



**Commission of
Correction**

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

In the Matter of the Death of

**Cecil Alves (00A0339),
an incarcerated individual of the
Wende Correctional Facility**

December 18, 2024

**To: Honorable Daniel F. Martuscello, III
Commissioner
NYS Department of Corrections
And Community Supervision
The Harriman State Campus
1220 Washington Avenue
Albany, New York 12226**

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 Cecil Alves, who died on February 23, 2022, while an incarcerated individual in the custody of the NYS Department of Corrections and Community Supervision at the Wende Correctional Facility, the Commission has determined that the following final report be issued.

FINDINGS:

1. Cecil Alves was a 43-year-old male who died on 2/23/22 from a suicidal hanging while in the custody of the New York State Department of Corrections and Community Supervision (NYS DOCCS) at the Wende Correctional Facility (CF).
2. Alves was born in Trinidad. Alves entered the United States from Trinidad via a plane in January 1984. There was no further demographic or social history available to the Commission for Alves.
3. [REDACTED]
4. [REDACTED]
5. [REDACTED] In the instant offense, on 4/26/98 in Long Beach, NY, Alves had a physical altercation with a 16-year-old female that ended with the 16-year-old female sustaining head and neck trauma that caused her death. The 16-year-old female was also raped by Alves. Alves was convicted by a jury and sentenced to life without parole in the New York State Department of Corrections and Community Supervision (NYS DOCCS).
6. Alves was admitted into NYS DOCCS at Downstate Reception CF on 1/21/00 to serve a Life sentence for Murder 1st Degree and Rape 1st Degree. Alves was transferred from Downstate CF to Sullivan CF on 7/26/00 where he was admitted to the [REDACTED]. NYS DOCCS' documentation indicated that Alves was transferred from the Sullivan CF [REDACTED] to Sullivan CF General Population (GP) on 3/16/01. Alves was transferred from Sullivan CF to Wende CF on 4/1/11. Alves was transferred from Wende CF to Sullivan CF on 2/7/13 for an area of preference. Alves was transferred from

Sullivan CF to Wende CF on 8/14/15 for a separation from other incarcerated individuals. This is where Alves remained until the terminal event. [REDACTED]

7. [REDACTED]

8. Between December 2000 and June 2021, Alves accrued 31 Tier II and 2 Tier III infractions that included direct order, creating a disturbance, unhygienic act, loss/damage property, violent conduct, fighting, count violation, altered item, contraband, unreported illness, false information, out of place, unauthorized medical, tamper with electric, drug use, movement violation, phone violation, lewd conduct, creating a disturbance, interference, smuggling, unauthorized exchange, tamper with property, and unauthorized property. Alves' sanctions included loss of recreation, loss of phone, loss of packages, loss of commissary, keeplock, loss of personal television, loss of earphones, loss of work detail, restitution, and counseling.

9. [REDACTED]

10. [REDACTED]

11. [REDACTED] The goal of the RCTP is to evaluate and treat incarcerated individuals-patients in need of short-term crisis mental health care.

12. [REDACTED]

13. [REDACTED]

14.

[REDACTED]

15.

[REDACTED]

16.

[REDACTED]

17.

[REDACTED]

[REDACTED]

18.

[REDACTED]

19.

[REDACTED]

20.

[REDACTED]

21.

[REDACTED]

22.

[REDACTED]

23.

[REDACTED]

24.

[REDACTED]

25.

[REDACTED]

26.

[REDACTED]

[REDACTED]

27.

[REDACTED]

The Medical Review Board opines that Alves documented escalation of self-harm behaviors over the previous month should have prompted a clinical review for possible inpatient admission to Central NY Psychiatric Center.

28.

[REDACTED]

29.

[REDACTED]

30.

[REDACTED]

[REDACTED]

31.

[REDACTED]

32.

[REDACTED]

33.

[REDACTED]

34.

[REDACTED]

35.

[REDACTED]

36.

[REDACTED]

The Medical Review Board found documentation in the progress notes between 7/9/21 and 2/9/22 were inconsistent whether Alves was assessed for lethality and suicide risk or whether it was indicated. This was also an issue that was identified by OMH Risk Management in their special investigation report. Indicated corrective action was for the Wende CF Unit Chief to conduct a review with all clinical staff regarding accurate documentation of progress notes and suicide risk assessment.

37.

[REDACTED]

38. On 2/23/22 at 11:30 a.m., Corrections Officer (CO) D.R. documented in the B Block 11 Company logbook that rounds and a count were completed.

39. On 2/23/22 at 11:55 a.m., CO D.R. was making a security round on B Block, 11 Company and observed Alves hanging in his cell #02S from a bed sheet that was tied around his neck and to the cell bars. CO D.R. immediately called for a medical emergency. COs J.M and F.R. arrived at the scene and CO D.R. supported Alves' body as CO J.M. used his personal knife to cut the garrote from Alves' neck. At 11:57 a.m., Sergeant (Sgt.) R.B arrived at the scene. COs T.B. and J.M. moved Alves out of his cell to the gallery floor. CO T.B initiated Cardiopulmonary Resuscitation (CPR) and CO J.M. applied the Bag Valve Mask (BVM) to aid with respirations. At 11:58 a.m., CO D.S. administered one dose of Narcan nasally without any response and CO T.W. applied the Automated External Defibrillator (AED) with no shock advised. RN [REDACTED] and RN [REDACTED] arrived at the scene and assumed the care of Alves [REDACTED]

[REDACTED]

40. Per documentation from a NYS DOCCS Memorandum written by Lieutenant (Lt.) A.C., on 2/23/22 at approximately 11:55 a.m., Lt. A.C. was notified that an ambulance was needed for Alves. Lt. A.C. immediately attempted to call 911 from the Watch Commander's desk and received a busy signal. Lt. A.C. made approximately five-to-seven attempts before being able to reach Emergency Medical Services (EMS).

41. [REDACTED]

42. [REDACTED]

ACTIONS REQUIRED:

TO THE OFFICE OF MENTAL HEALTH, DIVISION OF FORENSIC SERVICES

1. The Division shall conduct a quality assurance review to examine why clinical consideration for in-patient hospitalization was not made during Alves last RCTP admission.
2. The Division shall provide the Medical Review Board verification that corrective actions regarding documentation of suicide risk in progress notes was completed with Wende CF clinical staff and that continued quality assurance monitoring for this issue has been implemented.

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

In a response dated 11/1/24 to the Commission's preliminary report, the Division of Forensic Services indicated that the requested reviews were completed and provided verification that corrective action training was completed.

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 18th day of December 2024.



Yolanda Canty
Commissioner
Commission of Correction

YC:BB:vc
2022-M-0019
December 18, 2024

cc: Dr. Carol Moores, Chief Medical Officer
James Donahue, Associate Commissioner of Mental Health
Superintendent Christopher Yehl, Wende CF
Dr. Li-Wen Lee, Associate Commissioner
Division of Forensic Services, NYS Office of Mental Health
Danielle Dill, Executive Director, CNYPC
William Vertoske, Deputy Director of CBO, CNYPC
Meaghan Bernstein, Advocacy Letter Coordinator, CNYPC