



**Commission of
Correction**

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

In the Matter of the Death of

**Henry Maldonado (19A3666),
an incarcerated individual of the
Five Points 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 Henry Maldonado, who died on December 22, 2021, while an incarcerated individual in the custody of the NYS Department of Corrections and Community Supervision at the Five Points Correctional Facility, the Commission has determined that the following final report be issued.

FINDINGS:

1. Henry Maldonado was a 61-year-old male who died on 12/22/21 from a suicidal hanging while in the custody of the New York State Department of Corrections and Community Supervision (NYS DOCCS) at the Five Points Correctional Facility (CF).
2. [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] In the instant offense, on 5/11/16, in Bronx County, Maldonado stabbed his common law wife to death. Maldonado also stabbed the victim's granddaughter multiple times. The granddaughter was able to flee the apartment after being stabbed. While inside the apartment with the deceased victim, Maldonado set multiple fires. In January 2019, Maldonado was convicted of Manslaughter 1st Degree and Attempted Murder 2nd Degree and was sentenced to 17 years in state prison.
3. [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
4. On 10/9/19, Maldonado was received at Downstate CF. Maldonado had arrived from the county jail [REDACTED]
[REDACTED]
5. [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
6. Maldonado transferred to Five Points CF on 10/21/19.
7. [REDACTED]
[REDACTED]

- 8. [Redacted]
- 9. [Redacted]
- 10. [Redacted]
- 11. [Redacted]
- 12. [Redacted]
- 13. [Redacted]
- 14. [Redacted]
- 15. [Redacted]
- 16. [Redacted]
- 17. [Redacted]

18. [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

19. [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

20. [REDACTED]

21. [REDACTED]
[REDACTED]

22. [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

23. [REDACTED]
[REDACTED]
[REDACTED]

24. [REDACTED]
[REDACTED]

25. [REDACTED]
[REDACTED]
[REDACTED]

26. [REDACTED]
[REDACTED]

27. [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

28. [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

29. [REDACTED]

30. [REDACTED]

31. [REDACTED]

32. [REDACTED]

33. [REDACTED]

34. [REDACTED]

35. [REDACTED]

36. [REDACTED]

37. [REDACTED]

38. [REDACTED]

- [REDACTED]
- 49. [REDACTED]
[REDACTED]
[REDACTED]
- 50. [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
- 51. [REDACTED]
[REDACTED]
[REDACTED]
- 52. [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
- 53. [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
- 54. [REDACTED]
[REDACTED]
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[REDACTED]
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[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
- 55. [REDACTED]
[REDACTED]
- 56. [REDACTED]
[REDACTED]
[REDACTED]

57. [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] Later that day, Maldonado requested to see the chaplain and the chaplain was notified. At 7:00 p.m., Maldonado spoke with the chaplain. Maldonado was upset at being in isolation. Maldonado complained of increased back pain. The chaplain made a mental health referral. [REDACTED]
[REDACTED]
[REDACTED]

58. On 12/22/21 at 8:45 p.m., Maldonado was seen by security staff during rounds in the infirmary. [REDACTED]
[REDACTED] At 9:40 p.m., Maldonado was found hanging in the shower of his [REDACTED] cell with the shower hose around his neck. Cardiopulmonary Resuscitation was initiated, and a medical response was called. The Automated External Defibrillator (AED) was applied without shock advised. Medical staff responded. [REDACTED] Emergency Medical Services (EMS) was activated. [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] There was no documentation of a cervical collar being applied as per Health Services Policy 1.35 and no indication that Narcan was given as per Directive 4059. This was addressed in the DOCCS Office of Special Investigations report with a recommendation for all relevant staff to be re-trained.

59. A special investigation final report completed by OMH Risk Management identified the following issues with corrective actions noted:

[REDACTED]
[REDACTED]

[REDACTED]
[REDACTED]

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

[REDACTED]
[REDACTED]
[REDACTED]

[REDACTED]
[REDACTED]
[REDACTED]

[REDACTED]
[REDACTED]
[REDACTED]

[REDACTED]

[REDACTED]

60. Per the DOCCS mortality review, the nurse administrator was advised to remove all shower hoses from infirmary cell rooms and that they could be dispensed with a doctor's order.

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 quality assurance review regarding why Maldonado was not scheduled for his colonoscopy.
2. The Deputy Commissioner shall review planned corrective action from the mortality review to assure shower hoses have been properly removed from infirmary cell rooms.

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

In a response dated 4/30/25 to the Commission's preliminary report, the Deputy Commissioner for Health Services indicated that requested reviews were completed and corrective action including removal of shower hoses from infirmary rooms was completed.

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

The Forensic Services Division shall conduct a quality assurance review with clinical staff at Five Points CF to determine why no further attempts were made to see Maldonado on 12/22/21.

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

In a response dated 4/7/25 to the Commission's preliminary report, Office of Mental Health indicated that the requested review was completed with corrective action to include policy review and supervision with nursing staff.

