented in the housing unit logbook as complaining of chest pains. CO N. documented that main medical and the sergeant were notified. At 7:26 p.m., CO N. documented in the housing unit logbook that Stevenson went to main medical in a facility wheelchair. It was not documented in the logbook when Stevenson was returned to the housing unit. At 8:13 p.m., Stevenson was documented in the logbook as being out to recreation.
86. [REDACTED]
87. On 9/8/21 at 6:56 a.m., CO K.B. assumed the duties of the housing unit from CO W. CO K.B. documented timely watch tours through 11:00 a.m. when he was relieved by CO B.C. CO B.C. documented at 11:10 a.m. that the mid-day meal was served under active supervision.
88. On 9/8/21 [REDACTED]
On this day, there was difficulty with the facility's communication system. Security and medical staff waited 15 minutes for Stevenson, who did not arrive. [REDACTED]. At that time, a medical code was called for Stevenson.
89. CO B.C. documented a post tour in an officer's report that indicated the following: on 9/8/21 at 11:17 a.m., CO B.C. attempted to serve Stevenson his mid-day meal but Stevenson did not open his cell door or respond to the intercom. CO B.C. approached Stevenson's cell and banged on his door while yelling his name but received no response. CO B.C. opened Stevenson's cell and yelled his name, with no response. CO B.C. documented that he heard what he believed was Stevenson flatulate and thought that this was an attempt by Stevenson to lure the officer into his cell due to Stevenson's past history. CO B.C. called Sergeant J.M. and informed him of the situation. At 11:25 a.m., Sergeant J.M. arrived on the housing unit. Stevenson was observed laying on his bunk in the recovery position facing the cell door with his face partially covered. CO B.C. entered Stevenson's cell, yelled Stevenson's name and tapped his leg, with no response. CO B.C. checked Stevenson for a pulse and breathing and did not find either. At 11:26 a.m., CO B.C. called a medical emergency via the facility radio. Facility security and medical staff responded, [REDACTED].
[REDACTED] At 11:28 a.m., Emergency Medical Services (EMS) was activated.
[REDACTED]
[REDACTED] The Medical Review Board opines that the

time between noticing Stevenson was not responding to entering his cell and calling the medical emergency, approximately 10 minutes, was a significant delay to which interventions, such as the AED could have been potentially lifesaving for Stevenson.

90. At 11:34 a.m., Goshen Volunteer Ambulance Corps EMS arrived and assumed care of Stevenson. [REDACTED]

91. During an interview with Commission staff, RN [REDACTED] stated that the medical incident report is a security form utilized to document an unscheduled medical incident. RN [REDACTED] also stated that this form is not medical charting and would be accompanied with a medical progress note. During an interview with Commission staff, RN [REDACTED] stated that the facility's procedure was to complete the incident report for security but also include the information in the medical chart as the medical incident report did not replace a nursing progress note. RN [REDACTED] also indicated that the medical incident form would be copied, one copy would go to security, and one would be placed in the medical chart. The Medical Review Board found that there were 23 instances where Orange CJ medical staff documented a medical encounter on a facility medical incident report but failed to document in the medical progress notes. The Medical Review Board opines that these instances are 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.

92. [REDACTED] The Medical Review Board opines that based upon the autopsy findings, Stevenson had extensive and progressive cardiovascular disease which eventually led to a terminal acute cardiac event. The Medical Review Board finds that between 6/27/21 and 9/7/21, Stevenson made 21 complaints of chest pain to facility medical staff that went unrecognized, unassessed, or improperly diagnosed and was not treated. This was overall a gross deviation from the standard of care. The Medical Review Board opines that had proper referrals been made to cardiology and had the appropriate diagnostic testing been ordered, Stevenson's stenosing coronary artery disease would have been detected and corrective interventions could have been initiated and his death could have been prevented.

ACTIONS REQUIRED:

TO THE OFFICE OF THE ORANGE COUNTY SHERIFF AND JAIL ADMINISTRATION:

The Sheriff shall conduct a review of the delay in staff recognizing Stevenson was unresponsive and in need of emergency intervention and then entering his cell to render aid.

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

TO THE MEDICAL DIRECTOR FOR WELLPATH INC.:

1. The Medical Director shall conduct a comprehensive quality assurance review of the care provided to Stevenson including:
 - Why with multiple hospital admissions and continued complaints of chest pain, Stevenson was not referred to a cardiologist for a consultation.
 - Why the cardiology appointments that were made by GHMC were not attended by or offered to Stevenson.
 - Why Stevenson was not seen by a facility clinician as a follow-up from multiple hospital admissions.
2. The Medical Director shall conduct a comprehensive quality assurance review of the care provided to Stevenson to include why there were repeated instances of nursing staff not recording vital signs at sick call encounters, why there were failures to perform medical assessments and why medical records were not maintained in compartment with 9 NYCRR §7010.2(j).
3. The Medical Director shall obtain a peer review and consultation to examine and redevelop the chronic care clinic protocols for hypertension and cardiovascular disease patients at the Orange CJ.
4. The Medical Director shall request a peer review of Dr. [REDACTED] pertaining to Stevenson's total health care and specifically, why a cardiology consult was never ordered for Stevenson despite being documented as being a high-risk patient, why multiple findings of breakthrough hypertension symptoms were not addressed, and why there were multiple failures to maintain patient records of clinical encounters.

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

In a response dated 11/15/24 to the Commission's preliminary report, New York Correct Care Solutions, LLC indicated the requested reviews were completed but refuted the Medical Review Board's findings. The Medical Review Board remains affirmed in its findings and opinion that Stevenson died from coronary artery disease that was improperly managed and that his death could have been prevented. The Board notes that as of 1/1/25 New York Correct Care Solutions, LLC (Wellpath) will no longer be providing health services for the Orange CJ.

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 18th day of December 2024.



Yolanda Canty
Commissioner
Commission of Correction

YC:MB:vc
2021-M-0119
December 18, 2024