



**Commission of
Correction**

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

In the Matter of the Death of

**Deondra Walker (23G0053),
an incarcerated individual of the
Albion Correctional Facility**

December 17, 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

[REDACTED]

9.

[REDACTED]

10.

[REDACTED]

11.

[REDACTED]

12.

[REDACTED]

[REDACTED]

13.

[REDACTED]

14.

[REDACTED]

15. On 2/28/23, Walker was transferred from Bedford Hills CF to Albion CF.

16.

[REDACTED]

[REDACTED]

17.

[REDACTED]

18.

[REDACTED]

[REDACTED]

19.

[REDACTED]

20.

[REDACTED]

21.

[REDACTED]

22.

[REDACTED]

23.

[REDACTED]

24.

[REDACTED]

[REDACTED]

25.

[REDACTED]

26.

[REDACTED]

27.

[REDACTED]

28.

[REDACTED]

The Medical Review Board finds that both RN [REDACTED] and Dr. [REDACTED] failed to recognize Walker's complaints of 10 out of 10 leg pain as a possible indication of deep leg thrombosis and failed to assess for such. The Board opines that a person such as Walker with morbid obesity and limited mobility had high risk factors for developing deep leg thrombosis. As findings in the postmortem autopsy revealed early organizing thromboemboli, the Board opines that Walker was symptomatic of such at these clinical encounters. The Board opines that had Walker received a proper assessment and had the proper diagnostic tests ordered, an interventional treatment regimen could have

been prescribed and her death prevented.

29. [REDACTED]

30. [REDACTED]

31. [REDACTED]

32. [REDACTED]

33. [REDACTED]

34. On 8/29/23 at 3:45 a.m., per the NYS DOCCS Unusual Incident (UI) Report, Corrections Officer (CO) N.S. was alerted by an incarcerated individual that Walker was having a medical issue and that she had fallen to the floor in the bathroom. CO N.S. called a medical response on the radio and responded to the bathroom where he observed Walker lying on the bathroom floor. A review of the video recording of the K2 Dorm by Commission staff revealed that Walker independently walked into the bathroom and then out of the view of the video recording. Approximately one minute later, Walker walked back in view of the video recording, and she was observed standing with her back facing the sink. Walker was observed falling backwards and striking the back of her head on the sink and then she fell to the floor. CO N.S. responded to the bathroom and Walker remained laying on the bathroom floor. CO N.S. remained with Walker and other officers were observed responding to the scene.

35. Approximately eight minutes later, Sergeant J.C. and RN [REDACTED] arrived at the scene. [REDACTED]

36. A review of the video recording by Commission staff revealed that when Walker arrived to medical in the van at 3:58 a.m., Walker was sitting sideways in the van facing

outward. Walker appeared to be diaphoretic and short of breath. Walker appeared hesitant but she was able to step from the van independently and ambulate into medical. The video recording showed Walker entering medical and walking down the hallway to the emergency room. While ambulating in the medical hallway, Walker stopped and rested her arm on the wall on two occasions. Security staff asked Walker if she had taken anything and Walker reported, "No, I didn't take anything". Security asked Walker if she had eaten that day and Walker reported, "Yes". Security asked Walker if she took anything that she wasn't supposed to and Walker reported, "No, I swear to God". Security asked Walker if this was the first time she felt like that, and Walker reported, "Yes, I'm telling you it's my legs, my leg is numb". RN [REDACTED] was heard telling Walker that it was because of how she was breathing, and she needed to slow down because it was going to cramp her up. Walker began walking towards the emergency room and she took approximately nine steps before she turned towards the wall, placed her hands on the wall collapsed to the floor. RN [REDACTED] walked over to Walker, bent over Walker, shook her, and said, "Hey, come on, come on, this is all the hyperventilation now, come on, up you go". Walker was observed rolling to the side and sitting up. Security was observed fanning Walker with a large envelope. RN [REDACTED] told Walker that she had to slow her breathing down or it was going to continue to happen. There was no further video recording of the event available to the Commission.

37.

[REDACTED]

At 4:37 a.m., Sergeant R.W. notified Orleans Dispatch and requested Emergency Medical Services.

[REDACTED]

38.

[REDACTED]

- [REDACTED]
39. The Medical Review Board finds that Walker's medical emergency was grossly mismanaged by RN [REDACTED]. A review of Walker's medical record by the Board found that Walker demonstrated signs and symptoms of an impending pulmonary emboli in the hour prior to going into cardiac arrest. Walker was exhibiting an increased heart rate, shortness of breath, hyperventilating, diaphoresis, and had collapsed to the floor. On her initial assessment by RN [REDACTED], Walker had an oxygen saturation of 91%. RN [REDACTED] failed to do a proper assessment on Walker that included taking additional vital signs and a lung assessment. The Board opines that RN [REDACTED] should have retrieved a wheelchair from the medical department and brought it out to the van so that Walker did not have to ambulate into medical as Walker was clearly in distress. RN [REDACTED] also failed to notify the facility medical provider of Walker's acute symptoms and Emergency Medical Services was not contacted for Walker until approximately 50 minutes later when she was found to be in cardiac arrest. The Medical Review Board opines that had Walker received a proper medical assessment by RN [REDACTED] and had the facility physician been consulted, Walker could have received the appropriate prompt emergency care, and her death may have been prevented.
40. Per the documentation from the Office of Special Investigations (OSI), OSI's review of the available facility documentation, video footage, and interviews with the incarcerated individuals, there was no staff misconduct related to the death of Walker. However, the OSI's investigation revealed sufficient evidence for the substantiation of an additional finding that medical and security personnel's emergency response was not fully compliant with Departmental policies, requiring their retraining and the termination of RN [REDACTED].
41. [REDACTED]. As there was evidence of early organizing thrombi, the Medical Review Board finds that Walker had been having issues with developing thromboemboli for a period of time prior to her terminal event. A review of the autopsy findings by the Board revealed that there was no documented exploration of the extremities to try and identify a source region for the thromboemboli.

ACTIONS REQUIRED:

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

The Deputy Commissioner shall convene a comprehensive quality assurance review on the health care provided to Walker at Albion CF with a focus on:

1. Why on 7/18/23 at 10:30 a.m., RN [REDACTED] did not complete an assessment of Walker's legs to locate the site of Walker's pain, palpate her peripheral pulses, or document the condition of her legs.

2. Why on 7/19/23 at 1:25 p.m., Dr. [REDACTED] did not complete an assessment of Walker's legs to locate the site of Walker's pain, palpate her peripheral pulses, or document the condition of her legs.

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

In a response dated 11/5/25 to the Commission's preliminary report, the Deputy Commissioner for Health Services indicated that the requested reviews were completed with correction action training taken with cited staff.

TO THE MONROE COUNTY MEDICAL EXAMINERS OFFICE:

The Medical Review Board requests that the Medical Examiner review the findings of the Board's report and conduct a review as to why exploration of Walkers extremities was not documented as being completed to rule out a source of her terminal thromboemboli.

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

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 17th day of December 2025.



Yolanda Canty
Commissioner
Commission of Correction

YC:BB :vc
2023-M-0089
December 17, 2025

cc: Dr. Carol Moores, Deputy Commissioner Chief Medical Officer
James Donahue, Associate Commissioner of Mental Health
Superintendent Melinda Samuelson, Albion CF