NEW YORK STATE | Commission of Correction

Final Report of the New York State Commission of Correction:

In the Matter of the Special Investigation into the Care and Treatment Provided to

Cheree Byrd
(Infant Girl Ayanna Byrd),
an incarcerated individual of the
Onondaga County Justice Center

December 20, 2023

To: Sheriff Toby Shelley
Onondaga County Sheriff's Office
407 S. State Street
Syracuse, New York 13202

Allen Riley
Chairman

Yolanda Canty
Commissioner

GREETINGS:

WHEREAS, the Medical Review Board has reported to the NYS Commission of Correction pursuant to Correction Law, section 47(1)(e), regarding the care and treatment provided to Cheree Byrd and Infant Girl Byrd which occurred while an incarcerated individual in the custody of the Onondaga County Sheriff at the Onondaga County Justice Center, the Commission has determined that the following final report be issued.

FINDINGS:

1. Cheree Byrd was a 35-year-old female who on 8/2/2022 prematurely gave birth to her daughter while in the custody of the Onondaga County Sheriff at the Onondaga County Justice Center. Ms. Byrd was eventually released from custody however, her infant died at the hospital less than an hour after birth. The Medical Review Board has found that medical care and treatment of Byrd during her incarceration was both deficient and negligent and may have led to her child's death. The Board has found that Byrd was not properly assessed nor timely transferred to a hospital over the course of 6 days during which she made multiple reports of being in labor. The Board opines that the failures of staff from the contracted medical provider Proactive (Naphcare), to properly respond to Byrd's complaints could be attributed to implicit bias of an individual with serious and persistent mental illness by dismissing her complaints as behavior. The Board opines that had Ms. Byrd been provided with proper medical care, the baby's premature birth and death could have been prevented.

2. Byrd was born in New Jersey. She was survived by her parents. Byrd was unemployed. There was no further demographic or social history available to the Commission for Byrd.

3. Byrd had no significant medical history. [redacted]

4. [redacted]

5. On 7/1/22, Judge M.B. from the Syracuse City Court committed Byrd to the custody of the Onondaga County Sheriff after being charged with Petit Larceny. Byrd was remanded to the Onondaga County Justice Center without a $5,000 cash bail or bond. Byrd's next court date was scheduled for 7/7/22 at 1:30 p.m.

6. On 7/1/22 at 10:53 a.m., Byrd was admitted to the Onondaga County Justice Center by Deputy A.T. Byrd scored a zero on the Suicide Prevention Screen. Byrd was placed on constant supervision until she could be assessed by medical and mental health.

7. [redacted]

[redacted] During an interview with Commission staff, RN [redacted] reported that if an incarcerated individual (II) refuses their initial intake medical screen, the II would be approached daily by medical staff until the intake screen was completed.

8. [redacted]

9. [redacted]

10. [redacted]

11. [redacted]

12. [redacted]

13. [redacted]

[redacted]

14. [redacted]

15. [redacted]

16. [redacted]

17. [redacted]

18. [redacted]

19. [redacted]

[redacted]

20. [redacted] A review of Byrd's medical chart by Commission staff revealed that Byrd was not reapproached for the completion of her intake screening from 7/2/22 through 7/7/22.This was a violation of 9 NYCRR §7010.1(b) Health Services 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 serious physical deficiency or medical emergency will be obscured by drug or alcohol ingestion*. As Byrd was demonstrating signs and symptoms of active psychosis and delusional behavior, prompt screening was essential to rule out other possible related causes.

21. [redacted]

22. [redacted]

23. [redacted]

24. [redacted]

[redacted]

25. [redacted]

26. [redacted]

27. [redacted]

28. [redacted]

29. [redacted]

30. [redacted] A review of Byrd's medical chart by Commission staff revealed that Dr. [redacted] did not obtain vital signs on Byrd during the assessment. The Medical Review Board finds that there was an unacceptable delay in obtaining a full

psychiatric assessment on Byrd who presented with persistent signs of active psychosis since her admission on 7/1/22. Byrd's presenting symptoms coupled with a confirmed pregnancy should have prompted an immediate psychiatric assessment including the use of community hospital resources if the contracted providers were not immediately available. The Medical Review Board also finds that there was a lack of a mental health treatment plan for Byrd.

31. [redacted]

32. [redacted]

33. [redacted]

34. A review of Byrd's medical chart by Commission staff revealed that Byrd was not seen for her admission medical history and physical assessment within the 14 days of her admission. This is a violation of 9 NYCRR §7010.2(b)(1) Health Services which states: *Each prisoner shall be examined by a physician licensed to practice in the State of New York or by a medical personnel legally authorized to perform such examination at the time of admission or as soon as thereafter, but no later than 14 days after admission.*

35. [redacted]

36. [redacted]

37. [redacted]

38. [redacted]

39. [redacted]

40. [redacted]

41. [redacted]

42. [redacted]

43. [redacted]

44. [redacted]

45. [redacted]

46. [redacted]

47. [redacted]

[redacted]

48. [redacted]

49. [redacted]

50. [redacted]

51. [redacted]

52. [redacted]

53. [redacted]

[redacted] The Medical Review Board finds that RN [redacted] was not experienced in OB/GYN and although Byrd did not present with pain or appear to be in distress, it did not mean that Byrd did not experience preterm Prelabor Rupture of the Membrane (PROM). The Medical Review Board finds that RN [redacted] should have updated the on-call physician that Byrd reported that her water broke, and that there was a half dollar size area of clear liquid on Byrd's sheet.

54. [redacted] The Medical Review finds that it although unrelated to Byrd's pregnancy and pending complications, the changing of her classification status without a comprehensive psychiatric evaluation was substandard care.

55. [redacted] The Medical Review Board finds that Byrd was not examined by a physician until 30 hours after she first reported that her water broke, an unacceptable delay in care. The Medical Review Board opines that Byrd's reports of being able to ambulate and not appearing to have any discomfort should not have been viewed as contradictions to her reports of being in labor The Medical Review Board has also found that Dr [redacted] was negligent due to: failing to have Byrd transported to a hospital for an evaluation to determine if she had Prelabor Rupture of the Membrane and if the discharge was amniotic fluid, for taking Byrd's reports of not being in discomfort

and able to ambulate as signs that she was not in labor (to the contrary women may experience no pain and are able to ambulate in early stages of labor), and for failing to order any follow testing or monitoring to be done by facility staff. The Board opines that had Byrd been immediately referred to hospital, her infant's death may have been prevented.

56. [redacted] The Medical Review Board finds that there was no documentation that a physician was notified that Byrd reported that her water broke, and she was requesting to go to the hospital.

57. [redacted] The Medical Review Board finds that there was no documentation that a physician was notified that Byrd reported that the baby was in the birth canal and that her water broke.

58. [redacted] The Medical Review Board finds that there was no documentation that a physician was notified that Byrd reported having labor pains that started on 7/29/22 and that her water broke.

59. [redacted] The Medical Review Board finds that there was no documentation that a physician was notified that Byrd reported that her water broke two days prior and that she reported being in active labor.

60. [redacted] The Medical Review Board finds that over the course of six days Byrd made multiple complaints that her water had broken and baby's head was in the birth canal, however there was no documentation that a physician was ever notified beyond the report made on 7/27/22. The Board questions whether the repeated dismissing of Byrd's complaints by the medical staff was due to implicit bias of a person with Serious and Persistent Mental Illness, whereby attributing her reports of being in labor as a behavior.

61. On 8/2/22 at 4:53 a.m., Deputy P.T. documented in an Incident Report Narrative Summary that while conducting a frequent check tour, Byrd that housed in Pod 3C cell # 9 informed her that she was bleeding. Deputy P.T. observed a towel near the cell door that appeared to have light red liquid on it. Deputy P.T. also observed that Byrd had blood on her vaginal area. Deputy P.T. immediately called Control to call out for a medical emergency. Emergency Medical Services (EMS) was notified immediately. Deputy P.T. reported that medical staff responded to Pod C3 cell # 9 at 4:55 a.m. Documentation in the Medical Emergency Code Report indicated that RN [redacted] responded to Byrd's cell [redacted] EMS arrived [redacted]

62. [redacted]

63. On 8/2/22, Judge J.C. from the Syracuse City Court signed a release from custody for Byrd.

ACTIONS REQUIRED:

TO THE ONONDAGA COUNTY JAIL PHYSICIAN AND THE MEDICAL DIRECTOR FOR PROACTIVE (NAPHCARE):

1. The Medical Director shall conduct a comprehensive quality assurance review and

request an independent peer review regarding the following:

a. Why on 7/2/22 there was no documentation that any staff reviewed Byrd's pharmacy list that identified that Byrd was prescribed prenatal vitamins.
b. Why Dr. [redacted] did not obtain any vital signs on Byrd during assessments on 7/8/22, 7/13/22, and 7/18/22.
c. Why Byrd was not reapproached for the completion of her intake screening from 7/2/22 through 7/6/22.
d. Why Byrd was not reapproached from 7/7/22 to the end of her incarceration to have her intake screening completed.
e. Why Byrd did not receive a full psychiatric evaluation despite showing signs of and self-reporting having acute mental illness, nor was prescribed any psychotropic medications until 12 days into her incarceration.
f. Why on 7/13/22 Dr [redacted] did not follow the ultrasound technician's recommendations for Byrd to have further testing done.
g. Why Byrd was not seen for her admission medical history and physical assessment within the 14 days of her admission.
h. Why on 7/27/22 RN [redacted] did not update the on-call provider that Byrd reported that her water broke, and that there was a half dollar size area of clear liquid on Byrd's sheet.
i. Why on 7/27/22 Byrd was not seen by the facility provider after RN [redacted] scheduled a provider appointment for that morning.
j. Why Byrd was not examined by a physician until 30 hours after she first reported that her water broke.
k. Why on 7/28/22 Dr. [redacted] did not have Byrd transported to the hospital for an evaluation to determine if Byrd's discharge was amniotic fluid.
l. Why on 7/29/22 RN [redacted] did not notify a physician that Byrd reported that her water broke, and that she was requesting to go to the hospital.
m. Why on 7/30/22 RN [redacted] did not notify a physician that Byrd reported that the baby was in the birth canal and that her water broke.
n. Why on 7/31/22 DON [redacted] did not notify a physician that Byrd reported that her water broke two days prior and that she reported being in active labor.
o. Why on 8/1/22 DON [redacted] did not notify a physician that Byrd reported that her water broke twice, and that the baby's head was in the birth canal.

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

On 11/17/23, Costello, Cooney, & Fearon PLLC representing Proactive Health Care Medicine, PLLC, provided a response to the Commission's preliminary report disputing the Commission's findings and no corrective actions indicated as being taken. The Commission and the Medical Review Board remain affirmed in their findings regarding the medical care provided to Ms. Byrd and her infant.

TO THE DEPARTMENT OF EDUCATION, OFFICE OF PROFESSIONAL DISCIPLINE:

The Medical Review Board requests that an investigation be conducted into the professional misconduct of RN [redacted], RN [redacted], RN [redacted], and RN [redacted] for failure to notify a physician that Byrd continuously reported that her water broke and that the baby was in the birth canal.

TO THE OFFICE OF PROFESSIONAL MEDICAL CONDUCT:

The Medical Review Board requests that an investigation be conducted into the conduct of Dr. [redacted] who dismissed Byrd's reports of being in labor without ordering any requisite diagnostic testing to rule out Prelabor Rupture of the Membrane and or to order any follow up exams or testing, or provide any guidance to nursing staff leading up to Byrd's premature delivery of her infant.

TO THE CHAIR OF THE ONONDAGA 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.

WITNESS, HONORABLE ALLEN RILEY, Chairman, 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 20h day of December, 2023.

Allen Riley
Chairman
Commission of Correction

AR:BB: vc
Special Investigation
December 20, 2023