



**Commission of  
Correction**

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

**In the Matter of the Death of**

**James Evans (23B0006),  
an incarcerated individual of the  
Mohawk Correctional Facility**

**March 26, 2025**

**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*



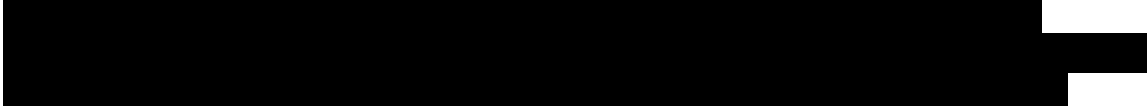
**Yolanda Canty**  
*Commissioner*

**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 James Evans, who died on June 7, 2023, while an incarcerated individual in the custody of the NYS Department of Corrections and Community Supervision at the Mohawk Correctional Facility, the Commission has determined that the following final report be issued.

FINDINGS:

1. James Evans was a 58-year-old male who died on 6/7/23 due to a 5-fluoro-PINACA 3, 3-dimethylbutanoic acid (synthetic marijuana) intoxication while in the custody of the New York State Department of Corrections and Community Supervision (NYS DOCCS) at the Mohawk Correctional Facility (CF).
2. Evans was born in Newburgh, NY. Evans was married and had six children. Evans received his GED and was unemployed. There was no further demographic or social history available to the Commission for Evans.
3. 
4. 
5. 
6. On 1/3/23, Evans was admitted into NYS DOCCS at Green Haven CF Intake for his fifth state incarceration. On 1/5/23, Evans was transferred from Green Haven Intake to Elmira CF Reception for program purposes. On 3/2/23, Evans was transferred from Elmira CF Reception to Mohawk CF for program purposes. This is where Evans remained until the terminal event.
7. During Evans's incarceration, Evans received one Tier 2 infraction at Mohawk CF for out of place and a movement violation. Evans sanction included no recreation for 30 days.

8. [REDACTED]

9. [REDACTED]

10. [REDACTED]

11. On 1/5/23, Evans was transferred from Green Haven Intake to Elmira CF Reception for program purposes.

12. [REDACTED]

13. [REDACTED]

14.

[REDACTED]

15.

[REDACTED]

16.

[REDACTED]

17.

[REDACTED]

18.

[REDACTED]

[REDACTED]

19. On 3/2/23, Evans was transferred from Elmira CF Reception to Mohawk CF for program purposes.

20. [REDACTED]

21. [REDACTED]

22. [REDACTED]

The Medical Review Board has found that this was an incorrect part of LMSW [REDACTED]'s assessment as multiple records including the Core History, Terminal Transfer Note, and Psychiatric Progress Notes all had detailed information about Evans having a prior suicide attempt.

[REDACTED]

23.

[REDACTED]

24.

[REDACTED]

25.

[REDACTED]

26. On 6/6/23 at 10:20 p.m., Officer A.K. documented in the 22-D Dorm logbook assuming the duty of the Dorm with a census of 52.

27. On 6/6/23 at 10:30 p.m., Officer A.K. documented in the 22-D Dorm logbook that rounds were completed.

28. On 6/6/23 at 11:00 p.m., Officer A.K. documented in the 22-D Dorm logbook that rounds were completed.

29. On 6/6/23 at 11:30 p.m., Officer A.K. documented in the 22-D Dorm logbook that rounds were completed.

30. On 6/7/23 at 12:00 a.m., Officer A.K. documented in the 22-D Dorm logbook that rounds

were completed.

31. On 6/7/23 at 12:16 a.m., Officer A.K. documented in the 22-D Dorm logbook that a count was taken of the Dorm.
32. On 6/7/23 at 12:37 a.m., Officer A.K. was conducting rounds on 22-D Dorm and observed Evans in his cubicle #27, unresponsive laying on the floor covered in vomit. Officer A.K. initiated a medical response and retrieved the first aid kit. Security staff responded to the scene immediately with the Automated External Defibrillator (AED), Bag Valve Mask (BVM), and Narcan. Cardiopulmonary Resuscitation (CPR) was initiated with the BVM, and two doses of Narcan were administered without any response. Registered Nurse (RN) [REDACTED] arrived at the scene [REDACTED]. EMS was notified to respond to the facility. [REDACTED]. At 12:53 a.m., AmCare Ambulance arrived at the scene and assumed the care of Evans. [REDACTED]
33. [REDACTED]

ACTIONS REQUIRED:

TO THE OFFICE OF MENTAL HEALTH, DIVISION OF FORENSIC SERVICES:

1. The Division shall conduct a quality assurance review regarding why Evans was not scheduled to be seen by his primary therapist after 4/26/23.
2. The Division shall conduct a quality assurance review with the social worker on 4/26/23 who documented Evans had no suicide attempt history in the record despite this information being documented a numerous prior clinical encounters.

A report of the findings and any corrective actions taken, including any training completed shall be forwarded to the Medical Review Board upon completion.

*In a response dated 1/8/25 to the Commission's preliminary report, the Office of Mental Health indicated that the requested reviews were completed.*

WITNESS, HONORABLE YOLANDA CANTY, Commissioner, NYS Commission of Correction, Alfred E. Smith State Office Building, 80 South Swan Street, 12<sup>th</sup> Floor, in the City of Albany, New York 12210 on this 26<sup>th</sup> day of March 2025,



Yolanda Canty  
Commissioner  
Commission of Correction  
YC:bb:vc

cc: Dr. Carol Moores, Chief Medical Officer  
James Donahue, Associate Commissioner of Mental Health  
Superintendent Alfred Montegari, Mohawk 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