NEW YORK STATE COMMISSION OF CORRECTION

In the Matter of the Death	:	FINAL REPORT OF THE
	:	NEW YORK STATE COMMISSION
of Angel Melendez, an inmate of	:	OF CORRECTION
the Orange CJ	:	
	:	

TO: Sheriff Carl E. DuBois
Orange County Sheriff's Office
110 Wells Farm Road
Goshen, NY 10924

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 Angel Melendez who died on May 3, 2007 while an inmate in the custody of the Orange County Sheriff's Office, the Commission has determined that the following final report be issued.

FINDINGS:

1. Angel Melendez was a 47 year old male who died on 5/3/07 from suicidal hanging while incarcerated in the Orange County Jail. [redacted] Deficiencies in policy and procedure and failures to comply with existing procedures are contained herein.

2. Angel Melendez was born in Puerto Rico but it is unknown when he came to the United States. He reported to have a 9th grade education and worked occasionally as a laborer, however, he was unemployed at the time of his arrest. Melendez was divorced and reportedly had three children.

3. [redacted]

4. [redacted]

5. [redacted]

[redacted]

6. Melendez was arrested by the Orange County Sheriff's Office on 4/30/07 at 6:00 p.m. for CPCS 3rd. He was booked into the Orange County Jail at 11:35 p.m. Melendez answered affirmatively on the suicide screening for a history of drug abuse and stated he was using up to 10 bags of heroin a day. A special watch/close watch with no continuous log was ordered at 11:55 p.m. by Officer S.R. due to reported heroin use and possible withdrawal.

7. [redacted]

8. Policy and procedure for Correctional Medical Services, the medical provider at the Orange County jail, states that *"If the intake nurse notices signs that the inmate is withdrawing from drugs or alcohol or if the inmate has a history of habitual alcohol or drug abuse and may be at risk of withdrawal symptoms, the inmate is to be sent to the Medical Housing Unit for observation."* Policy also states that "Assessments including vital signs of the inmate will be done at least once every shift."

[redacted] At 8:00 a.m. he was sent out to county court and did not return until 6:30 p.m. [redacted]

9. At approximately 8:30 p.m. on 5/1/07, Sgt. D.F. called RN G.B. to report that Melendez was feeling worse and needed to be seen in the medical department. RN G.B. changed Melendez' close watch order to a close watch with a 30 minute written log and stated during the subsequent investigation that she requested Melendez be brought down to medical for an evaluation, and that he refused emergency sick call. However, there is no supporting documentation that Melendez was requested to be seen in the medical department or any supporting documentation that he refused to be seen. Sgt. D.F. informed Commission staff that he was told by RN G.B. that Melendez would be seen at the next available sick call time, i.e., the following day.

10. [redacted]

11. Melendez was logged every 30 minutes on the Special Watch Activity Form from the evening of 5/1 into the morning of 5/2/07. He was mostly noted to be lying on his bed. [redacted]

12. Melendez was observed throughout the evening of 5/2/07 into 5/3/07 at 30 minute intervals which were logged both on the Special Watch Activity Form and in the housing area logbook. Melendez was noted to be lying on his bunk appearing to sleep. Officer D.H. and Officer Trainee K.M. were assigned to Bravo 2 housing area for the 11:00 p.m. to 7:00 a.m. tour on 5/3/07. At approximately 5:00 a.m., Trainee K.M. conducted a round of the housing areas and gave inmates due out to court access to the showers. At approximately 5:10 a.m., Sgt. B.D. came on the unit to conduct a round. Sgt. B.D. documents in the log book Melendez was lying on his bunk appearing to be sleeping.

13. At approximately 5:45 a.m., Officer Trainee K.M. began conducting another round of Bravo 2 when he came to Melendez' cell (cell #3) and saw him slumped over his bunk with a sheet around his neck and affixed to the shelf. Officer Trainee K.M. called on his radio for a medical emergency in Bravo 2. Officer D.H. responded to cell #3, observed Melendez, and then called on the radio that they had an inmate hanging in Bravo 2.

14. Staff responded immediately to the unit. Officer D.H. keyed into the cell and Officer S.R. and Nurse C.T. entered. Officer D.H. attempted to use a cut down tool but could not get around Officer S.R. who was holding Melendez up. After several attempts, Officer S.R. was able to cut the ligature away from Melendez' neck and place him on the cell floor. [redacted]

15. [redacted]

[redacted]

16. During his incarceration, Melendez was placed on a "30 minute close watch." A review of this procedure revealed that it violated *Minimum Standards* 9 NYCRR §7003.3(h), Supervision of prisoners in facility housing areas, which states:

> 8. 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:
>
> 1. more frequent supervisory visits;
> 2. active supervision when only general supervision is required; or
> 3. constant supervision

As set forth in the statewide Chairman's Memorandum #17-1999 from the Commission entitled "Additional Supervision Requirements," the requirement of the regulation for providing "Additional Supervision" is to exceed the minimum mandated level of supervision for all inmates. "Active Supervision" is the acceptable level of supervision for general population inmates and by definition requires supervisory visits at 30 minute intervals. To properly affect a "close watch" as additional supervision requires that supervision of the inmate exceed the 30 minute minimum intervals. Instituting a "close watch" that includes an observation log with supervisor visits at 30 minute intervals does not meet the standard for additional supervision as set forth in 9 NYCRR §7003.3(h).

RECOMMENDATIONS:

TO THE SHERIFF OF ORANGE COUNTY:

1. The Sheriff should review and revise policy and procedure for "close watch" to assure compliance with the intent of 9 NYCRR §7003.3(h). The Sheriff should assure that when additional supervision is required due to an inmate's physical or mental condition that the frequency of supervisory visits is increased or that constant supervision is implemented.

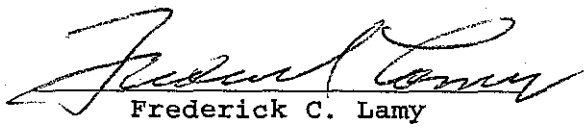
2. The Sheriff should conduct a review of the actions on 5/1/07 of the nurse who failed to follow up on Melendez' scheduled vital sign checks and who contacted a physician for a medication order without performing a physical assessment. Corrective and/or disciplinary action should be taken if the nurse is found to be in violation of policy and procedure.

3. The Sheriff should review policy and procedure for inmates who are in withdrawal or detoxing from drugs or alcohol. Consideration should be given to utilizing available medical observation cells that have closer proximity to medical staff and can be medically supervised more adequately.

TO THE MEDICAL DIRECTOR OF CORRECTIONAL MEDICAL SERVICES, INC.:

That CMS, Inc. conduct a review of the medical services current withdrawal protocol. Consideration should be given to establishing protocols for the use of buprenorphine for managing opiate withdrawal patients as outlined in the Commission of Correction's statewide Chairman's Memorandum 9-2006.

WITNESS, HONORABLE FREDERICK C. LAMY, Commissioner, NYS Commission of Correction, 80 Wolf Road, 4th Floor, in the City of Albany, New York 12205 this 21st day of December, 2007.



Frederick C. Lamy
Commissioner

FCL:mj
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9/07

cc: Anne Perhan, F.N.P., M.S.N.,
Vice President of Operations
Correctional Medical Services, Inc.