



**Commission of
Correction**

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

In the Matter of the Death of

**Toby Smith (19A4696),
an incarcerated individual of the
Great Meadow 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 Toby Smith, who died on May 4, 2022, while an incarcerated individual in the custody of the NYS Department of Corrections and Community Supervision at the Great Meadow Correctional Facility, the Commission has determined that the following final report be issued.

FINDINGS:

1. Toby Smith was a 48-year-old male who died on 5/4/22 from coronary artery disease along with acute fentanyl intoxication while in the custody of New York State Department of Corrections and Community Supervision (NYS DOCCS) at the Great Meadow Correctional Facility (CF). Both the Medical Review Board and NYS DOCCS found that there were deficiencies of security rounds by corrections staff assigned to Smith's housing area.

2. [REDACTED] In the instant offense, in September 2018, Smith was burglarizing a home and, in the process, struck an 83-year-old woman in the head with a vase and then choked her resulting in her death. While attempting to flee the scene, Smith struck another individual in the face with a vase causing substantial pain. Smith was restrained by community citizens prior to the arrival of local police. In September 2022, Smith was convicted of Murder 2nd Degree, Attempted Assault 1st Degree, and Assault 2nd Degree and was sentenced to 37 years to life.

3. [REDACTED]

4. On 12/24/19, Smith was received in NYS DOCCS. On 1/30/20, Smith transferred from Downstate CF to Great Meadow CF.

5. [REDACTED]

6. [REDACTED]

7. [REDACTED]

8. [REDACTED]

9. [REDACTED]

10. [REDACTED]

11. [REDACTED]

12. [REDACTED]

13. [REDACTED]

14. [REDACTED]

15. [REDACTED]

16. [REDACTED]

17. [REDACTED]

- 18. [REDACTED]
- 19. [REDACTED]
- 20. [REDACTED]
- 21. [REDACTED]
- 22. [REDACTED]
- 23. [REDACTED]
- 24. [REDACTED]
- 25. On 5/3/22 at 9:30 p.m., on housing area C4 which was general population housing, Smith was seen alive on supervisory rounds. At 11:50 p.m., CO R. completed a security tour and noted that Smith was slumped over on his bunk and was unresponsive. A medical response was called and at approximately 11:50 p.m., the Automated External Defibrillator (AED) was applied without shock advised and Cardiopulmonary Resuscitation (CPR) was initiated. RN L.B. arrived. Emergency Medical Services (EMS) was activated.
[REDACTED] At 12:22 a.m. EMS arrived [REDACTED]
- 26. DOCCS Office of Special Investigations (OSI) final report indicated that a review of the C-Company logbook from 5/3/22 until 5/4/22 revealed that Correction Officer (CO) T.T. failed to conduct a security round between 9:30 p.m. and 11:00 p.m. and CO K.R. failed to conduct security rounds between 11:00 p.m. and 12:00 a.m. CO T.T. and CO K.R. failed to follow Directive 4091 Logbooks, Section III, Letter J, when they did not specifically document the gallery in which rounds were made, and the name of the staff member who conducted the rounds of the galleries on C-block. Previous OSI investigations have revealed a commonality at Great Meadow CF that security rounds were not being conducted between 10:00 p.m. and 12:00 a.m. Corrective Action was taken in December 2022 by Superintendent C.C. Correction Supervisors were advised to notify line staff and ensure security pipe rounds were conducted beginning at 11:00

p.m. on all companies. Additionally, correction staff were advised to document in the Block-logbooks, the name of the staff who conducted the round, the time, and the company location a security round was conducted. This matter was referred to the Bureau of Labor Relations (BLR). BLR indicated that there would be no additional action taken outside of the corrective action taken by Superintendent C.C. and the updated memorandum issued by Deputy Commissioner J.N. regarding quality rounds.

ACTIONS REQUIRED:

That this case be closed as natural causes.

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:DC:vc
2022-M-0052
December 18, 2024

cc: Dr. Carol Moores, Deputy Commissioner Chief Medical Officer
James Donahue, Associate Commissioner of Mental Health
Superintendent Christopher Collins, Great Meadow CF