



**Commission of  
Correction**

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

**In the Matter of the Death of**

**Alvin Yates (12B0308),  
an incarcerated individual of the  
Attica 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 Alvin Yates, who died on December 30, 2021, while an incarcerated individual in the custody of the NYS Department of Corrections and Community Supervision at the Attica Correctional Facility, the Commission has determined that the following final report be issued.

FINDINGS:

1. Alvin Yates was a 64-year-old male who died on 12/30/21 due to COVID-19 while in the custody of the New York State Department of Corrections and Community Supervision (NYS DOCCS) at Attica Correctional Facility (CF).
2. On 2/2/12, Yates was admitted into NYS DOCCS at Wende CF reception [REDACTED]. [REDACTED]. [REDACTED]. In the instant offense, Yates was sentenced in January 2012 to 12 years for a Robbery 1<sup>st</sup> Degree conviction. Additionally, he was to serve 8 months and 15-days for time owed on a parole violation. Yates spent time in Attica CF, Auburn CF, Five Points CF, and Elmira CF before being transferred back to Attica CF on 9/15/21 for distribution of population purposes. This is where Yates remained until the terminal event.
3. [REDACTED]
4. [REDACTED]
5. [REDACTED]
6. [REDACTED]

[REDACTED]

7. [REDACTED]

8. [REDACTED]

9. [REDACTED]

10. [REDACTED]

11. On 9/14/21, Yates was transferred from Elmira CF to Attica CF for distribution of population purposes.

12. [REDACTED]

13. [REDACTED] Documentation in the Attica Mortality Review identified that Yates was not seen for his incoming evaluation due to a reported misunderstanding that the staff who normally assigned incarcerated individuals to see the medical provider for incoming visits thought that it had already been addressed. The facility completed a corrective action for all incoming incarcerated individuals to be seen as per agency policy regarding drafting unless seen by the medical provider for a physical or full evaluation within 30-days prior to coming to the facility.

14. [REDACTED] The facility completed a corrective action to educate the providers on the need for making visits/admission notes in the medical record when sending an incarcerated individual to the infirmary along with writing orders for the infirmary admission and filling out the admission form. [REDACTED]

[REDACTED] As both hyper-and hypoglycemia can mimic intoxication signs, the Medical Review Board opines that a blood glucose level should have been obtained.

15. [REDACTED]

16. [REDACTED]

17. [REDACTED]

18. [REDACTED]

[REDACTED] A mortality review conducted by DOCCS also identified these issues. The facility completed a corrective action plan to educate nursing on the need for documenting actions provided prior to sending an incarcerated out of the facility that included any Telemed orders that were addressed, the time that EMS arrived at the facility, the time that care was turned over to EMS, and the status of the incarcerated individual prior to leaving the facility including a set of vital signs.

19. [REDACTED]

[REDACTED]

20.

[REDACTED]

21.

[REDACTED]

22.

[REDACTED]

23.

[REDACTED]

[REDACTED]

24. [REDACTED]

25. [REDACTED]

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 with the medical staff at Elmira CF regarding the review of the Ambulatory Health Record (AHR) for provider orders and the implementation of processing such orders.
2. The Deputy Commissioner shall convene a quality assurance review with the medical staff at Attica CF regarding obtaining a blood glucose finger stick on diabetic patients that appear to be under the influence.
3. The Deputy Commissioner shall provide to the Medical Review Board verification that corrective actions taken based upon the mortality review have been completed and implemented.

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

*In a response dated 5/8/25 to the Commission's preliminary report, the Deputy Commissioner for Health Services indicated that the requested reviews were completed with a Quality Improvement/Corrective Action Plan developed to include provider and nursing education. A Quality Improvement Project was opened for monitoring compliance with health appraisals and health services policies.*

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 25<sup>th</sup> day of June 2025.



Yolanda Canty  
Commissioner  
Commission of Correction

YC:BB :vc  
2021-M-0177  
June 25, 2025

cc: Dr. Carol Moores, Deputy Commissioner Chief Medical Officer  
James Donahue, Associate Commissioner of Mental Health  
Superintendent Julie Wolcott, Attica CF