NEW YORK STATE | Commission of Correction

Final Report of the New York State Commission of Correction:

In the Matter of the Death of

Terra Bonanza, an incarcerated individual of the Oneida County Jail

March 29, 2022

To: Sheriff Robert M. Maciol
Oneida County Sheriff's Office
6065 Judd Road
Oriskany, New York 13424

Allen Riley
Chairman

Thomas J. Loughren
Commissioner

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 Terra Bonanza who died on April 22, 2021, as a result of circumstances which occurred while an incarcerated individual in the custody of the Oneida County Sheriff at the Oneida County Jail, the Commission has determined that the following final report be issued.

FINDINGS:

1. Terra Lynn Bonanza was a 40-year-old woman who died at St. Luke's Hospital in Utica, NY on 4/22/21 due to COVID-19 related complications. Bonanza's death occurred five weeks after being released from the custody of the Oneida County Sheriff at the Oneida County Jail on 3/18/21. Bonanza, at her admission to the hospital, was found to have multiple medical issues including MRSA, sepsis with extensive complications including bacterial endocarditis and septic pulmonary emboli and COVID which collectively resulted in her death. Prior to her prolonged hospitalization, the Medical Review Board found that while Bonanza was at the Oneida CJ for 9 days, there were multiple failures of medical and mental health staff to assess, treat, provide medications, perform diagnostic testing, and otherwise provide care to person who was clinically deteriorating and in dire need of medical attention. The Medical Review Board has also found that in addition to the cited deficiencies, this case repeatedly showed that there was poor to absent communication among medical and mental health providers resulting in a compromised continuity of care for Bonanza. The findings of this case raise serious concern to the Board regarding CBH Inc.'s (the contracted medical service for Oneida CJ) ability to adequately provide medical care to the individuals in the custody at the jail. The Medical Review Board opines that Bonanza's death was preventable had she been properly and timely assessed by a physician, had proper and competent intervention by medical staff, and had been referred to a hospital for diagnostic exams and treatment.

2. Bonanza was born in New Hartford, NY. Bonanza was divorced with 5 children. Bonanza was survived by parents, 5 children, a brother, grandparents, and many extended family members. At the time of arrest, Bonanza had been living in Utica but was unemployed [redacted]). Bonanza had previously been licensed and employed as a Licensed Practical Nurse but had a registration that expired in 2013.

3. [redacted]. In the instant offense, on 2/18/21, Bonanza was arrested for Petit Larceny and was eventually sentenced to 6 months in the Oneida County Jail. Bonanza was released from custody on 3/18/21 while in St. Luke's Hospital. While hospitalized, Bonanza was arrested for possession of contraband after being found to be in possession of illicit suboxone. These charges were abated by her death on 4/22/21.

4. [redacted]

5. [redacted]

6. On 3/5/21 at 12:51 p.m., Bonanza was admitted to the Oneida CJ to serve a 6-month sentence. On the initial suicide screening performed by CO K.B., Bonanza had scored a total of "3" for "yes" answers which included: having a history of drug or alcohol abuse, having a history of counseling or mental health evaluation and treatment, and appearing to have been under the influence of alcohol or drugs. CO K.B. indicated on the suicide risk assessment that the supervisor was notified, a non-emergent referral was made to mental health and an emergent referral was made to medical for the possibility of Bonanza being under the influence of drugs. On Bonanza's initial risk assessment, CO B.C. documented that Bonanza had thyroid problems, asthma and possible drug use, was in treatment for anxiety, depression, PTSD, and substance abuse. CO B.C. also documented that Bonanza was on medications, had a history of drug and/or alcohol abuse, had prior charges/criminal convictions and previous incarcerations. Bonanza was referred to medical and mental health and was placed on a medical constant watch. An initial COVID-19 screening was performed by CO R.W. in which Bonanza answered "no" to traveling, having any contact with anyone positive for COVID-19, and having signs and symptoms of COVID. It was noted, however, that a temperature was not taken on Bonanza during her admission to the Oneida CJ. This was found to be in violation of both CDC guidelines and Oneida CJ policy, CD 06-02-09. Policy CD-06-02 Emergency Plan: Communicable Illness-of epidemic or pandemic concern which states*:*

2) D. Every Person entering the secured area of the correctional facilities may be screened prior to entering the correctional facilities using Centers for Disease Control and Prevention (CDC) guidelines.

7. [redacted]

[redacted] The Medical Review Board opines that there was a failure by the mental health services to follow up continued care for a known psychiatric patient with recent suicidal ideation and inpatient hospitalization history.

8. [redacted]

9. Bonanza was admitted to housing block C, cell 3, [redacted]

10. At 4:00 p.m., RN [redacted] The refusal form was witnessed by CO A.W. because Bonanza refused to sign. Potential consequences of the refusal were not documented as being explained to Bonanza by RN [redacted] as that portion of the form was found to be incomplete. There was no indication that medical staff physically observed Bonanza at the time of the refusal and therefore it is questionable if the consequences of the refusal were properly explained to Bonanza. This does not comport with the requirements of CBH Medical P.C. Procedure J-G-05 (11.) which state: *Informed Consent and the right to refuse which indicates that any health evaluation or treatment refusal is documented including evidence that the inmate is aware of any adverse health effects that may occur as a result of the refusal.*

Per the Temperature for Orientation Inmates/Exposed Inmates form, no temperature was taken on Bonanza and no temperature refusal was located. Per the CBH Segregation Record Review, Medical/Constant Rounds Log, there were no rounds made by medical at any time on 3/5/21. From Bonanza's admission date on 3/5/21 through 3/12/21, Bonanza repeatedly refused to be seen by medical for an intake assessment and remained on constant supervision.

11. On 3/6/21 at 8:30 a.m., RN [redacted] signed a refusal and CO J.P. witnessed the form indicating that Bonanza had refused an intake assessment with medical. The reason for the refusal was illegible and the potential consequences explained were a delay in treatment and care. There was no indication that RN [redacted] physically observed Bonanza at the time of the refusal. No temperature was taken on Bonanza and no temperature refusal was located. There were no corresponding nursing progress notes entered.

12. At 11:50 p.m., RN [redacted] signed a refusal and CO E.K. witnessed the form indicating that Bonanza had refused the medical intake assessment. The consequences of the refusal, which were a delay in treatment and care, were explained to Bonanza. There was no indication that RN [redacted] physically observed Bonanza at the time of the refusal. No temperature was taken on Bonanza and no temperature refusal was located. Per the CBH Segregation Record Review, Medical/Constant Rounds Log, there were no rounds made by medical at any time on 3/6/21. There were no corresponding progress notes entered into Bonanza's chart.

13. On 3/7/21 at 9:20 a.m., RN [redacted] signed a refusal and CO S.C. witnessed the form indicating that Bonanza had refused a medical intake assessment. The reason for the refusal was illegible and the potential consequences explained were a delay in treatment and care. There was no indication that RN [redacted] physically observed Bonanza at the time of the refusal. No temperature was taken on Bonanza and no temperature refusal was located in the chart. There were no rounds made by medical at any time on 3/7/21 and there were no corresponding progress notes entered by RN [redacted] on 3/7/21.

14. At 4:17 p.m., [redacted] On the refusal form for 4:17 p.m., it was documented that Bonanza stated, "I cannot physically move. Medical will have to come to me". The potential consequences of the refusal were not documented as being explained to Bonanza. There was no evidence that RN [redacted] went cell side to assess the reason that Bonanza stated she was unable to move. There were no rounds made by medical on 3/7/21 and no temperature was taken on Bonanza in the morning or the evening of 3/7/21.

15. On 3/8/21 at 9:30 a.m., [redacted] The potential consequences of the refusal were not documented as being explained to Bonanza. There was no nursing documentation that mental health staff, a mental health provider, or a medical provider were notified of this behavior or that Bonanza had refused multiple medical intakes since her admission.

    During an interview with Commission staff, LMSW [redacted] reported that mental health staff was never given any information from medical staff that Bonanza had smeared feces on herself. There was no documentation to indicate that RN [redacted] went cell side to assess Bonanza's mentation or medical condition. There was no nursing documentation that RN [redacted] had inquired about Bonanza being offered a shower, clean clothes, or bedlinens after documenting that Bonanza had smeared feces on herself. No rounds were made by RN [redacted] and no temperature was taken on Bonanza in the morning on 3/8/21. CO S.C. had signed the refusal for medical that also indicated Bonanza had been smearing

feces on herself. During an interview with Commission staff, CO S.C. stated that she didn't recall physically seeing Bonanza smearing feces but had signed the refusal. CO S.C. stated that the nurses are not usually present with the incarcerated individual (II) when the refusals are signed, as they are usually in the medical office. When CO S.C. was asked if nursing would go down to the units to assess situations when an II had this type of behavior, CO S.C. stated, "No". CO M.L. was the housing unit CO at the time of Bonanza's refusal and smearing excrement. CO M.L.'s shift log did not include any documentation of Bonanza's behavior, only that Bonanza had refused medical. After a review of the shift log summary, Bonanza was not offered a shower until 3 days later on 3/11/21, in which the log entry indicated that Bonanza had refused. Per a review of the documentation, Bonanza went 4 days without a shower. This is a violation of both 9 NYCRR §7005.2(a) and (b) and Oneida CJ policy 05-01-06 (4)(B)(2). which state:

9 NYCRR §7005.2(a) Hot showers shall be made available to all prisoners daily. Consistent with facility health requirements, the chief administrative officer may require prisoners to shower periodically

9 NYCRR §7005.2(b) Notwithstanding the requirements of subdivision (a) of this section, hot showers shall be made available to all prisoners confined in special housing, as that term is defined in section 7013.2(h) of this title, at least 3 times per week.

Oneida CJ policy 05-01-06 (4)(B)(2) incarcerated individuals be permitted to shower and shave three times a week.

16. At 3:40 p.m., RN [redacted] signed a refusal indicating that Bonanza had refused the medical intake assessment. The witness' signature was illegible. The reason for the refusal was listed as Bonanza stating, "Maybe tomorrow" and the potential consequences that were explained were documented as a delay in diagnosis of abnormal findings. There was no indication that RN [redacted] physically observed Bonanza at the time of the refusal. [redacted] CDC COVID-19 pandemic guidelines and policies regarding daily temperature recordings were in place, however, this was the first temperature recording noted for Bonanza since her arrival to the jail three days previously. The time the temperature was taken and by what medical staff was not documented. There were no rounds made by RN [redacted] and there were no corresponding progress notes entered by RN [redacted]

17. At 8:00 p.m., per the CBH Segregation Record Review, Medical/Constant Rounds Log, RN [redacted] did rounds and documented that Bonanza had refused the medical intake, however, there was no refusal form located in the medical chart nor corresponding nursing progress note entered by RN [redacted] The time the temperature was taken and by what medical staff, however, was not documented.

18. At 11:51 p.m., RN [redacted] signed a refusal and CO B.S. witnessed the form indicating that Bonanza had refused the medical intake. On the refusal form, RN [redacted] documented under the reason for refusal that Bonanza refused to come to medical for the intake assessment as she was too sick. [redacted]

[redacted]. There was no documentation that RN [redacted] went cell side to assess Bonanza, her potential need for medication nor any attempt to obtain a temperature. Bonanza reported to RN [redacted] that she was "too sick" to complete the medical intake. As it was now over 72 hours since Bonanza had arrived at the Oneida County Jail and it was known that Bonanza reported drug use on her risk assessment at admission, a notification to the medical provider should have been completed by RN [redacted] Bonanza had been without medication since her arrival and displayed signs and symptoms of physical and mental deterioration. In an interview with Commission staff, when asked if an II refuses to go to medical does medical staff sees the II at cell side assess their status, CO R.D. stated, "No". The Medical Review Board opines that Bonanza was acutely ill with obvious drug withdrawal symptoms and required a referral to a physician. Additionally, the Board opines that individuals who repeatedly refuse to be assessed by medical after three times from their admission should have an immediate notification and referral made to the jail physician.

19. On 3/9/21, [redacted] The time the temperature was taken and by what medical staff, however, was not documented.

20. At 12:45 p.m., RN [redacted] signed a refusal form indicating that Bonanza had refused the [redacted]. Per the CBH Segregation Record Review, Medical/Constant Rounds Log, there were no rounds made by any medical staff on 3/9/21. [redacted].

21. [redacted]. In an interview with Commission staff, RN [redacted] was asked about the refusal process and if the nurses were cell side at the time of the refusals. RN [redacted] stated that if she was cell side, she would have documented it and if not, the nurses would write that the officer relayed the message that Bonanza had been refusing to come down for the medical intake. Commission staff asked RN [redacted] if it was procedure to have the Corrections Officers relay medical information to the nurses, to which RN [redacted] stated, "I don't know if it's procedure, but it's what happens here". [redacted]

[redacted]. Per the CBH Segregation Record Review, Medical/Constant Rounds Log, there were no rounds made by any medical staff on 3/10/21. In an interview with Commission staff, RN [redacted] stated that there were nurses in the pod 3 times a day, one on each shift giving medications [redacted].

22. On 3/10/21, the Oneida CJ Special Housing Chart form indicated that security staff documented that Bonanza was restless and moaning on A shift (days), B shift (evenings), and C shift (overnights). On the 3/10/21 shift log Entry summary, CO R.H. documented multiple times throughout the day and afternoon that Bonanza was restless, moaning, and that Bonanza had been repeating, "Help me" and "I don't feel well". On 3/10/21, medical initialed on the A shift indicating that they were aware of Bonanza being restless and moaning on their rounds, however, no corresponding nurses' notes were found in Bonanza's chart indicating this. A review of the Oneida CJ Special Housing Chart form indicated that Bonanza had not been eating on any shift but was occasionally observed drinking milk since her admission on 3/5/21 through 3/10/21. Nursing staff initialed on the A shift only for each day from 3/5/21 through 3/10/21. There were no medical initials indicating that medical rounds were done on Bonanza on the B or C shifts from 3/5/21 through 3/10/21.

23. On 3/11/21 at 8:15 a.m., per the Segregation Record Review, Medical/Constant Rounds Log, RN [redacted] completed rounds on Bonanza [redacted]. Per the unit shift log entry summary, CO R.H. documented that at 8:27 a.m., Bonanza had been holding onto the toilet saying, "Help me". At 9:59 a.m., CO R.H documented that Bonanza had been laying in her bunk saying, "Oh my God, help me". At 11:41 a.m., CO R.H. documented in the shift log entry summary that Bonanza had been laying on the bunk saying that she couldn't get up, and at 11:35 a.m., CO R.H. documented that Bonanza had been moaning while trying to get up. At 11:47 a.m., CO R.H. called zone one for medical. At 11:52 a.m., CO R.H. documented in the shift log entry summary that "medical had been advised of situations". In an interview with Commission staff, CO R.H. was unable to recall what, "situations medical was advised of". There were no shift log entry summaries logged by CO R.H. that medical had come on the unit after she had called for them. [redacted]. The MRB has found that there was a pattern of incomplete documentation by the nursing staff regarding a patient's assessment and refusals. This is a violation of 9 NYCRR §7010.2(j) which states:
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.

This is also a violation of CBH Medical P.C. Procedure: Informed Consent and Right to Refuse, Number: J-G-05, 9 which states:
Patients may refuse treatment at any time by signing a Refusal of Treatment Form

(CBH-MD-26) and 11. Any health evaluation or treatment refusal is documented including the following: description of services being refused, evidence that the inmate is aware of any adverse health effects that may occur as a result of the refusal, inmate signature and health staff signature.

Additionally, Commission staff found that COVID-19 management protocols which included 14-day temperature checks on newly admitted individuals and was reported to the Commission on 10/8/20 in response to the Commission's COVID compliance assessment was not properly followed with Bonanza.

24. [redacted]. There was no indication that RN [redacted] had notified the medical provider or mental health regarding the findings. This was a violation of 9 NYCRR § 7010.1(b) which states:
"Prompt screening is essential to identify serious or life-threatening medical conditions requiring immediate evaluation and treatment. Appropriate medical appraisal of inmates is necessary to reduce the risk that a serious physical deficiency or medical emergency will be obscured by drug or alcohol ingestion".

This was also a violation of CBH Medical P.C. Hunger Strike Procedure A. Initial Medical Evaluation and Management 1 which states:
During the initial evaluation of a detainee on a hunger strike, medical staff shall: measure and record height and weight; measure and record vital signs; perform urinalysis; conduct psychological/psychiatric evaluation; examine general condition; and if clinically indicated, proceed with other necessary studies.

[redacted] On 3/11/21, A, B, and C shift housing unit officers documented Bonanza as being restless and moaning. Medical did not initial on the form that they had seen her on rounds for any shifts on 3/11/21.

The Medical Review Board opines that medical staff erred in determining that Bonanza's refusal to eat food was a hunger strike rather than dysphagia for opiate withdrawal for which she needed to be referred to the jail physician for assessment.

25. [redacted]. There were no nursing progress notes that indicate medical staff physically saw Bonanza on any of the A, B, or C shift rounds. The Medical Review

Board has found that there was a failure by the medical staff to recognize clinical incapacitation and incompetence to sign consent for refusal of medical care by Bonanza. The Medical Review Board opines that Bonanza was clinically incapacitated and incompetent to acknowledge or consent to any of the multiple refusals of care that were documented. The Board finds that medical staff appear to have used Bonanza's multiple "refusals of care" as justification for failures to provide care to a patient who was in obvious distress and in dire need of critical medical treatment.

26. On 3/12/21 at 10:11 a.m., in the shift log entry summary, CO G.P. documented that CO J.C.-O. entered the unit to give Bonanza a shower. During an interview with Commission staff, CO. J.C.-O. reported that Bonanza was weak and unable to get out of bed, ambulate, or shower. CO J.C.-O. stated that Bonanza had been covered in her own feces. CO J.C.-O. was asked if medical was aware of Bonanza's poor hygiene to which CO J.C.-O replied that everyone was aware because the whole unit had a stench to it for days. CO J.C.-O. reported obtaining a wheelchair from medical and covering it in garbage bags and then using it to physically assist Bonanza to the shower. CO J.C.-O. then helped Bonanza bathe and redress in clean clothing. A review of the Segregation Record Review, Medical/Constant Rounds Log indicated that there was contradictory information recorded as RN [redacted] documented that she had performed rounds on Bonanza [redacted] however, per the security shift log entry summary CO J.C.-O. had been caring for Bonanza on the unit at that time.

27. At 10:34 a.m., CO J.C.-O. brought Bonanza via the wheelchair directly to medical to be seen. During an interview with Commission staff, CO J.C.-O. stated that Bonanza had been grateful and welcomed CO J.C.-O.'s help. CO J.C.-O. stated that she informed medical and insisted that Bonanza was not refusing the medical intake at that time and that CO J.C.-O. was bringing Bonanza down to be seen by the physician. CO J.C.-O. stated that she had stayed with Bonanza while Bonanza's medical intake was completed. While Bonanza was seen by Dr. N.A., CO J.C.-O. stated that she asked medical staff to give Bonanza depends to wear as Bonanza had stated she did not want to mess herself anymore. CO J.C.-O. told Commission staff that during her time working on the unit from 3/9/21 to 3/12/21, she only witnessed Bonanza get up to use the toilet one time and that the rest of the time, she observed Bonanza in bed and unable to get up. When CO J.C.-O. was asked how Bonanza received her meals trays when Bonanza was not able to get out of bed, CO J.C.-O stated that the CO'S would put the tray where Bonanza could reach it. When asked if Bonanza ever told CO J.C.-O. why she had been refusing medical CO J.C.-O. stated that Bonanza did not specifically say why she had been refusing but did say that she felt weak. CO J.C.-O. was asked by Commission staff how medical refusals are documented and if medical physically came to the unit to sign the refusals. CO J.C.-O. informed Commission staff that medical usually does not come to the unit when the incarcerated individuals refuse, and that the RN's ask the CO's sign as witnesses. During interviews with Commission staff, all of the CO's reported that whenever medical goes onto a unit, it is always logged in the housing area logbook.

28. [redacted]

“[redacted]. The medical COVID screening was completed 7 days after Bonanza’s arrival to the Oneida CJ. [redacted]. A review of Bonanza’s record revealed that RN [redacted] entered contradictory information on Bonanza’s admission/medical intake. [redacted]. Due to the COVID-19 pandemic and the lack of temperatures and oxygen saturations taken on Bonanza, Bonanza was in fact at risk for and may have had COVID-19 while residing in the Oneida CJ. The Medical Review Board opines that this determination could not be properly made as full sets of vital signs, adequate assessments and blood work had not been completed by medical staff or addressed by Dr. [redacted] During an interview with Commission staff, RN N.M., the Nurse Administrator, stated that no medications are provided to any female incarcerated individual until a urine drug screen confirms pregnancy status. When asked if this was a

CBH policy, RN [redacted] stated that, "That practice was not in any CBH policy" but that, "It's something we just do". [redacted] he Medical Review Board opines that policy J-F-04, Medically Supervised Withdrawal and Treatment is inadequate as it does not address those incarcerated individuals who were unable or refused a urine pregnancy test.

29. [redacted]. When Commission staff asked Dr. [redacted] what the follow-up procedure would be for a patient that IV access could not be obtained on, Dr. [redacted] replied, "They would be sent to the hospital if not stable". [redacted] The Medical Review Board opines that if Bonanza was in need of 2 liters of IV fluid hydration, then she was not hemodynamically stable and that the improper delay of being hospitalized was further contributory to her terminal illness. The Medical Review Board opines that Dr. [redacted] abandoned Bonanza's care by failing to complete the necessary and ordered management of dehydration and failing to send her

to a hospital for definitive treatment when such treatment could not be completed at the facility.

30. [redacted].

31. Dr. [redacted] identified himself as the Acting Medical Director of the Oneida County Jail and that he was contracted for that position through CBH medical. Dr. [redacted] reported to Commission staff that he works at the jail a total of 12 hours per week, usually consisting of two 6 hours shifts. When Commission staff asked Dr. [redacted] if he ever got any calls notifying him of Bonanza's multiple refusals, possible hunger strike, or of the 3/14/21 hospital admission, Dr. [redacted] replied, "No, I'm only here at the jail for 6 hours and then I leave. I'm not on call". Dr. [redacted] told Commission staff that his job responsibilities include chart review but that he had not been made aware of Bonanza's deteriorating health status or hospital admission. Dr. [redacted] stated that he would not be called on this matter because he doesn't take calls and that NP [redacted] would have been notified because NP [redacted] is the medical provider assigned to take the 24-hour calls. Dr. [redacted] further stated that the RNs on duty were responsible for notifying NP [redacted] of any health problems with Bonanza. Dr. [redacted] stated that NP [redacted] is not in collaboration with his medical practice.

32. During an interview with Commission staff, NP [redacted] stated that she works 24 – 40 hours a week at the Oneida County Jail. NP P.C stated there was no set schedule of when she comes to the jail and that she is on call to the jail 24 hours a day per her contract with CBH medical. NP [redacted] could not recall having been notified about Bonanza's refusals, her decline in physical and mental status or that Bonanza had been sent to the hospital on 3/14/21. [redacted] hen asked by Commission staff if Dr. [redacted] was her collaborating doctor, NP [redacted] stated that she did not know who her collaborating physician was but that she knew it was a physician contracted by CBH medical. The Medical Review Board finds that there was a systems failure to assure continuity of care for Bonanza as the facility's primary medical care provider, a nurse practitioner assigned to cover 24 to 40 hours per week had no record of involvement or awareness of a critically ill patient on a medical constant supervision with both hunger strike and withdrawal protocols initiated.

33. [redacted].

34. [redacted]

35. [redacted].

36. [redacted] Per a review of the Segregation Record Review, Medical/Constant Rounds Log, medical staff did not do rounds on Bonanza at any point on 3/13/21, [redacted]

37. [redacted]

38. [redacted]

39. [redacted]

[redacted] The medical provider was not notified regarding the findings of increased weakness and incontinence or that Bonanza was in need of medication. Mental health was also not notified and there was no corresponding chart note documented. During an interview with Commission staff, RN [redacted] stated that no corresponding notes were necessary because the refusal forms have all the documentation that is needed.

40. [redacted]

41. [redacted] During an interview with Commission staff, RN [redacted] was asked if she recalled what provider she had notified as it was not listed on the CBH ER transfer note. RN [redacted] replied, "I'm assuming it was NP [redacted] because Dr. [redacted] doesn't take call." However, a review of prior interviews with Commission staff revealed that NP [redacted] reported that she had never been notified of Bonanza's declining health status or that Bonanza had been sent out to the hospital.

42. Central Oneida Ambulance crew arrived at the Oneida County Jail at 4:29 p.m. [redacted]

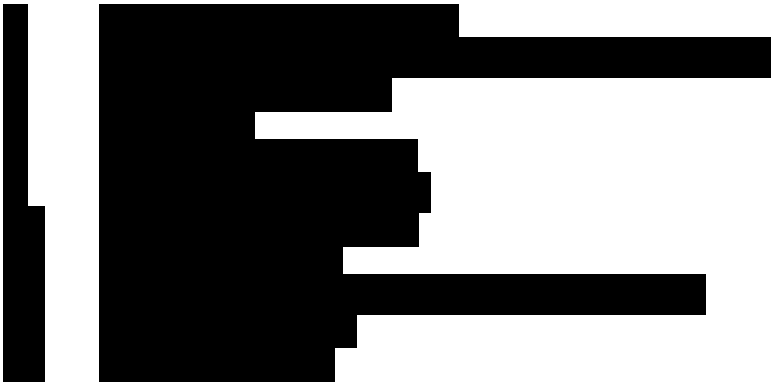
[redacted].

43. [redacted]

44. [redacted]. CO R.D. was interviewed by Commission staff and reported having been on the hospital detail supervising Bonanza when the nurse found the suboxone strips. Bonanza was being transferred from the ER stretcher to the hospital bed and during the movement from one bed to another, the nurse discovered the suboxone strips partially out of Bonanza's body. Bonanza initially claimed not remembering having the suboxone inside her body and then later told hospital staff that the suboxone had been inside her body since admission to the jail 9 days previously.

45. [redacted]. Bonanza was released from the Oneida County Jail's custody on 3/18/21 per an order from court due to her medical condition.

46. [redacted]. Bonanza did not have an autopsy performed as Bonanza was not in the custody of the Oneida County Jail at the time of her death. [redacted]:



ACTIONS REQUIRED:

TO THE OFFICE OF THE ONEIDA COUNTY SHERIFF:

1. The Sheriff shall conduct a review and retraining with admissions officers who failed to perform a temperature check on Bonanza when completing the initial COVID-19 screening of an incarcerated person on admission to the jail. The Sheriff shall also conduct a review the COVID-19 screening protocols with all admission staff to assure consistent compliance with the requirements.

2. The Sheriff shall conduct a review to assure compliance with the requirements of 9 NYCRR §7005.2(a) and (b) and Oneida CJ policy 05-01-06 (4)(B)(2) regarding proper access to showers for incarcerated individuals.

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

TO THE MEDICAL DIRECTOR OF CBH INC.:

1. The Medical Director in coordination with the Sheriff shall conduct a review into the violation of Oneida County Sheriff's Office COVID screening guideline as reported to SCOC staff on the October 8, 2020 site visit that included the jail's report that all new admissions are screened for COVID upon entry to the facility and that all newly incarcerated individuals have daily temperature checks for 14 days while in the orientation unit by the RNs on duty.

2. The Medical Director shall conduct an investigation into why Bonanza had been admitted to the Oneida CJ under the suspected influence of drugs and was not assessed for withdrawal or placed on a withdrawal protocol in accordance with 9 NYCRR §7010.1(b) nor sent to the hospital when refusing care.

3. The Medical Director shall conduct a quality assurance review with medical staff regarding:
   -Why daily temperatures were not taken on Bonanza per the COVID Policy guidelines
   -Why vital signs and assessments were not completed when Bonanza was

displaying altered mental status by smearing feces on herself and why mental health and the provider were not notified.
-Why no oxygen saturations were obtained on Bonanza until 3/14/21.

4. The Medical Director shall conduct a quality assurance review to address and investigate a pattern of multiple violations of 9 NYCRR §7010.2(j) for the cited absence of nursing notes for clinical encounters and a pattern of illegible signatures, notations, titles, and times.

5. The Medical Director shall conduct a quality assurance review to address and investigate a pattern of multiple violations of CBH Medical P.C. Procedure J-G-05 as there were multiple instances where the consequences of refusals were not documented as being explained to Bonanza and there was no documentation that medical was cell side to explain those consequences at the time of the refusals.

6. The Medical Director shall conduct an investigation and review regarding the assessment and treatment of Bonanza by Dr. [redacted] who failed to complete a thorough assessment and failed to obtain hospitalization for a patient needing intravenous hydration which could not be completed at the facility.

7. The Medical Director shall consider revising policy J-F-04. Medically Supervised Withdrawal and Treatment to reflect the management of incarcerated individuals who are unable or refuse to give urinalysis and criteria for treating alcohol and drug withdrawal up to and including hospitalization.

8. The Medical Director shall consider revising the policy and procedure regarding patient medical refusals whereby an individual who refuses an intake assessment after three times is immediately referred to the jail physician.

9. The Medical Director shall conduct a quality assurance review as to why the facility's primary attending medical provider nor jail physician was never notified of Bonanza's medical status for over 9 days despite being placed on constant supervision, hunger strike and withdrawal protocols. Revision to current policy and procedures should be considered to require such if found to not be currently required.

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

In a response to the Commission's preliminary report dated 3/1/22, CBH Medical Inc. provided required reviews for each action required including changes to procedures and counseling of staff. In regards to Action Required #6, CBH Medical Inc. has indicated that the physician was suspended from his duties at the Oneida CJ. The Medical Review Board however remains opined in all of its findings regarding Bonanza's medical care.

TO THE DIRECTOR OF QUALITY IMPROVEMENT AND COMPLIANCE HELIO HEALTH:

The director shall conduct a quality assurance review with the mental health clinicians at the Oneida CJ to ascertain why Bonanza was never seen by a psychiatric provider, prescribed medications, nor followed up by a clinician despite having a known psychiatric history and

recent inpatient hospitalization for suicidal ideation.

In a response to the Commission's report dated 2/10/22, Helio Health indicated the requested review was completed and that scheduling patients for prescribers as soon as feasible was emphasized with the forensic mental health staff. The Medical Review Board however remains opined in its findings that Bonanza's mental health care was deficient.

TO THE CHAIR OF THE LEGISLATURE OF ONEIDA COUNTY:

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 currently designated provider.

TO THE OFFICE OF PROFESSIONAL MEDICAL CONDUCT:

The Board requests that the Office take note of the report findings and initiate an investigation of Dr. N.A., who committed professional misconduct of patient abandonment by failing to send Bonanza out to the hospital for an evaluation after documenting the findings of weakness, dehydration, fecal and urine incontinence, and scleral icterus. Dr. [redacted] ordered Bonanza to receive 2 liters of normal saline for hydration by IV but was unable to access a venous site, did not complete the ordered treatment, and had Bonanza returned to her jail cell without any prescribed follow up orders.

TO THE NYS DEPT OF EDUCATION, OFFICE OF PROFESSIONAL DISCIPLINE

The Board requests that the Office take note of the report findings and initiate an investigation of RN [redacted] and RN [redacted]., who committed professional misconduct by failing to notify both the medical and mental health providers when there was documented evidence of Bonanza's deteriorating medical and psychological condition.

WITNESS, HONORABLE THOMAS J. LOUGHREN, 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 29th day of March, 2022.

Thomas J. Loughren
Commissioner & Chair
Medical Review Board

TJL:JW:jdb
Special Investigation
March 2022