



**Commission of
Correction**

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

In the Matter of the Death of

**Brian Harmon,
an incarcerated individual of the
Monroe County Jail**

December 17, 2025

**To: Sheriff Todd K. Baxter
Monroe County Sheriff's Office
130 Plymouth Avenue So.
Rochester, New York 14614**

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 Brian Harmon, who died on October 1, 2023, as a result of circumstances which occurred while an incarcerated individual in the custody of the Monroe County Sheriff at the Monroe County Jail, the Commission has determined that the following final report be issued.

FINDINGS:

1. Brian Harmon was a 62-year-old male who died on 10/1/23 from advanced obstructive uropathy that lead to sepsis while in the custody of the Monroe County Sheriff at the Monroe County Jail. The Medical Review Board has found that there were multiple deficiencies in the medical assessments and the treatment of Harmon during his incarceration that led to his death. The Board opines that had Harmon been properly assessed and timely transferred to a hospital for treatment to his complaints, his death would have been prevented.

2. Harmon was born in Rochester, NY. Harmon received his GED and was unemployed.

3. [REDACTED]

4. [REDACTED]

5. On 9/22/23 at 8:09 a.m., Harmon was admitted to the Monroe County Jail by Deputy D.Z. on a parole violation. Harmon scored a "0" on the Suicide Prevention Screening Guidelines at admission.

6. [REDACTED]

Per the PrimeCare intake screening form, it states, "Within the past month, how often do you have three or more drinks on one occasion?" "Place patient on Alcohol Detox below". [REDACTED]

[REDACTED]

7.

[REDACTED]

8.

[REDACTED]

9.

[REDACTED]

The Medical Review Board finds that documenting "WNL" for a respiratory assessment is not acceptable to describe the breathing rate, depth, rhythm, and effort of the respirations.

10.

[REDACTED]

11.

[REDACTED]

12.

[REDACTED]

13.

[REDACTED]

14.

[REDACTED]

15.

[REDACTED]

16.

[REDACTED]

17.

[REDACTED]

18.

[REDACTED]

[REDACTED] The Medical Review Board finds that had Harmon been sent to the hospital for an evaluation of the weakness and a heart rate of 125, his death may have been prevented.

19.

[REDACTED]

20.

[REDACTED]

21.

[REDACTED]

22.

[REDACTED]

The Medical Review Board finds that the closure of the urinalysis and culture sensitivity task for Harmon was detrimental to his life as a urinalysis and culture sensitivity test during this time could have detected his progressing infection and prevented his death.

23.

[REDACTED]

24.

[REDACTED]

25.

[REDACTED]

[REDACTED]

26.

[REDACTED] The Medical Review Board found that PA [REDACTED] did not consult with the facility physician about Harmon's current medical condition prior to changing his observation status. The Medical Review Board opines that Harmon should not have been removed from medical observation due to Harmon experiencing weakness, recent weight loss, decreased food consumption, pending labs, a pending abdominal/pelvic ultrasound, and a pending urinalysis and culture sensitivity results. The Medical Review Board finds that PA [REDACTED] was negligent in releasing Harmon from medical observation and placing him on medical segregation.

27.

[REDACTED]

28.

[REDACTED] During an interview with Commission staff, Doctor (Dr.) [REDACTED] reported that the provider that signed the report would be the provider that would address the findings of the report. The Medical Review Board finds that NP [REDACTED] was grossly incompetent for failing to properly review the ultrasound report findings that documented Harmon's hyperextended and obstructed bladder. The Board finds that NP [REDACTED] failed to order immediate medical intervention including catheterization of the bladder and a urinalysis. Had these basic procedures been obtained, Harmon's progressing infection could have been detected, treated, and his death could have been prevented.

29.

[REDACTED]

30.

[REDACTED]

31.

[REDACTED]

32.

[REDACTED]

The Medical Review Board opines that there was an uncoordinated process of assigning Harmon to both Medical Observation and Medical Segregation. The Commission inquired with both the Monroe County Jail and their contracted medical provider, PrimeCare, regarding what the policy and procedure was for both Medical Observation and Medical Segregation statuses. A clear policy that defines each status and their respective requirements for medical and security staff was not established.

33.

[REDACTED]

34.

[REDACTED]

35.

[REDACTED]

36.

[REDACTED]

37.

[REDACTED]

[REDACTED]

The Medical Review Board opines that Harmon should have been sent to the hospital for an evaluation for a significant cognitive/development impairment and demonstrating the inability to independently complete his activities of daily living. The Medical Review Board opines that there was an uncoordinated process of assigning Harmon to both Medical Observation and Medical Segregation. The Commission inquired with both the Monroe CJ and their contracted medical provider, PrimeCare, regarding what policy and procedure was for both Medical Observation and Medical Segregation statuses. A clear policy that defines each status and their respective requirements for medical and security staff was not established. The Medical Review Board also finds that PA [REDACTED] was negligent in releasing Harmon from medical observation and placing him on medical segregation where there were less frequent medical checks performed by the facility providers and medical staff and failing to consult with a supervising physician. Additionally, the Board finds that there was a lack of physician supervision of the physician assistants assigned to the Monroe CJ by the contracted medical provider PrimeCare.

38.

[REDACTED]

39.

[REDACTED]

40. [REDACTED]

41. [REDACTED]

42. [REDACTED]

43. [REDACTED]

44. [REDACTED]

45. [REDACTED]

46. [REDACTED]

47. [REDACTED]
[REDACTED] During an interview with Commission staff, Dr. [REDACTED] reported that he was the only doctor at the facility at that time [REDACTED]

48. [REDACTED] During an interview with Commission staff, [REDACTED]
[REDACTED] RN [REDACTED] was asked what she would do if someone didn't answer her, such as knock on the window or call out their name, and RN [REDACTED] reported that between the deputy and herself, they would do that, [REDACTED]
[REDACTED] A review of the video recording of the Rec Annex by Commission staff revealed LPN [REDACTED] and a deputy in the corridor by cell # 123 that housed Harman. The deputy was observed knocking on the cell door glass as LPN [REDACTED] looked in the cell door window. LPN [REDACTED] and the deputy moved away from Harmon's cell and continued their duties.

49. On 10/1/23 at approximately 10:56 a.m., Deputy D.K. and Deputy M.Z. approached Reception Annex cell # 123 that housed Harmon to serve him his lunch tray. Harmon appeared to be sleeping, and the deputies attempted to wake him by calling his name and knocking on his cell door window. Harmon did not respond to the deputies and the deputies notified Deputy M.S. to respond to Harmon's cell to assist with waking Harmon. Deputy M.S. immediately notified RN [REDACTED] to help evaluate Harmon. Deputy M.S. and RN [REDACTED] entered Harmon's cell [REDACTED]
[REDACTED]

50. On 10/1/23 at 11:05 a.m., American Medical Response (AMR) responded to the scene [REDACTED]
[REDACTED]

51. [REDACTED]
[REDACTED]

52. [REDACTED]

53. After Harmon's death the Monroe CJ and PrimeCare conducted an extensive internal review and obtained an outside consulting physician for a peer review. Upon completion of the review, which highlighted several medical care deficiencies, PrimeCare providers PA [REDACTED], NP [REDACTED], and NP [REDACTED] were terminated.

54. A review of the video recording of Rec Annex Housing Unit by Commission staff found that supervisory rounds by corrections staff were conducted per minimum standard requirements.

55. [REDACTED]

ACTIONS REQUIRED:

TO THE MONROE COUNTY JAIL PHYSICIAN AND THE MEDICAL DIRECTOR FOR PRIMECARE:

1. The Medical Director shall conduct a comprehensive quality assurance review regarding the following:
 - a. Why on 9/22/23, RN [REDACTED] did not enter a nurses note that she spoke with NP [REDACTED] and obtain an order for Harmon to have an abdominal/pelvic ultrasound.
 - b. Why on 9/22/23, RN [REDACTED] did not place Harmon on the Clinical Institute Withdrawal Assessment to monitor for signs of alcohol withdrawal after he reported drinking two 16 oz beers about three times a week
 - c. Why on 9/22/23, there was no documentation that a medical observation assessment was attempted or completed on the evening shift for Harmon.
 - d. Why on 9/24/23 at 11:44 p.m., RN [REDACTED] did not notify NP [REDACTED] that Harmon refused the EKG and reported that he was too weak to walk.
 - e. Why on 9/25/23 at 10:12 a.m., Medical Assistant (MA) [REDACTED] completed the task for the urinalysis and culture sensitivity that was ordered by NP [REDACTED] on 9/24/23 when the urine sample had not been obtained at that time
 - f. Why on 9/26/23 at 10:02 a.m., MA [REDACTED] did not notify a provider that Harmon refused his lab draw.
 - g. Why on 9/28/23 at 9:44 a.m., Dr. [REDACTED] created an appointment date for Harmon to be seen by him on 9/29/23 for a follow-up on the urinalysis and urine culture, but there was no documentation by Dr. [REDACTED] that the appointment on 9/29/23 was completed.

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

In a response dated 11/6/25 to the Commission's preliminary report, contract medical provider PrimeCare Inc. indicated that the requested reviews were completed with corrective actions taken. The Commission will verify corrective actions taken at a later scheduled health services evaluation.

TO THE MONROE COUNTY SHERIFF AND THE MEDICAL DIRECTOR FOR PRIMECARE:

The Jail Administration in conjunction with the Jail physician shall develop policy and procedures for both Medical Observation and Medical Segregation statuses with definitions of security and medical staff's roles and responsibilities.

In a response dated 11/7/25 to the Commission's preliminary report, the Sheriff's Office and PrimeCare Inc indicated that a revised policy and procedure was completed. The Commission will verify the revised policy and procedure at a later scheduled health services evaluation.

TO THE CHAIR OF THE MONROE COUNTY LEGISLATURE:

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 formally designated provider.

TO THE OFFICE OF PROFESSIONAL MEDICAL CONDUCT:

The Medical Review Board requests that the Office of Professional Medical Conduct note the findings of the Board and conduct an investigation of professional misconduct of PA [REDACTED] due to practicing with gross negligence on a patient.

TO THE OFFICE OF PROFESSIONAL DISCIPLINE:

The Medical Review Board requests that the Office of Professional Discipline note the findings of the Board and conduct an investigation of professional misconduct of NP [REDACTED] due to practicing with gross incompetence on a patient.

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 17th day of December 2025.



Yolanda Canty
Commissioner
Commission of Correction

YC:BB:vc
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