

REPORT ON THE DECEMBER 27, 2025 DEATH AT YORK CORRECTIONAL INSTITUTION



JULY 2026



July 30, 2026

Department of Correction
Attn: Commissioner Sharonda Carlos
24 Wolcott Hill Road
Wethersfield, CT 06109

Re: Investigation and Decision Concerning December 27, 2025 Death at York Correctional Institution - Patricia Taylor #455313

Dear Commissioner Carlos:

Pursuant to the authority vested in the Office of the Correction Ombuds under Conn. Gen. Stat. § 18-81qq, as amended, I write to formally transmit the enclosed investigative report and decision concerning the medical care provided to Patricia Taylor while she was incarcerated at York Correctional Institution.

This investigation was initiated after a member of Ms. Taylor's family contacted the Office and raised concerns regarding the circumstances preceding her death on December 27, 2025. The Office reviewed Ms. Taylor's medical records and master file; relevant Department nursing policies and protocols; the Department's critical-incident and Security Division investigations; Incident Report YCI-2025-12-139; information attributed to the Office of Inspector General; available telephone information; and the findings of the Office of the Chief Medical Examiner.

As detailed in the enclosed report, the Office identified material deficiencies involving clinical assessment and monitoring, documentation supporting the administration of as-needed medication, compliance with nursing protocols, required prescriber review, and the timeliness and reliability of clinical documentation. These deficiencies included the absence of documented vital signs for more than four days before Ms. Taylor's medical emergency, despite her infirmary placement, repeated administration of acetaminophen, and a reported respiratory complaint.

The Office does not conclude that the deficiencies identified in the report caused or contributed to Ms. Taylor's death. Nor does the available evidence permit the Office to determine that any particular Department employee possessed the state of mind necessary to establish a constitutional violation. The record does, however, establish departures from applicable Department nursing policies and protocols and demonstrates the need for corrective action to strengthen clinical monitoring, nursing assessment, protocol compliance, and contemporaneous documentation.

Pursuant to Conn. Gen. Stat. § 18-81qq(e)(4), please provide the Office with a written response within thirty days of the date of this letter. The Department's response should address each recommendation contained in the report:

1. Identify any corrective action already taken or planned;
2. Provide anticipated implementation dates;
3. Identify the person or division responsible for implementation; and
4. Explain the Department's reasons for declining to implement any recommendation, in whole or in part.

The Office further requests a written implementation update within ninety days describing the status of each corrective action and providing any relevant audit results, revised policies, training materials, or other documentation demonstrating compliance.

The findings in this report warrant prompt and meaningful corrective action. The Office remains available to engage constructively with the Department regarding the implementation of these recommendations.

Thank you for your attention to this matter.

Sincerely,

A handwritten signature in cursive script that reads "DeVaughn L. Ward".

DeVaughn L. Ward, Esq.
Correction Ombuds
State of Connecticut

Enclosure: Investigation and Decision Concerning December 27, 2025 Death at York Correctional Institution - Patricia Taylor #455313

Introduction

Pursuant to Connecticut General Statutes § 18-81qq, as amended by Public Acts 25-161 and 26-40, the Office of the Correction Ombuds has statutory authority to receive communications from, or on behalf of, persons who are incarcerated regarding decisions, actions, omissions, policies, procedures, rules, and regulations of the Department of Correction. Pursuant to Conn. Gen. Stat. § 18-81qq, the Correction Ombuds is authorized to:

1. Investigate complaints by, or behalf of, persons in the custody of the Department of Correction;
2. Inspect and monitor the conditions and operation of any facility or program operated by or under contract with the Department of Correction;
3. Review policies, procedures, and practices that may adversely affect persons in custody; and
4. Make recommendations to the Commissioner of Correction regarding improvements to correctional operations, policies, and procedure.

The Correction Ombuds is not required to investigate a complaint if the Correction Ombuds determines that an investigation is not warranted¹. During the course of an investigation, however, the Correction Ombuds shall rely on a variety of sources to corroborate matters raised by persons who are incarcerated or others. Where such matters turn on validation of particular incidents, the Correction Ombuds shall endeavor to rely on communications from persons who are incarcerated. The Correction Ombuds shall also make good-faith efforts to provide the Commissioner of Correction an opportunity to investigate and respond to such concerns before making them public².

At the conclusion of an investigation, the Correction Ombuds shall render a public decision on the merits of the complaint and communicate that decision to the person making the complaint and to the Department. The decision shall include findings concerning any Department administrative directive, state right, or constitutional right violated by the Department or an employee of the Department. The decision shall also include recommendations and supporting reasoning when, in the Correction Ombuds' opinion, the Department or an employee should further investigate a complaint, modify or cancel an action, alter a rule, practice, or ruling, explain an action in detail, or rectify an omission³.

Section 18-81qq further authorizes the Office to evaluate the provision of health-care services to persons incarcerated by the Department; investigate complaints regarding access to or quality of such services; employ or contract with licensed health-care professionals to provide independent clinical review when necessary; collect and analyze health-related data, including incidences of hospitalization and mortality; and recommend improvements in the delivery of correctional health care⁴.

At the Correction Ombuds' request, the Department shall, during a period agreed upon with the Correction Ombuds, inform the Correction Ombuds of any action taken on recommendations contained in a decision or any reason for not complying with such recommendations⁵.

¹ Conn. Gen. Stat. § 18-81qq(e)(1).

² Conn. Gen. Stat. § 18-81qq(e)(2).

³ Conn. Gen. Stat. § 18-81qq(e)(3)(A).

⁴ Conn. Gen. Stat. § 18-81qq(a)(2)(J), (q)(1)–(4), as amended by 2026 Conn. Pub. Acts No. 26-40, § 1.

⁵ Conn. Gen. Stat. § 18-81qq(e)(4).

Background

On January 23, 2026, a member of Patricia Taylor's family contacted the Office of the Correction Ombuds ("the Office") and raised concerns regarding the circumstances surrounding Ms. Taylor's death while she was incarcerated at York Correctional Institution ("YCI") in Niantic, Connecticut. A formal investigation was initiated shortly thereafter.

Ms. Taylor entered the custody of the Connecticut Department of Correction ("the Department") on December 3, 2025⁶. The medical record reflects that, on December 4, 2025, Dr. Homiski documented mobility concerns and indicated that Ms. Taylor might require a walker. The medical record further reflects that she was admitted to the infirmary that same day, where she remained until her hospital transfer and death on December 27, 2025.

On the evening of December 27, 2025, Ms. Taylor experienced a medical emergency. At approximately 7:20 p.m., 911 was activated. She was transported from York Correctional Institution at approximately 8:10 p.m. and was pronounced deceased at Lawrence & Memorial Hospital at approximately 8:40 p.m.

As part of this investigation, OCO reviewed the following: Ms. Taylor's medical records and master file; the Department's Nursing Practice Manual, including Nursing Policy D2.19 and Common Cold Protocol 6.3; the Department's critical incident report and the Security Division investigation; Incident Report YCI-2025-12-139; the findings attributed to the Office of Inspector General; available Securus telephone information; and the findings of the Office of the Chief Medical Examiner.

Office of Inspector General Findings

According to findings attributed to the Office of Inspector General, Ms. Taylor's cellmate reported that, on the morning of the incident, Ms. Taylor was not feeling well, lacked energy, and was having difficulty breathing. The cellmate reportedly provided no further details.

Department Critical Incident and Security Division Investigations

The Department's critical incident report states that Officer Ieraci was conducting a routine tour when Ms. Taylor's cellmate alerted him that Ms. Taylor was not feeling well. Medical staff were notified, and Nurse Norman determined that 911 should be activated. At approximately 7:19 p.m., Lieutenant Bychowsky and Officer Browning responded to 4-South and activated a handheld camera. The report states that Ms. Taylor was awake and moaning while the ambulance was en route, but then became unresponsive, prompting medical staff to initiate life-saving measures for a possible cardiac arrest.

The critical incident report further states that East Lyme ambulance personnel and paramedics arrived at approximately 7:30 p.m. Facility medical staff and emergency responders continued life-saving measures until Ms. Taylor was moved to a gurney at approximately 8:07 p.m. The ambulance departed at approximately 8:10 p.m., and Ms. Taylor remained unresponsive. She was pronounced deceased at Lawrence & Memorial Hospital at approximately 8:40 p.m. The report also states that continuous tours were implemented in 4-South, Cell 26 was secured as a crime scene, and Security Division and Connecticut State Police were notified. The Department's Security Division investigation states that Ms. Taylor placed 32 telephone calls during her incarceration period. During her final reviewed telephone call, placed on December 26, 2025, at approximately 7:59 p.m., Ms. Taylor reportedly stated that she had aches and pains throughout her body and felt as though she had been 'sucker punched'. She also stated that she had been coughing during the evenings but believed the cough was improving. Security Division further reported that no electronic messages were sent by or received by Ms. Taylor.

⁶Ms. Taylor's authorized family representative consented in writing to the publication of her name and the relevant medical information contained in this decision.



Security Division also interviewed Ms. Taylor's cellmate, who reportedly stated that she had been housed with Ms. Taylor for only a few days. The cellmate denied that Ms. Taylor had ingested illegal substances and stated that Ms. Taylor requested Mucinex earlier on December 27, 2025, which medical staff provided. The cellmate further reported that Ms. Taylor had not been feeling well, appeared weak, and did not attend evening recreation. Staff were then notified that Ms. Taylor might require medical attention. The cellmate provided a written statement that Security Division characterized as consistent with her interview.

DOC Incident Report YCI-2025-12-139

Incident Report YCI-2025-12-139 provides additional detail concerning Ms. Taylor's condition when medical staff arrived. According to the report, Officer Ieraci was alerted by Ms. Taylor's cellmate that Ms. Taylor was not feeling well and immediately notified Nurse Norman. Upon arriving at the cell, Nurse Norman reportedly observed Ms. Taylor lying on her left side, twisting in bed, disoriented, mumbling to herself, and bleeding slightly from the mouth. Nurse Thomas directed Nurse Norman to activate 911.

The report states that Ms. Taylor subsequently went into cardiac arrest. Medical staff deployed an automated external defibrillator, applied pads, were unable to obtain a manual blood pressure, and detected no pulse. Ms. Taylor was moved from the bed to the floor, and Nurses Thomas, Pukay, Pangelinan, and Guilleram reportedly performed approximately 10 to 15 cycles of chest compressions before emergency responders arrived.

Ombuds Investigation

Vital Sign Documentation:

York Correctional Institution activated emergency medical services in response to Ms. Taylor's condition on December 27, 2025, at approximately 7:21 p.m. The most recent vital signs documented in her medical record before that emergency were recorded on December 23, 2025, at 5:45 p.m. Accordingly, although Ms. Taylor was housed in the medical infirmary, the record contains no documented vital-sign assessments for approximately 97 hours before the medical emergency. This gap coincided with the Christmas holiday period, including Christmas Eve and Christmas Day.

Nursing Assessment Documentation and Medication Review:

Beginning on December 25, 2025, the medication administration record reflects repeated administration of as-needed acetaminophen without corresponding documentation explaining the symptoms or clinical findings that prompted the medication, or follow-up documentation on Ms. Taylor's response to the medication.

Ms. Taylor was administered acetaminophen (a pain reliever and fever reducer medication) on December 25, 2025 at approximately 7:38 p.m.; December 26, 2025 at approximately 8:52a.m. and 7:44 p.m.; and December 27, 2025, at approximately 8:49 a.m.

This omission is particularly significant in light of the Security Division account of Ms. Taylor's December 26 telephone call, during which she reportedly described generalized aches and pains and an evening cough. Those symptoms do not appear in the contemporaneous clinical documentation reviewed by the Office. The medical record therefore does not permit a reliable determination of whether nursing staff were aware of the same symptoms, whether the acetaminophen was administered in response to them, or whether the pattern warranted further assessment.

On the morning of December 27, 2025, Ms. Taylor reportedly complained of a cough. At approximately 10:33 a.m., Nurse Effio entered an order for guaifenesin, an expectorant medication, pursuant to a nursing protocol. The medication was administered by Nurse Effio at approximately 10:45 a.m.



An infirm nursing note describing the reported cough and Ms. Taylor's presentation during the morning shift was signed by Nurse Pangelinan at approximately 9:47 p.m. on December 27, 2025. This entry was completed more than two hours after 911 had been activated and after Ms. Taylor had been transported from York Correctional Institution, and 11 hours after the medication was ordered and administered. The note stated:

"IM presents A&Ox4, observed to be laying awake in bed talking with roommate, RR appear even/unlabored. Reported c/o cough to primary RN- N.P. Mucinex ordered and administered. Compliant with morning meds. No rec this shift d/t facility lock. Reports eating/drinking adequately. Educated on importance of hydrating while taking Mucinex, verbalized understanding. No further complaints offered at this time. Will continue with current plan of care and provide support as needed."

The note was authored by a nurse other than the nurse who entered the guaifenesin order and administered the medication. It does not clearly identify the time of each observation, whether the author personally observed all of the information documented, when the information was communicated to the author, or why the entry was not completed until after the emergency event. It does not document any vital signs.

The Department's Nursing Practice Manual Common Cold Protocol 6.3 addresses the nursing assessment and treatment of cough, chest discomfort, sore throat, and related symptoms. For a complaint of cough, the protocol directs nursing staff to offer a cough lozenge available through commissary. The protocol identifies chest congestion as the condition for initiating guaifenesin and requires vital signs as part of the assessment.

The documentation reviewed by the Office identifies a cough as Ms. Taylor's reported symptom. The record does not document chest congestion, explain why guaifenesin was selected when the documented symptom did not correspond with the stated protocol criteria, or reflect consultation with a prescriber before the medication was administered. Vital signs were not documented during this encounter either.

The Department's Nursing Policy D2.19 provides that medications initiated pursuant to a nursing protocol shall be entered into the electronic health record for co-signature by a prescriber. The Office did not identify a prescriber co-signature for the December 27 guaifenesin order.

The last documented vital signs before the 911 event identified by the Office were recorded on December 23, 2025 at approximately 5:45 p.m. The incident report states that staff were unable to obtain a manual blood pressure during Ms. Taylor's medical emergency on December 27. This was after 4 days without vital sign or focused assessment documentation, despite PRN acetaminophen administration and a reported cough with guaifenesin ordered and given.

A second infirm nursing note was signed by Nurse Norman at approximately 10:55 p.m. on December 27, 2025, more than three hours after 911 was activated and after Ms. Taylor had been transported from the facility. The note stated:

"LE: I/M seen during second and third shift rounds on unit. During second shift I/M was OOB for rec with walker. She presented to medline with euthymic affect, A&O x4. No complaints offered. At this time the I/M appears to be resting with her eyes closed, under the blanket within her cell- but was seen up earlier reading a soft cover book with the head of the bed elevated. Respirations are equal and unlabored bilaterally with even chest rise and fall. No apparent mental or medical distress is noted at this time. No behavioral outbursts noted. Care will be provided as ordered, and as requested. Chart audit was completed for this I/M without issue. Any acute changes will be communicated to the on call MD."



The wording of this note is difficult to reconcile with the emergency chronology. It states that Ms. Taylor appeared to be resting 'at this time' even though the entry was signed after she had been transported from York Correctional Institution. It also states that she was out of bed for recreation during second shift, while the cellmate reportedly told Security Division that Ms. Taylor appeared weak and did not attend evening recreation. These accounts may refer to different portions of the shift, but the lack of precise observation times prevents the discrepancy from being resolved.

The Office of the Chief Medical Examiner performed an autopsy on December 29, 2025, and determined that Ms. Taylor's cause of death was 'acute bronchopneumonia complicating chronic immunotherapy treatment for rheumatoid arthritis.' The Office does not independently determine that the deficiencies identified in this report caused or contributed to Ms. Taylor's death.

The Medical Examiner's finding does, however, underscore the importance of documenting and assessing vital signs, respiratory complaints and systemic symptoms in a patient receiving chronic immunotherapy and housed in the medical infirmary setting.

Findings

1. Clinically Relevant Symptoms Reported Before the Emergency Were Not Reflected in the Contemporaneous Medical Record

The Security Division investigation documents that, during a telephone call on December 26, 2025, Ms. Taylor described generalized aches and pains and an evening cough. Her cellmate later described Ms. Taylor as not feeling well, appearing weak, and not attending evening recreation. The account attributed to the Office of Inspector General also indicates that the cellmate reported that Ms. Taylor lacked energy and was having difficulty breathing.

These reports indicate that clinically relevant symptoms were present before the emergency response. The contemporaneous medical record, however, does not document the full nature, timing, or progression of those symptoms.

2. Repeated Administration of Acetaminophen Was Not Supported by Adequate Documentation

Ms. Taylor received four doses of as-needed acetaminophen between December 25 and December 27, 2025, without documentation identifying the indication for each dose, relevant assessment findings, her response to the medication, or whether the underlying symptom continued or worsened.

This deficiency prevents the Office and other reviewers from determining whether acetaminophen was administered for the generalized body aches described during Ms. Taylor's telephone call, for fever, or for another symptom that may have warranted additional evaluation.

3. Required Vital Signs and a Focused Respiratory Assessment Were Not Documented

No vital signs were documented when Ms. Taylor reported a cough, or during the period in which she repeatedly received acetaminophen. Her last documented vital signs were recorded more than four days before the emergency occurred.

The absence of vital signs during the December 27 cough encounter was inconsistent with Common Cold Protocol 6.3 and deprived clinical staff and subsequent reviewers of objective information relevant to Ms. Taylor's temperature, respiratory rate, oxygenation, heart rate, blood pressure, and possible clinical deterioration.



4. The Guaifenesin Order Was Not Supported by the Documented Protocol Criteria and Lacked Required Prescriber Review

Guaifenesin was ordered and administered pursuant to a nursing protocol, although the record documents a cough rather than the chest congestion identified by the protocol as the indication for guaifenesin. No vital signs were documented when the medication was ordered or administered.

The record does not explain the clinical basis for departing from the documented protocol criteria, and the Office did not identify the prescriber co-signature required by Nursing Policy D2.19.

5. Delayed and Internally Inconsistent Nursing Documentation Undermines the Reliability of the Medical Record

Two nursing notes describing Ms. Taylor's condition before the emergency were entered only after she had been transported from York Correctional Institution. Neither entry clearly identifies the precise times of the underlying observations, the source of all information documented, or the reason the entry was delayed.

The later note describes Ms. Taylor as resting "at this time" after she had already been transported from the facility. It also states that she attended recreation during second shift, while the cellmate reportedly told Security Division that Ms. Taylor appeared weak and did not attend evening recreation. These accounts may concern different portions of the shift, but the absence of precise observation times prevents the discrepancy from being resolved. Neither note contains vital-sign documentation.

6. Required Physician or Physician-Extender Rounds Were Not Appropriately Documented

Administrative Directive 8.1, Section 9, required the physician or physician extender responsible for the care of infirmary patients to make rounds at least every 72 hours with appropriate documentation. Ms. Taylor remained in the York Correctional Institution medical infirmary from December 4 through December 27, 2025. The medical record reviewed by the Office does not contain documentation sufficient to establish that physician or physician-extender rounds occurred at the required intervals during that period.

Legal & Administrative Review

Connecticut General Statutes § 18-81qq requires the Office, when rendering a public decision at the conclusion of an investigation, to include findings concerning any Department administrative directive, state right, or constitutional right violated by the Department or an employee of the Department. Consistent with that statutory responsibility, the Office reviewed the conduct identified in this investigation against the version of Administrative Directive 8.1, Scope of Health Services Care, in effect during Ms. Taylor's incarceration; the Department's applicable nursing policies and protocols; and federal constitutional standards governing the provision of medical care to persons in custody.

Administrative Directive 8.1: Scope of Health Services Care

At the time of the events examined in this report, Administrative Directive 8.1 required the Department to provide, either directly or through an agent, "quality healthcare" to persons committed to the custody of the Commissioner. A.D. 8.1 § 1. The Directive defined the "community standard" as the scope and quality of medical, dental, and mental-health services—including the type, amount, frequency, level, setting, and duration of care appropriate to the patient's diagnosis or condition—that is consistent with generally accepted practice parameters in the State of Connecticut. A.D. 8.1 § 3(A). Section 4 further required the Department to provide all incarcerated persons access to healthcare services meeting those community standards.



Administrative Directive 8.1 also required all healthcare services rendered to an incarcerated person to be documented in the individual's health record in accordance with Administrative Directive 8.7, Health Records Management. A.D. 8.1 § 6.

Section 9 established additional requirements for infirmary care. It required Department infirmaries to provide 24-hour nursing care; required a registered nurse to be available at all times to plan and administer nursing care; and required the physician or physician extender responsible for the care of infirmary patients to make rounds at least every 72 hours with appropriate documentation. Section 9 also required infirmaries to maintain written protocols providing nurses with guidelines for approved nursing practice.

Ms. Taylor was housed in the York Correctional Institution medical infirmary from December 4 through December 27, 2025. Despite her placement at an infirmary level of care, no vital signs were documented for more than four days before her medical emergency. During that period, she received repeated doses of as-needed acetaminophen without documentation identifying the symptoms or clinical findings supporting the medication, any focused assessment performed, or her response to the medication.

When Ms. Taylor later reported a cough, guaifenesin was ordered and administered without documentation of the chest congestion identified by Common Cold Protocol 6.3 as the applicable criterion, without the vital signs required by that protocol, and without the prescriber co-signature required by Nursing Policy D2.19. Two nursing notes purporting to describe her condition before the emergency were not entered until after she had been transported from the facility. Those entries did not identify the precise times or sources of the underlying observations and contained information that could not be reconciled with the emergency chronology and the account provided by Ms. Taylor's cellmate.

The medical record also does not contain documentation sufficient to establish that a physician or physician extender made rounds at least every 72 hours. Ms. Taylor remained in the infirmary for more than three weeks, yet the record reviewed by the Office does not reflect appropriately documented provider rounds at the intervals expressly required by Section 9. Because Section 9 requires both the performance of those rounds and appropriate documentation, the absence of such documentation establishes noncompliance with at least the documentation component of that requirement, regardless of whether undocumented rounds may have occurred.

The record similarly fails to reflect the ongoing nursing assessments, objective monitoring, and contemporaneous clinical documentation reasonably expected in an infirmary providing 24-hour nursing care with continuous registered-nurse availability. The Office does not conclude from the medical record alone that nursing personnel were physically absent from the infirmary or that a registered nurse was unavailable during any particular shift. The deficiencies in the record do, however, prevent the Department from demonstrating that the ongoing nursing assessment, clinical monitoring, and registered-nurse oversight contemplated by Section 9 were consistently provided.

Based on the independent clinical review conducted by the Correction Healthcare Ombuds, the identified deficiencies were not merely technical or isolated recordkeeping errors. The failure to obtain and document objective clinical information, perform and document an adequate focused assessment, comply with the applicable nursing protocol, document the indication for and response to repeated as-needed medication, obtain required prescriber review, and maintain a reliable contemporaneous medical record impaired the ability of clinical staff to recognize, communicate, and respond to changes in Ms. Taylor's condition.

The Office therefore finds that the Department violated Administrative Directive 8.1, Sections 1 and 4. The absence of required vital signs and focused assessments, the unsupported use of a nursing protocol, the lack of required prescriber review, and the deficiencies in ongoing infirmity monitoring were inconsistent with the Directive's requirements for quality healthcare meeting community standards.

The Office further finds that the Department violated Section 6 because the healthcare services and nursing encounters at issue were not fully, accurately, and reliably documented in Ms. Taylor's health record. The record did not adequately document the clinical basis for repeated medication administration, Ms. Taylor's response to those medications, the assessment associated with her respiratory complaint, or the timing and source of material nursing observations.

The Office also finds that the Department violated Section 9's requirement that the physician or physician extender responsible for the care of infirmity patients make rounds at least every 72 hours with appropriate documentation. The record does not establish that appropriately documented provider rounds occurred at the required intervals. The absence of documented vital signs for more than four days, the lack of focused assessments associated with repeated as-needed medication and a respiratory complaint, and the delayed and internally inconsistent nursing entries were also inconsistent with the ongoing assessment, monitoring, and reliable documentation reasonably expected in an infirmity providing 24-hour nursing care with continuous registered-nurse availability.

These failures also constituted departures from Common Cold Protocol 6.3 and Nursing Policy D2.19.

Constitutional Considerations

The circumstances identified in this investigation also warrant consideration under federal constitutional standards governing medical care for sentenced persons.

The Eighth Amendment prohibits deliberate indifference to the serious medical needs of incarcerated persons. A deliberate-indifference claim contains both an objective and a subjective component. First, the medical need or deprivation of care must be sufficiently serious. Second, the responsible official must actually know of and disregard an excessive risk to the individual's health or safety. Negligence, medical malpractice, inadequate documentation, or an incorrect medical judgment, standing alone, does not satisfy this constitutional standard. *Estelle v. Gamble*, 429 U.S. 97, 104–06 (1976); *Farmer v. Brennan*, 511 U.S. 825, 834, 837 (1994).

The United States Court of Appeals for the Second Circuit has further recognized that delayed or inadequate treatment of a serious medical condition may support an Eighth Amendment claim where the evidence establishes a sufficiently serious deprivation and that the responsible official knew of and disregarded the risk to the incarcerated person's health. *Hathaway v. Coughlin*, 37 F.3d 63, 66–69 (2d Cir. 1994).

Here, the record does not reliably establish the precise onset and progression of Ms. Taylor's clinical deterioration, the time and substance of each observation made by individual staff members, what each staff member knew about her condition, or whether any employee consciously disregarded a substantial risk to her health. The delayed, incomplete, and internally inconsistent documentation identified in this report contributes directly to the Office's inability to make those determinations.

Accordingly, the Office does not make a definitive finding that Ms. Taylor's rights under the Eighth Amendment were violated. This conclusion does not diminish the established violations of Administrative Directive 8.1, Sections 1, 4, 6, and 9; the departures from Common Cold Protocol 6.3 and Nursing Policy D2.19; or the need for corrective action intended to prevent serious symptoms from going unassessed, undocumented, or untreated.



Decision

Based on the record developed during this investigation, the Office substantiates the complaint in part.

The Office substantiates the complaint as to material deficiencies in clinical monitoring, nursing assessment, medication documentation, compliance with applicable nursing protocols, required prescriber review, and contemporaneous clinical documentation.

The Office finds that the Department violated Administrative Directive 8.1, Sections 1 and 4, by failing to provide and document infirmary care consistent with the Directive's requirements for quality healthcare meeting community standards. The Office further finds that the Department violated Section 6 because the healthcare services and nursing encounters at issue were not fully, accurately, and contemporaneously documented in Ms. Taylor's health record.

The Office also finds a violation of Section 9. The medical record does not contain appropriately documented physician or physician-extender rounds at least every 72 hours, as expressly required by that section. In addition, the absence of documented vital signs for more than four days, the lack of focused assessments associated with repeated as-needed medication and a respiratory complaint, and the delayed and internally inconsistent nursing entries are incompatible with the level of ongoing assessment, monitoring, and documentation required in an infirmary providing 24-hour nursing care with continuous registered-nurse availability.

The Office does not conclude from the medical record alone that nursing personnel were physically absent from the infirmary or that a registered nurse was unavailable during any particular shift. Rather, the record fails to demonstrate that the required nursing assessment, clinical monitoring, registered-nurse oversight, and appropriately documented provider rounds were consistently provided.

The Office finds that the care documented in Ms. Taylor's medical record departed from Common Cold Protocol 6.3 and Nursing Policy D2.19. Specifically, required vital signs were not documented during the cough-related encounter; the documented symptoms did not satisfy the stated protocol criteria for initiating guaifenesin; the clinical basis for administering the medication under the protocol was not documented; and the Office did not identify the required prescriber co-signature.

The available evidence does not permit the Office to determine that the identified violations and deficiencies caused or contributed to Ms. Taylor's death. The Office also does not find, on the present record, that a state statutory or constitutional right or Ms. Taylor's rights under the Eighth Amendment were violated.

The absence of sufficient evidence to establish causation or a constitutional violation does not diminish the seriousness of the established violations of Administrative Directive 8.1, the departures from applicable nursing policies and protocols, or the need for corrective action.

Recommendations

1. Provide Supplemental Education Regarding Vital-Sign Assessment and Documentation

The Office recommends education to nursing staff regarding the circumstances in which vital signs are required and the way those vital signs must be documented. The education should emphasize that vital signs are a necessary component of clinical assessment when a patient reports new or worsening symptoms, receives repeated as-needed medication, presents with respiratory complaints, or is housed in an infirmary setting requiring ongoing monitoring. The training should also reinforce the importance of documenting the date, time, results, and clinical significance of each assessment.



2. Conduct an Audit of Required Vital-Sign Documentation

The Office recommends an audit of vital-sign documentation for patients whose condition, housing status, treatment plan, or applicable nursing protocol requires that vital signs be obtained. The audit should determine whether vital signs were completed at the required frequency, whether the results were entered into the medical record contemporaneously, and whether abnormal or changing results were appropriately communicated and addressed. The results of the audit should identify facility-level, shift-level, or individual patterns of noncompliance requiring corrective action.

3. Conduct an Audit of Nursing Protocol Orders

The Office recommends an audit of Nursing Protocol Orders to determine whether nurses are complying with the requirements established in the Nursing Practice Manual. The audit should evaluate whether the patient's documented symptoms satisfied the criteria for use of the protocol, whether all required assessments and vital signs were completed, whether the medication and its indication were properly documented, and whether required prescriber review or co-signature occurred. The audit should also assess whether the patient's response to the intervention and any need for further evaluation were documented.

4. Review Nursing Protocol Orders for Safety and Clarity

The Office recommends a review of all available Nursing Protocol Orders to ensure that they contain clear, specific, and clinically appropriate parameters. Each protocol should identify the symptoms or conditions that permit its use, the assessments that must be completed before treatment, required vital signs, contraindications, follow-up requirements, circumstances requiring consultation with a prescriber, and criteria for escalation to a higher level of care. Protocols should be revised where their language permits ambiguity or does not clearly distinguish between symptoms requiring different assessments or treatments.

5. Establish an Express Real-Time Documentation Requirement in Nursing Policy

The Office recommends updating nursing policies, procedures and protocols to expressly require that nursing assessments, medication administration, patient complaints, clinical observations, interventions, and responses to treatment be documented in real time or as close to the time of care as reasonably possible. The policy should distinguish contemporaneous documentation from late entry and establish the information that must be included when documentation cannot be completed at the time of the underlying event. Any late entry should clearly identify the date and time the entry was made, the date and time of the care or observation being documented, the reason for the delay, the source of the information, and whether the author personally observed the matters described.

6. Provide Supplemental Education Regarding Real-Time Clinical Documentation

The Office recommends education to nursing staff regarding the expectations for and importance of, real-time documentation. The education should explain that timely documentation is necessary to preserve continuity of care, communicate changes in a patient's condition, support clinical decision-making, and establish what information was available to staff at a particular time.

The training should further emphasize that documentation entered only after an emergency or adverse event may not reliably establish what was observed, communicated, or acted upon before the event occurred. Nurses should be instructed on the proper use of late entries and the requirement that such entries not be presented as though they were recorded contemporaneously.



7. Establish Ongoing Oversight and Accountability for Nursing Documentation

The Office recommends a structured system of supervisory oversight and accountability to ensure that nursing notes, medication administration records, vital signs, protocol orders, and other required clinical documentation are completed accurately and in real time. Oversight should not only identify missing documentation but also determine whether the record adequately reflects the patient's condition, the care provided, and the clinical response to reported symptoms or changes in presentation.

At a minimum, the Department should implement the following measures:

a. Daily Shift Audits

Nursing supervisors should conduct daily shift audits of required documentation, including nursing notes, medication administration records, vital signs, protocol orders, and documentation of follow-up or provider notification. Deficiencies should be identified promptly so that missing information can be addressed while the events remain recent and responsible staff remain available.

b. Weekly Supervisory Audits

Nursing supervision should conduct broader weekly audits to identify recurring deficiencies, delayed entries, incomplete assessments, missing vital signs, unsupported medication administration, and failures to obtain required prescriber review. Audit findings should be tracked over time and reviewed by facility healthcare leadership to identify systemic or repeated compliance concerns.

c. Individual Follow-Up and Progressive Corrective Action

Nurses who are found not to be compliant with real-time documentation requirements should receive prompt individual follow-up, counseling, supplemental training, and discipline, if necessary. The Department should document the deficiency, the corrective instruction provided, and the employee's subsequent compliance. Where noncompliance is repeated, significant, or creates a risk to patient safety, the Department should impose progressive corrective or disciplinary measures, as appropriate and consistent with applicable personnel policies and collective bargaining agreements.

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