



**Commission of
Correction**

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

In the Matter of the Death of

**Joshua Hunter (10B3307),
an incarcerated individual of the
Sullivan Correctional Facility**

June 25, 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 Joshua Hunter, who died on April 26, 2021, while an incarcerated individual in the custody of the NYS Department of Corrections and Community Supervision at the Sullivan Correctional Facility, the Commission has determined that the following final report be issued.

FINDINGS:

1. Joshua Hunter was a 31-year-old male who died on 4/26/21 from a suicidal hanging while in the custody of the New York State Department of Corrections and Community Supervision (NYS DOCCS) at the Sullivan Correctional Facility (CF)¹.
2. Hunter was born in Charleston, WV. Hunter completed the 10th grade, received his GED and joined the United States Army. Hunter was a Military Police Officer at Fort Drum. Hunter is survived by his mother, father, two brothers, two sisters, and an ex-wife.
3. Hunter's criminal history began with the instant offense. On 11/29/09, Hunter caused the death of two male victims by repeatedly stabbing them with a knife about the head, body and neck. In September 2010, Hunter was convicted of Murder 2nd Degree. Hunter was sentenced to 45 years to life in the custody of NYS DOCCS. He was received by NYS DOCCS on 11/4/10. [REDACTED]
In February 2021, upon his transfer to Sullivan CF, [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
4. During Hunter's incarceration, he received three Tier 2 infractions and six Tier 3 infractions. The Tier 2 infractions included violent conduct, creating a disturbance, fighting, direct order and being out of place. Hunter's Tier 2 sanctions included 15-day keeplock and commissary, phone, and package restrictions. Hunter's Tier 3 infractions included five for drug use, unauthorized exchange, contraband, tampering with property and a weapon. His Tier 3 sanctions included 90-day non-program hours, and package, commissary and phone restrictions as well as six months of good time being withheld and a referral to an alcohol and substance abuse treatment program.
5. On 11/4/10, Hunter was admitted into NYS DOCCS at Auburn CF and subsequently transferred to Elmira CF reception. Hunter was then transferred to Attica CF. Hunter transferred on to Southport CF, Clinton CF, Upstate CF, Great Meadow CF, and Green Haven CF general population. In July 2015, Hunter was transferred to [REDACTED]
[REDACTED] Green Haven CF. [REDACTED]
[REDACTED] In November 2015, Hunter was transferred to Green Haven CF [REDACTED] [REDACTED] [REDACTED]

10. [REDACTED]

11. [REDACTED]

12. [REDACTED]

13. [REDACTED]

14. [REDACTED]

[REDACTED]

15. [REDACTED]

16. [REDACTED]

17. [REDACTED]

18. [REDACTED]

19. [REDACTED]

20. [REDACTED]

21. On 4/25/21 at 8:35 p.m., Correction Officer (CO) E.B. documented a response to a code for fighting in the D&E corridor. Documentation indicated that Hunter and Incarcerated

Individuals [REDACTED] and [REDACTED] were on the ground striking each other with closed fist punches. CO E.B. gave the direct order to stop fighting. Hunter complied, and all three incarcerated individuals were separated and went to the wall. Hunter received a Tier II violation for violent conduct, creating a disturbance and fighting. [REDACTED]

[REDACTED] Hunter returned to his cell. At 9:00 p.m., as documented in the housing area logbook, Hunter and Incarcerated Individuals [REDACTED] and [REDACTED] were placed on keeplock per Sergeant (Sgt.) S. The NYS DOCCS fight investigation form indicated that Hunter refused to provide a statement while Incarcerated Individual [REDACTED] stated that Hunter stole tobacco from him. The Sergeant's assessment indicated that this was a premeditated fight because when the medication run was called, the three incarcerated individuals left the E-North block and started fighting while in the hallway.

22. On 4/25/21 at 11:25 p.m., CO A.B. documented in the housing area logbook that she was on duty with all the state equipment and she assumed the housing officer duties. At approximately 11:30 p.m., CO A.B., while conducting a housing unit watch tour, observed Hunter standing at his cell sink alive.
23. On 4/26/21 at approximately 12:00 a.m., CO A.B. was conducting a housing unit watch tour. CO A.B. observed Hunter in his cell standing between the sink and his toilet with his back against the wall with his knees slightly bent. CO A.B. attempted to communicate with Hunter, but Hunter did not respond. CO A.B. observed a piece of cloth hanging down from the vent between the toilet and sink and around Hunter's neck. The cloth observed was later identified as a piece of torn white shoelace that was tied from the cell grate vent and around Hunter's neck. CO A.B. called a code for assistance via her facility radio. At 12:02 a.m., CO M.S. responded with the facility cut down tool. CO A.B. and CO M.S. entered Hunter's cell. CO M.S. cut the garrote from the grate vent and placed Hunter onto his back on the cell floor. CO A.B. began cardiopulmonary resuscitation (CPR). At 12:04 a.m., Sgt. C.C. responded to the unit and entered Hunter's cell. The ligature was found to be still around Hunter's neck and was loosened. CPR was continued with Hunter showing no reaction or response. At 12:07 a.m., RN [REDACTED] arrived on the scene [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] This is in violation of NYS DOCCS directives. As documented in a report by NYS DOCCS Office of Special Investigations (OSI), the Department's Bureau of Labor Relations was notified of OSI's investigative findings, and the retraining of relevant staff was completed to address the issue.
24. At 12:20 a.m., Lieutenant E.D. activated emergency medical services (EMS). The Medical Review Board opines that that there was a significant delay of over 17 minutes by facility staff who first observed Hunter to be unresponsive to when EMS was

requested. [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] At 12:45 a.m., EMS arrived at the facility [REDACTED]
[REDACTED]
[REDACTED]

25. Hunter's cell was searched with negative results for contraband.

26. [REDACTED]

¹ Sullivan CF closed in November 2024

ACTIONS REQUIRED:

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

1. The Deputy Commissioner shall convene a comprehensive quality assurance review on the health care provided to Hunter at the Sullivan CF with a focus on:
 - a. Why there was a significant delay in activating EMS to the scene for an unresponsive incarcerated individual.
 - b. Why facility staff did not maintain CPR during the transport of Hunter from his housing unit to the medical unit.

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

In a response dated 5/9/25 to the Commission's preliminary report, the Deputy Commissioner indicated that the requested reviews were completed prior to the closure of Sullivan CF with corrective actions training taken.

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

The Division shall conduct a quality assurance review regarding Hunter's OMH level service designations and placement criteria.

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

In a response dated 4/28/25 to the Commission's preliminary report, the Office of Mental Health 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 25th day of June 2025.



Yolanda Canty
Commissioner
Commission of Correction

YC:MB:vc
2021-M-0061
June 25, 2025

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