



**Commission of
Correction**

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

In the Matter of the Death of

**Lacey Williams (16A0875),
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 Lacey Williams, who died on May 11, 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. Lacy Williams was a 53-year-old male who died on 5/11/22 from a sudden cardiac arrest that occurred after an altercation with another incarcerated individual while in the custody of the New York State Department of Corrections and Community Supervision (NYS DOCCS) at the Riverview Correctional Facility (CF). Based on a review of documented evidence, the Medical Review Board has found that Williams's death was a homicide.

2. [REDACTED]

In the instant offense, Williams was convicted of Robbery 2nd and 3rd Degrees after knowingly and illegally entering and remaining in a building with the intent to commit a crime. On two separate instances, Williams entered the victims' residence through a window and stole their laptop computers.

3. [REDACTED]

4. On 3/4/16, Williams was received at Downstate CF. On 3/21/16, Williams was transferred to Franklin CF. On 2/5/18, Williams was transferred to Riverview CF where he remained until the terminal event.

5. [REDACTED]

[REDACTED]

6. [REDACTED]

7. [REDACTED]

8. [REDACTED]

9. [REDACTED]

10. [REDACTED]

11. [REDACTED]

12. [REDACTED]

[REDACTED]. The Medical Review Board opines that Williams's hypertension was not controlled and should have been subjected to closer monitoring by the physician.

13. [REDACTED]

14. [REDACTED]

- [REDACTED]
15. [REDACTED]
16. [REDACTED]. The Medical Review Board opines that Williams's hypertension was not controlled and required monitoring along with the consideration of direct medication therapy to improve medication compliance.
17. On 5/11/22 at 8:55 a.m., Deputy Superintendent for Administration (DSA) M.C. was documented in the logbook as being on the housing unit. Williams was seen by DSA M.C. while conducting rounds. Williams was noted as appearing "ok" although he did want his program changed.
18. Between 3/11/22 and 5/11/22, Williams completed no phone calls.
19. On 5/11/22 at 9:40 a.m., Correction Officer (CO) M.L. was completing a housing unit watch tour when Williams and two other incarcerated individuals were observed to be involved in a physical altercation. CO M.L. gave verbal commands to stop fighting but was ignored. CO M.L. activated her personal alarm system. CO M.L. observed Williams drop what appeared to be an ice pick type weapon to the floor. Once the response team arrived, the incarcerated individuals separated and stopped fighting. CO M.L. recovered the weapon. All of the incarcerated individuals that were involved in the fight were escorted to the infirmary. Williams was placed into the strip frisk room by CO W. alone where he was to wait to be examined by medical. There were no visible injuries to Williams documented at that time.
20. At 10:24 a.m., CO K.O. and CO J.B. arrived at the strip frisk room and observed Williams on the floor unresponsive. CO K.O. and CO J.B. picked Williams up and brought him to the closest exam room while calling for assistance. [REDACTED]

[REDACTED]

At 10:32 a.m., emergency medical services (EMS) were activated.

[REDACTED]

21. An investigation into the incident by DOCCS Office of Special Investigation (OSI) revealed that Doctor (Dr.) [REDACTED] was in the area of the emergency at the facility and failed to respond to the medical emergency. Dr. [REDACTED] has since resigned from NYS DOCCS.

22. [REDACTED]

The Medical Review Board disagrees with the pathologist's listed manner of death as natural causes. Consistent with the findings that there was no obvious anatomic cause of death or significant trauma, and that Williams's death occurred immediately after a physical altercation with others, an event that produces an abnormal stress response, the Board opines that Williams's manner of death should have been listed as a homicide.

ACTIONS REQUIRED:

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 Williams's hypertension monitoring and treatment.

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 review along with corrective action training was completed.

TO THE DIRECTOR OF PATHOLOGY FOR LOURDES HOSPITAL:

The Medical Review Board requests that the Director review this case in view of the Board's findings to consider revising the manner of death ruling to homicide.

A report of the findings and any 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:MB :vc
2022-M-0056
December 17, 2025

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