



**Commission of  
Correction**

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

**In the Matter of the Death of**

**Alexander Williams (19R2019),  
an incarcerated individual of the  
Riverview 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*

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 Alexander Williams, who died on March 3, 2022, while an incarcerated individual in the custody of the NYS Department of Corrections and Community Supervision at the Riverview Correctional Facility, the Commission has determined that the following final report be issued.

FINDINGS:

1. Alexander Williams was a 54-year-old male who died on 3/3/22 from atherosclerotic and hypertensive cardiovascular disease while in the custody of the New York State Department of Corrections and Community Supervision (NYS DOCCS) while at the Riverview Correctional Facility (CF).

2. Williams was born in Manhattan, NY. Williams was divorced at the time of his death with one child. Williams obtained his GED in 1989. At the time of his arrest, Williams's employment status was unknown.

3. [REDACTED]

4. [REDACTED]

5. On 10/18/19, Williams was received at Ulster CF for his [REDACTED] NYS DOCCS incarceration. On 11/7/19, Williams was transferred to Riverview CF where he remained until the terminal event. Williams was scheduled to be transferred to Walkill CF on 3/4/22.

6. [REDACTED]

7. [REDACTED]

8. [REDACTED]

9. [REDACTED]

The absence of specialist notes from cardiology in Williams's chart does not comport with the requirements of 9 NYCRR §7651.19(b) which states:

*All health care services provided to inmates by facility health care staff or by independent health care providers shall be permanently recorded in the medical record.*

Additionally, the Medical Review Board finds that the absence of cardiology records was a failure to assure continuity of care as Williams had significant cardiovascular disease history.

10. [REDACTED]

11. [REDACTED]

12. [REDACTED]

13. [REDACTED]

14. [REDACTED]

15. A review of the housing area logbooks from 2/26/22 at 2:55 p.m. through the terminal event described day to day interactions between NYS DOCCS personnel, medical personnel, OMH personnel and incarcerated individuals. Williams was not documented in the logbooks prior to the terminal event.

16. Between 2/27/22 and 3/3/22, Williams did not make any phone calls from the facility.

17. Correction Officer (CO) E.H. documented that on 3/3/22 at 12:00 a.m., Williams was awake on his bunk for the housing unit count. CO E.H. documented that Williams was not seen in the incarcerated individual's bathroom while conducting the 12:30 a.m. housing unit watch tour.

18. On 3/3/22 at approximately 12:51 a.m., CO E.H. heard yelling from the B2 dorm bathroom. CO E.H. responded and observed Williams lying on the floor unresponsive. An emergency response was called immediately. At 12:52 a.m., CO E.H. administered nasal Narcan without the desired effect. Responding staff arrived and Williams was found without a pulse and was not breathing. CO K.K. initiated cardiopulmonary resuscitation (CPR) with rescue breathing via Bag valve mask (BVM). At 12:54 a.m., Registered Nurse (RN) C.D. arrived and directed CO T.W. to retrieve the Automated External Defibrillator (AED). At 12:55 a.m. and 12:58 a.m., a second dose and third dose of Narcan were administered without the desired effect. At 12:56 a.m., CO K.K. applied the AED. Williams received a total of four shocks delivered without the desired effect.

19. [REDACTED] NYS DOCCS unusual incident report indicated at 1:01 a.m., Lieutenant N. completed a 911 phone call. [REDACTED]

20. [REDACTED]

21. Members of the facility's Crisis Intervention Unit including CO S.B., C.O. G.B. and CO C.L. conducted interviews of the incarcerated individuals who were housed in the B2 dorm. No information was obtained relating to foul play, drug, gang or unauthorized related activity. Incarcerated Individual (II) [REDACTED] stated that when he finished the recreation area clean up that night at approximately 12:25 a.m., he walked by Williams on the way to his cube. Williams was sitting up on his bunk rubbing the middle of his chest. A short time later, approximately five or 10 minutes, Williams was heard getting up and going to the bathroom. II [REDACTED] stated that about 20 minutes later, he heard a commotion coming from the bathroom with officers responding. II [REDACTED] stated that Williams was on the dorm a short time, kept to himself and mostly slept.
22. As documented in the DOCCS Office of Special Investigation Closing Report, RN [REDACTED] was found to have failed to respond to the medical emergency with an AED. RN [REDACTED] was counseled and retrained.
23. [REDACTED]
24. [REDACTED]

ACTIONS REQUIRED:

TO THE ACTING COMMISSIONER OF THE DEPARTMENT OF CORRECTIONS AND COMMUNITY SUPERVISION:

The Commission acknowledges the administrative action previously taken with the NYS DOCCS Corrective Action recommendations that included retraining of staff regarding an emergency medical response, specifically the bringing of an AED for any unresponsive individual.

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

The Deputy Commissioner shall conduct a quality assurance review regarding patient medical records at Riverview CF to assure compliance with the requirements of 9 NYCRR §7651.9.

A report of the findings and any 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.*

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 17<sup>th</sup> day of December 2025.



Yolanda Canty  
Commissioner  
Commission of Correction

YC:MB :vc  
2022-M-0028  
December 17, 2025

cc: Dr. Carol Moores, Deputy Commissioner Chief Medical Officer  
James Donahue, Associate Commissioner of Mental Health  
Superintendent Robert Brabant, Riverview CF