

NEW YORK STATE COMMISSION OF CORRECTION

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In the Matter of the Death :  
                                  :  
of Chuniece Patterson an inmate :  
of the Onondaga JC              :  
                                  :  
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FINAL REPORT OF THE  
NEW YORK STATE COMMISSION  
OF CORRECTION

TO: Sheriff Kevin E. Walsh  
Onondaga County Sheriff's Office  
407 S. State Street  
Syracuse, NY 13202

GREETINGS:

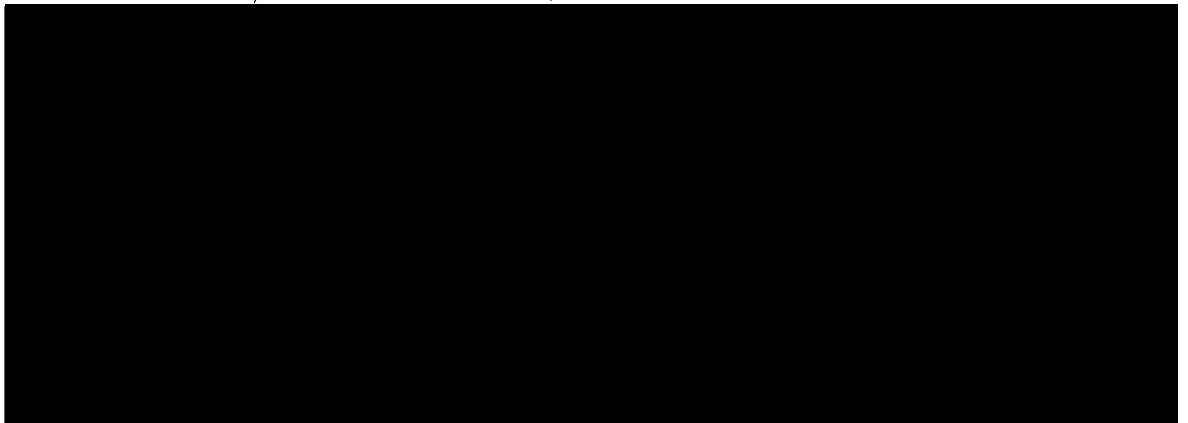
WHEREAS, the Medical Review Board has reported to the NYS Commission of Correction pursuant to Correction Law, section 47(1)(d), regarding the death of Chuniece Patterson who died on November 12, 2009 while an inmate in the custody of the Onondaga County Sheriff's Office at the Onondaga County Justice Center, the Commission has determined that the following final report be issued.

FINDINGS:

1. Chuniece Patterson was a twenty-one year old black woman who died on 11/12/09 at 8:30 a.m. from a ruptured ectopic pregnancy while in the custody of the Onondaga County Sheriff at the Onondaga County Justice Center. Patterson was found unresponsive by a Sheriff's deputy at 7:45 a.m. lying on the floor of her cell. Patterson was transported in full cardiac arrest to the SUNY Upstate Medical Center's Emergency Department where she was pronounced following unsuccessful resuscitation efforts. Had Ms. Patterson received adequate and competent medical care, her death would have been prevented.
2. On 11/10/09 at 11:45 a.m., Patterson was booked into the Onondaga County Justice Center. Deputy V.S. completed the booking and a Suicide Prevention Screening on which Patterson scored zero.



3.



Part of the protocol would have been that the nurse practitioner would order prenatal vitamins, an ultrasound to determine gestation, and an extra snack for bedtime. However, the nurse practitioner was on holiday leave on 11/11/09 because of Veterans' Day and did not see Patterson for her initial medical examination. There was no coverage factor for the nurse practitioner position.

4. A security log entry on 11/11/09 at 3:18 a.m. by Deputy T. indicates Patterson arrived on 3C-pod and was placed in cell #7. On 11/11/09 at 6:58 a.m., Deputy C.S. assumed duty for the day shift on 3C-pod. There is no notation regarding Patterson having any complaints or not eating. This was confirmed upon interview with Deputy C.S.
5. On 11/11/09 at 6:00 p.m., Deputy S.N. locked Patterson in her cell after the evening meal. Deputy S.N. was completing a supervisory round when she passed by Patterson's cell (#7). Some of the female inmates from the B-pod were sitting near cell #7 and reported to Deputy S.N. that Patterson had been vomiting. Deputy S.N. stated she looked into Patterson's cell and verified that Patterson had vomited. At about 6:15 p.m., Deputy S.N. called for the medical unit for nursing personnel to check on Patterson. According to the statement RN M.C. gave the Onondaga County Sheriff's Office, she was informed by Deputy S.N. that Patterson complained of abdominal pain and vomiting.
6. According to the Onondaga County Justice Center's videotape, at 6:40 p.m. RN M.C. arrived on 3C-pod and evaluated Patterson.

This is a violation of Onondaga County Justice Center's policy #333.0 dated 3/22/96 entitled Vital Signs which states:

Vital signs will be taken at each scheduled inmate encounter, emergency response, when there is a change in inmate condition, as ordered, and more frequently than ordered if nursing judgment deems it necessary. Any significant changes in vital signs will be reported to the physician by the charge nurse.

Nurse M.C. provided grossly and flagrantly negligent and incompetent nursing care to inmate Patterson in that she completely misinterpreted and minimized the significance of pain and vomiting at this juncture

7. On 11/11/09 at approximately 8:00 p.m., Deputy S.N. was conducting a frequent fifteen minute check of cells 5 and 6 when she observed Patterson in cell 7 wearing only her underwear. The deputy stated that Patterson was lying on the floor. Patterson reported to Deputy S.N. that she was hot. At about 8:20 p.m., Deputy S.N. then made a second telephone call to the medical unit stating Patterson was sick and was on the floor. Per videotape at 8:22 p.m., RN M.C. responded to Patterson's cell.

Per videotape, RN M.C. left the 3C-pod at 8:28 p.m.

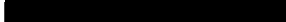
The nursing encounters on 11/11/09 at 6:40 p.m. and at 8:22 p.m. were not recorded until the following day by RN M.C. following Patterson's death. This is a violation of the Onondaga County Justice Center's policy #711.00 entitled Documentation: (A) which states:

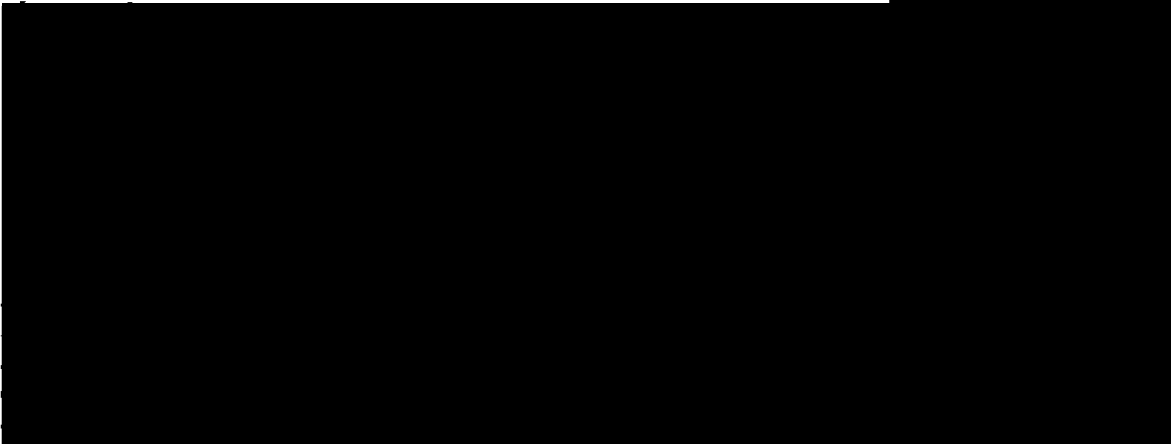
All inmate encounters will be documented in the health record. These encounters include emergency and scheduled encounters with physicians including psychiatrists, NP/PA, nurses, social workers and other ancillary staff. Any observed changes in an inmate's condition shall also be documented.

Nurse M.C.'s professional conduct in this second encounter was again grossly negligent and incompetent, again failed to appreciate the gravity of Patterson's condition and appeared to be without training, background, orientation or supervision in the approach to this patient.

8. Deputy S.N. stated that, as she was locking Patterson's cell after RN M.C. left, she observed Patterson drink a glass of water, get dressed, and go back to bed. Deputy S.N. stated that Patterson did not complain of any pain. Patterson was able to transfer herself back into bed. In interview, Deputy S.N. stated she observed Patterson in bed and out of bed standing but was quiet and did not have any complaints for the remainder of the evening shift.
9. On 11/11/09 at 11:00 p.m., Deputy E.S. reported to duty on Pod 3C. In Deputy E.S.'s statement, she reported that Deputy S.N. informed her that Patterson was "rolling around on the floor making noise throughout her shift (3:00 p.m. to 11:00 p.m.)." In her statement, Deputy E.S. reported that she was unsure if Deputy S.N. contacted the medical unit in regards to Patterson. However, the 3C-pod security log indicated that Deputy E.S. documented that she would review the prior two shifts log entries. The nursing encounters were documented in the security log book by Deputy S.N.
10. According to her statement, Deputy E.S. indicated on 11/11/09 at 11:00 p.m. until around 12:00 a.m., Patterson's breathing was very heavy and loud. In her statement, Deputy E.S. described the breathing sounds as a "fake asthma attack." Patterson's loud breathing went on for about an hour from 11:00 p.m. to 12:00 midnight. At about 1:40 a.m., Patterson activated the emergency button in her cell. Deputy E.S. stated she knocked several times on Patterson's cell door. The deputy turned on the light in Patterson's cell. Deputy E.S. stated that it took a minute or two for Patterson to respond. When she went into the cell, the deputy observed Patterson sitting on the floor with her arm on the bunk. Patterson was breathing hard and stated "I'm sorry I cannot breathe." The deputy asked Patterson if she would like to have a nurse called and she

responded in the affirmative. Deputy E.S. contacted RN R.D. and he came to Pod 3C. Sgt. A.B. was relieving Deputy E.S. for a break when RN R.D. arrived.

11. Per videotape on 11/12/09, RN R.D. arrived on 3C-pod and at 1:51 a.m. went into Patterson's cell with Sgt. A.B. at the cell door. 



12. In interview, RN R.D. stated he knew Patterson was pregnant as he had completed the pregnancy test the night before. RN R.D. stated he reviewed her progress notes to see if she had any prior problems, but there was no documentation by RN M.C. for the evening shift for her two encounters with Patterson. RN R.D. stated he did not have any knowledge of the previous encounters as RN M.C., the evening charge nurse, did not report these nursing encounters with him verbally on the change of shift at 11:00 p.m. In interview, RN M.C. stated she did report this to RN R.D. as she only used generalizations during the nursing report and did not include the inmate's name. RN R.D. did not complete a full set of vital signs for Patterson. This is a violation of the Onondaga County justice Center's policy #711.00 entitled Documentation: (A) which states:

All inmate encounters will be documented in the health record. These encounters include emergency and scheduled encounters with physicians including psychiatrists, NP/PA, nurses, social workers and other ancillary staff. Any observed changes in an inmate's condition shall also be documented.

13. When Deputy E.S. arrived back from a fifteen minute break, Sgt. A.B. told the deputy that Patterson had her oxygen level checked and Patterson would be placed on the sick call list for the morning.
14. In interview, Sgt. A.B. stated he was on 3C-pod twice for Deputy E.S.'s relief for breaks. Sgt. A.B. stated he made rounds at 3:45 a.m. and 4:15 a.m. Sgt. A.B. indicated he was on 3C-pod for a total of one hour. In interview, Sgt. A.B. stated he heard nothing from Patterson for both times he was on 3C-pod. Also, Sgt. A.B. reported that he did frequent fifteen minute checks on cells 5 and 6 and looked in Patterson's cell at 4:30 a.m. He did state that Patterson had moved from the floor to the bunk when he saw her. At 4:45 a.m., Deputy E.S. returned from her break and relieved another housing officer. She reported that Patterson was quiet for the remainder of the shift. Deputy E.S. stated Patter had moved from the bunk to the floor but was quiet.

15. On 11/12/09 shortly before 7:00 a.m., Deputy D.S. stated she reported for duty and received a briefing from Deputy E.S. According to Deputy D.S.'s statement, she stated that Deputy E.S. reported to her that Patterson had been moaning all night. Deputy D.S. stated that Patterson had a cell-side encounter by the nurse during the nights due to Patterson's complaints of being short of breath. The nurse had checked Patterson then left. Per videotape at 6:56 a.m., Deputy E.S. and Deputy D.S. completed their administrative round at 7:00 a.m. when they observed Patterson lying on the cell floor covered with a blanket. Both Deputy E.S. and Deputy D.S. reported that Deputy D.S. told Patterson to get into bed which Patterson complied with a "yes, ma'am."
16. At approximately 7:09 a.m., Deputy D.S. was walking on the 3C-pod to make a frequent fifteen minute check on cells 5 and 6. As Deputy D.S. went by cell #7, the deputy observed Patterson kneeling against the toilet, splashing toilet water on her face. Deputy D.S. told Patterson to stop it and described Patterson then sliding down next to the toilet onto the floor. At one point during Deputy D.S.'s administrative rounds, as she was descending the 3C stairs, she acknowledged that she heard Patterson moaning and the deputy told her to "knock it off."
17. At approximately 7:17 a.m., the cart with the breakfast trays arrived. Deputy D.S. stated inmate S.C. was passing breakfast trays and reported to her that Patterson "was on the floor again."
18. At approximately 7:30 a.m. while completing her next supervisory round, Deputy D.S. observed Patterson still lying on the cell floor. The deputy observed a cup in the toilet and went into Patterson's cell to remove the cup. Deputy D.S. stated Patterson looked up at her from the floor. Deputy D.S. reported she ordered Patterson to get off the floor, to come out of the cell, and retrieve her breakfast tray. Patterson did not respond. Deputy D.S. left the cell and closed Patterson's door. Deputy D.S. stated she closed the door because she wanted Patterson to get up, ring her buzzer, come out, and get her breakfast tray. Deputy D.S. stated she observed Patterson was lying on the floor and not verbally responding to her orders. This should have been an indication that Patterson needed medical attention. This is a violation of the Onondaga County Sheriff's Office Written Directive CUS-052 entitled Health Services dated 8/1/03 H, (1) which states:

Staff will remain alert for inmates who are too ill to present themselves for sick call and will assist them in obtaining medical care.
19. At 7:45 a.m., Deputy D.S., while completing a supervisory round, observed Patterson lying in the same position on the floor as she was at 7:30 a.m. Deputy D.S. ordered Patterson to get off the floor. Patterson did not respond and Deputy D.S. shook her arm and leg with no response. Deputy D.S. stated Patterson's arms were cold. Deputy D.S. states she checked for a carotid pulse and when she moved Patterson's head, white foaming liquid came out of her mouth. Deputy D.S. immediately called central control on her radio for a medical emergency.
20. At 7:45 a.m., Sgt. J.D. responded first with the AED bag after hearing the medical emergency over the radio. Sgt. J.D. saw Deputy D.S. walking to her control desk. Sgt. J.D. asked "where is she?" and inquired if Patterson was alive. Deputy D.S. replied "she has been faking all night." Sgt. J.D. went to Patterson's cell leaving the AED on the desk. Sgt. J.D.

observed Patterson lying on her back with her eyes glazed over and she was foaming at the mouth. Sgt. J.D. yelled to bring the AED over and rubbed Patterson's sternum to check for any reaction to which there was none. She checked for a pulse and none was palpable. Sgt. J.D. started rescue breathing after observing her with no pulse or respirations.

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22.

23. Per the Onondaga County Justice Center's administrative staff, RN M.C. received a counseling memo regarding her lack of nursing documentation for the two encounters with Patterson during the evening of 11/11/09. RN R.D. received a counseling memo for not completing a full set of vital signs for Patterson during the early morning hours of 11/12/09.

All of the housing deputies who supervised Patterson stated on interview that they were unaware she was pregnant.

RECOMMENDATIONS:

TO THE SHERIFF OF ONONDAGA COUNTY:

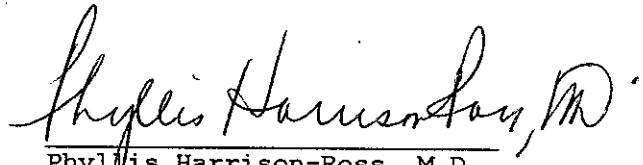
1. The Sheriff shall direct the Health Services Division to conduct a comprehensive review and revision of its policy and procedure for management of inmate pregnancy followed by an in-service education colloquium to the professional nursing staff at the Onondaga County Justice Center regarding the physical assessment, treatment, and documentation of pregnancy complications.
2. The Sheriff shall take appropriate disciplinary action against the Housing Unit Deputy who supervised Patterson from 7:00 a.m. to 3:00 p.m. for failing to recognize Patterson was in need of medical attention at 7:30 a.m. on 11/12/09.
3. The Sheriff shall direct the Health Services Division to develop improvements with the communication between the registered nursing staff that are giving and receiving shift report.

4. The Sheriff will monitor the two registered nurses, M.C. and R.D., for their practice of professional nursing in the areas of assessment and documentation of inmate sick call encounters for a period of not less than six months. The Board requests that the Sheriff advise it within nine months as to the outcome of such review and action(s) taken for continuing enhanced supervision of these registered nurses' practice.

TO THE STATE EDUCATION DEPARTMENT, OFFICE OF PROFESSIONAL DISCIPLINE (OPD):

That the OPD conduct an investigation into the professional conduct of M.C., RN, for gross negligence and incompetence in nursing care afforded to Chuniece Patterson and for failure to make a medical record.

WITNESS, HONORABLE PHYLLIS HARRISON-ROSS, M.D., Commissioner, NYS Commission of Correction, 80 Wolf Road, 4<sup>th</sup> Floor, in the City of Albany, New York 12205 this 18<sup>th</sup> day of June, 2010

  
Phyllis Harrison-Ross, M.D.  
Commissioner

PH-R:mj  
09-M-150  
3/10