



**Commission of
Correction**

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

In the Matter of the Death of

**Altemio Sanchez (07B2617),
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 Altemio Sanchez, who died on September 22, 2023, 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. Altemio Sanchez was a 65-year-old male who died on 9/22/23 from hemorrhagic complications from an incised wound while in the custody of the New York State Department of Corrections and Community Supervision (NYS DOCCS) at the Wende Correctional Facility (CF). The Medical Review Board opines that Sanchez's manner of death was a suicide.
2. Sanchez was born in San Juan, Puerto Rico. Sanchez was married with two children. Sanchez graduated from high school and was employed at the American Brass Corporation. There was no further demographic or social history available to the Commission for Sanchez.
3. Sanchez's criminal history per records available to the Commission, commenced in January 2007 at the age of 34 after being charged with three counts of Murder. Sanchez raped and strangled three victims in parks in Western New York. Sanchez's crimes gained notoriety as the Bike Path Rapist/Bike Path Killer.
4. [REDACTED]
5. [REDACTED]
6. Sanchez was admitted to NYS DOCCS at the Wende CF Reception on 8/14/07 to serve a 75-years to Life sentence for three counts of Murder 2nd Degree. Sanchez was transferred from Wende CF Reception to Elmira CF Reception on 8/14/07. Sanchez was transferred from Elmira CF Reception to Clinton CF Assessment and Program Preparation Unit (APPU) on 9/13/07. On 10/27/22, Sanchez was transferred from the Clinton CF APPU to Wende CF for an area of preference. This is where Sanchez remained until the terminal event.
7. On 2/8/13, Sanchez accrued one Tier III infraction for unauthorized exchange, false information, and facility correspondence. Sanchez's sanction included keep lock, loss of recreation, loss of packages, loss of phone, and loss of commissary. On 9/19/23, Sanchez accrued a Tier II infraction for violent conduct, creating a disturbance, fighting, and direct order. There was no further information available to the Commission regarding this infraction.

8. [REDACTED]
9. On 9/19/23, Correction Officer (CO) M.G. documented on an Incarcerated Individual (II) Misbehavior Report that at approximately 1:00 p.m., Sanchez and another II were exchanging closed fist punches to the head and upper torso of each other and that they both were given a direct order to stop fighting which was ignored. Documentation indicated that upon the arrival of the response team, CO M.G. gave Sanchez and the other II another direct order to stop fighting and both of them complied without any further incident.
10. [REDACTED]
11. On 9/19/23 at 1:45 p.m., documentation in the B Block logbook indicated that Sanchez was received on B Block. Sanchez was previously housed on A Block.
12. [REDACTED]
13. On 9/20/23 at 5:40 p.m., Sergeant (Sgt.) B.S. attempted to interview Sanchez in response to a letter written by Sanchez regarding harassment. Sanchez refused to be interviewed and he refused to be placed in voluntary protective custody. Sanchez signed a voluntary protective custody refusal form and documented, "I do not want PC".
14. A review of the B Block logbook by Commission staff found that from 9/20/23 at 5:40 p.m. through 9/22/23 at 6:45 a.m., there were no specific logbook entries made for Sanchez.
15. On 9/22/23 at 5:50 a.m., documentation in the B Block logbook indicated that a count with the pipe rounds checker was completed.
16. Documentation from a NYS DOCCS Memorandum written by CO J.S. indicated that during the 5:50 a.m. rounds, CO J.S. was able to confirm that all IIs on 9 company were alive. CO J.S. documented, " They all either sat up, or I awakened them and gave them a direct order to sit up or stand up, to which all II complied for the count". CO J.S. documented that when completing the last round at approximately 6:20 a.m. in order to send mess hall workers out, everyone was alive and breathing.

17. Per the NYS DOCCS Unusual Incident Report, on 9/22/23 while conducting rounds on 11 Company, CO G.J. observed Sanchez unresponsive in his cell and a medical emergency was initiated at approximately 7:15 a.m. The area supervisor, medical, and other security staff responded to the scene. COs G.R. and R.B. removed Sanchez from his cell and placed him on the gallery floor. CO G.R. immediately began Cardiopulmonary Resuscitation (CPR) that was rotated between staff members including Dr. [REDACTED]. At 7:20 a.m., the Automated External Defibrillator (AED) arrived at the scene and CO G.R. applied it to Sanchez's chest with no shock advised. CPR continued and CO G.R. administered the first dose of Narcan at 7:22 a.m. with no effect. CPR continued and an additional two doses of Narcan were administered to Sanchez at 7:25 a.m. and 7:44 a.m. without effect. [REDACTED] Sgt. N.S. notified Lancaster Volunteer Ambulance Corp. (LVAC) at 7:30 a.m. [REDACTED] the arrival of LVAC at 7:50 a.m.

18. [REDACTED]
 [REDACTED] Per documentation from the DOCCS Office of Special Investigations (OSI) and the review of medical records by Commission staff, Dr. [REDACTED] did not document the response or the medical care that was rendered to Sanchez during the emergency response in Sanchez's medical record. The Medical Review Board finds that this was not in comportment with the requirements of 9 NYCRR §7651.9(b) Medical Records which states:
(b) All health care services provided to inmates by facility health care staff or by independent health care providers shall be permanently recorded in the medical record.

19. Per the NYS DOCCS Memorandum written by Lieutenant (Lt.) R.S., during the medical event with Sanchez, he was unaware that there was a delay in notification for the ambulance. The Lt. indicated that he maintained telephone contact with the onsite supervisor for a constant update of the information as it was relayed to them. As soon as the gravity of the situation was made to him, Lt. R.S. directed Sgt. N.S. to contact LVAC immediately. Per the documentation from the DOCCS OSI report, all of the security staff were retrained on Directive 2124-Automatic External Defibrillators/911 activation.

20. [REDACTED]

21. [REDACTED]

[REDACTED]

22.

[REDACTED]

23. Commission staff reviewed photographs that were taken inside of Sanchez's cell after the incident. Photo #DSCF3016.JPG showed one-half of a nail clipper and photo #DSCF3058.JPG showed one half of a nail clipper with the spring. Additional photos showed multiple items of bedding and clothing in Sanchez's cell that were blood soaked. Investigations by both DOCCS OSI and NYS Police Bureau of Criminal Investigation found that Sanchez was alone in his cell with evidence that the lacerations to his left arm were self-inflicted with broken parts of a nail clipper. Therefore, the Medical Review Board has found that Sanchez's manner of death was a suicide.

ACTIONS REQUIRED:

TO THE DEPUTY COMMISSIONER OF THE NYS DEPARTMENT OF CORRECTIONS AND COMMUNITY SUPERVISION, DIVISION OF HEALTH SERVICES:

The Deputy Commissioner shall conduct a quality assurance review with the Health Services staff at Wende CF to assure compliance with 9 NYCRR §7651.9(b) which requires proper maintaining and recording of patient care records.

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

In a response dated 11/8/24 to the Commission's preliminary report, NYS DOCCS indicated that the requested review 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

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2023-M-0100
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