



Office of the New York State Attorney General Letitia James

Office of Special Investigation

Office of Special Investigation
Fourth Annual Report
October 1, 2024

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1. INTRODUCTION

This is the Fourth Annual Report of the New York Attorney General's Office of Special Investigation (OSI), issued October 1, 2024, pursuant to Paragraph 7 of New York Executive Law Section 70-b (Section 70-b). Prior OSI Annual Reports, including two biennial reports from OSI's predecessor unit, can be found on the [OSI Annual Reports page](#).

OSI

Section 70-b

Effective April 1, 2021, Section 70-b directs OSI to investigate any incident in which a police officer or a peace officer, as defined, has caused a death, or when there is a question whether an officer has caused a death. Section 70-b further directs OSI, if warranted, to prosecute any criminal offense the officer may have committed in connection with the incident.¹

Section 70-b makes no distinction between on-duty and off-duty officers or between armed and unarmed decedents. Peace officers, as defined in Section 70-b, include corrections officers in all jails and prisons in the state.

The Attorney General's investigative authority and criminal jurisdiction over such incidents are state-wide and arise, by operation of law, at the time of death (Section 70-b, Paragraph 2). The Attorney General's criminal jurisdiction over such incidents supersedes and displaces that of the district attorney for the county in which the incident occurred (Section 70-b, Paragraph 4).

OSI's Personnel

OSI is authorized for 23 assistant attorneys general (AAGs), including supervisors, who are currently assigned to eight offices around the state (Manhattan, Nassau County, Poughkeepsie, Albany, Rochester, Binghamton, Syracuse, and Buffalo). The Attorney General has authorized 20 detectives (including supervisors) in her Investigation Division to work with OSI, similarly distributed. In addition, OSI is authorized for 11 analysts: nine are designated as legal support analysts, who work with attorneys and detectives in investigations, trial preparation, and the preparation of video (such as body-worn camera footage) for public release; two analysts work on responding to the increasing volume of Freedom of Information

¹ The full text of Section 70-b can be read here: [Section 70-b](#). Prior to the effective date of Section 70-b, Executive Order 147, issued in 2015 and in effect through March 31, 2021, gave the Attorney General a narrower form of authority, to investigate and, when warranted, prosecute offenses arising from incidents in which a police officer (but not a peace officer) caused the death of an unarmed (but not of an armed) civilian. Executive Order 147 can be read here: [Executive Order 147](#).

Law requests that OSI handles. OSI is authorized for two senior criminal justice coordinators and two criminal justice liaisons who, together with attorneys and detectives, attend meetings with family members of persons who have died in law enforcement encounters and provide continuing support to those family members (as described in more detail in the subsection on Family Meetings, below).

OSI's Process: Assessments and Investigations

Under Section 70-b, OSI has investigative authority and criminal jurisdiction when an officer, as defined, has caused a death, or when there is a question whether an officer has caused a death. At the time OSI is notified of an incident it is not always clear whether these three elements – a death, a defined officer, and causation – are present.

Regarding the first element, a death, there are times OSI receives a notification about a person believed to be “likely” to die. If the person does not die, OSI will close the case when it becomes clear that the person is going to survive and will communicate with the district attorney for the county where the incident occurred to confirm that the district attorney will review the matter for any potential criminal conduct.

Regarding the second element, a defined officer, there are times when OSI receives a notification involving an officer mistakenly believed to be a police officer or a peace officer as defined in Section 70-b. For example, OSI sometimes receives notifications of incidents where the officer involved is a federal officer. In such cases, OSI will close the case when it confirms with objective evidence that an officer as defined by Section 70-b was not involved.

However, the vast majority of notifications received by OSI clearly involve a death and a defined officer. When the third element – causation – is not initially clear, OSI calls its investigations “preliminary assessments,” though they often take months to complete. For example, if a person dies from illness in a prison, OSI, in the course of its preliminary assessment, gathers evidence to determine whether the death was caused by the neglect of a corrections officer. This may require the review of many hours of video, review of handwritten logbooks and electronic logs, incident reports, medical records, autopsy and toxicology reports, as well as interviews of corrections officers, medical staff, incarcerated persons housed near the person who died, and the medical examiner. At the end of the assessment, OSI may conclude that it does not find reason to believe that a corrections officer caused the death and will close the matter.

When OSI closes a case after a preliminary assessment because it does not find causation, OSI sends a letter, pursuant to Paragraph 2 of Section 70-b, to the district attorney for the county in which the incident occurred, informing the district attorney that a preliminary assessment shows that the Attorney General does not have investigative authority or criminal jurisdiction in the matter. At that point jurisdiction reverts to the district attorney.

On the other hand, when OSI has a case where it is clear from the start that an officer has caused a death, such as a shooting case, or where OSI's preliminary assessment establishes that an officer has caused a death, OSI pursues a full investigation. At the conclusion of the investigation, pursuant to Section 70-b, OSI must do one of two things: (a) present evidence to a grand jury to seek an indictment, or (b) issue a public report detailing the investigation and its results and explaining why OSI did not present evidence to a grand jury (Investigation Report). OSI must also issue an Investigation Report if it presents evidence to a grand jury and the grand jury does not return an indictment.

Family Meetings

When OSI begins a full investigation, we reach out to the family members of the person who has died and ask to meet with them in person. In these family meetings the AAG and the detective assigned to the investigation, as well as a senior criminal justice coordinator or a criminal justice liaison (Coordinator or Liaison), introduce themselves, provide their contact information, explain OSI's independent investigative role under the law, and describe OSI's investigative process.

The Coordinator or Liaison, in addition, provides the family with information about services that might be available to them (for example, counseling) and offers to help the family access those services, if they wish. The Coordinator or Liaison thereafter continues to support the family throughout the investigation process, often speaking with family members by phone, answering their questions and providing updates.

When the investigation is completed, whether it is going to result in an Investigation Report or a grand jury presentation, the AAG, the detective, and the Coordinator or Liaison ask to meet with the family again. At that meeting, the team will explain the results of the investigation to the family and provide them with the reasons why OSI made the determination either to issue an Investigation Report or to present evidence to a grand jury.

If OSI is going to issue an Investigation Report, the OSI team explains the steps OSI took in the investigation and OSI's investigative findings and legal analysis.² In cases where OSI obtains an indictment, followed by pretrial hearings and a trial, the Coordinator or Liaison keeps family members informed of the progress of the proceedings and accompanies the family members in the courtroom.

When an OSI case has video evidence, the Attorney General will publicly release relevant segments, in accordance with the Attorney General's published video release policy.³ OSI will

² In addition, in many investigations, OSI staff and members of the Attorney General's office of Intergovernmental Affairs will meet with elected officials and community leaders.

³ The Attorney General's video release policy is here: [Release Policy](#).

always provide the family an opportunity to view video before the Attorney General releases it.

Sections in This Report

Guilty Plea and Trials

Since the last Annual Report, one defendant in an OSI case pleaded guilty to homicide charges, one defendant was convicted of Menacing after a jury trial, and one defendant was acquitted after a bench trial. See Section 2, below, for a summary of the guilty plea and trials.

Indictments

There are four pending indictments in OSI cases: grand juries returned indictments in two OSI cases since the last Annual Report, and two indictments summarized in the last Annual Report remain pending. See Section 3, below, for a summary of pending indictments.

Investigation Reports

OSI has issued 21 Investigation Reports since the last Annual Report about incidents in which an officer caused a death, but OSI concluded that criminal charges were not warranted. Public issuance of such reports is required by Paragraph 6 of Section 70-b. See Section 4, below, for a summary of the Investigation Reports OSI has published since the last Annual Report.

New York City Department of Correction

OSI investigates (or assesses to determine causation) the deaths of persons in the custody of corrections departments around the state, including persons in the custody of the New York City Department of Correction (NYC DOC) at Rikers Island. Since the last Annual Report OSI has completed 10 investigations and assessments of NYC DOC cases. See Section 4, below, for summaries of two Investigation Reports and Section 5, below, for summaries of eight assessments OSI has completed of NYC DOC matters since the last Annual Report.

Recommendations

Section 70-b authorizes OSI to make recommendations based on its investigative work. See Section 6, below, for OSI's recommendations.

Data

Because Section 70-b requires that OSI's Annual Report be published on October 1, OSI uses a data year ending August 31, to provide for 30 days to collate and analyze OSI's annual data.

See Section 7, below, for a discussion of selected data, and see the [tables](#) on OSI's webpage of the Attorney General's website for OSI's complete data from April 1, 2021 (the effective date of Section 70-b) through August 31, 2024.

2. GUILTY PLEA AND TRIALS

Guilty Plea

People v Yvonne Wu, Kings County

Yvonne Wu, who was an officer in the New York City Police Department (NYPD) at the time of the incident, pleaded guilty to Manslaughter in the First Degree for shooting and killing Jamie Liang, and Attempted Murder in the Second Degree for shooting and wounding Jenny Li.

On October 13, 2021, the defendant, while off duty, went to the Brooklyn home of Jenny Li, whom she knew, and used her service weapon to shoot and kill Jamie Liang, a friend of Li's, and to shoot and wound Li. Neither Ms. Liang nor Ms. Li was armed.

The defendant pleaded guilty in Kings County Supreme Court on June 24, 2024, and was sentenced on August 28, 2024 to 22 years' imprisonment on the Manslaughter charge and five years' imprisonment on the Attempted Murder charge, to run consecutively, plus five years' post-release supervision.

Jamie Liang was Asian and was 24 years old when she died.⁴ NYPD terminated the defendant after the incident.

Trials

People v Errick Allen, Nassau County

OSI tried the indictment of Errick Allen, who was an NYPD officer at the time of the incident, to a Nassau County jury in February and March of 2024. On March 28, 2024, the jury returned a verdict convicting the defendant of Menacing in the Second Degree and acquitting him of other charges. On May 28, 2024, the judge sentenced the defendant to one year in jail.

The victim, Christopher Curro, was white and was 25 years old at the time of the incident.

⁴ Paragraph 7 of Section 70-b directs OSI to include in the Annual Report "racial, ethnic, age, gender and other demographic information concerning the persons involved" in its investigations. In this report, OSI bases these items of information on records obtained in the course of its assessments and investigations.

Erie County Trial

OSI tried an indictment to an Erie County judge in March of 2024.⁵ On March 13, 2024, the judge returned a verdict of not guilty on all counts. As a result, information about this case is sealed.⁶

3. PENDING INDICTMENTS

Indictments are accusations. Every criminal defendant is presumed innocent unless and until a jury determines that the evidence proves the defendant's guilt beyond a reasonable doubt, or unless and until the defendant pleads guilty.

Indictments Returned Since the Last Annual Report

People v Tyler Paul, Queens County

The indictment charges that Tyler Paul, who was a member of NYPD at the time of the incident, committed Manslaughter in the Second Degree and other crimes on April 26, 2023, when he was off duty and driving his personal car on the Grand Central Parkway in Queens and struck and killed a highway worker, Kawan Edwards.

The fatal event began when the defendant, who was allegedly speeding and driving recklessly, struck a car in the right lane of the highway. The collision caused the defendant to lose control of his car, which skidded at high speed into Mr. Edwards, who was working on the shoulder of the road as a contractor for the Department of Transportation, killing him.

Kawan Edwards was Black and was 36 years old at the time of his death. The defendant was terminated by NYPD after the incident. The indictment, which was returned by the grand jury in March 2024, is here: [Tyler Paul Indictment](#).

People v Erik Duran, Bronx County

The indictment charges that Erik Duran, who was a member of NYPD at the time of the incident, committed Manslaughter in the Second Degree and other crimes on August 23, 2023, in the Bronx, when he was working in plain clothes in a narcotics "buy and bust" operation. Eric Duprey, who was unarmed, had just sold drugs to an undercover officer and was riding past the defendant on a motorbike when the defendant allegedly forcefully threw

⁵ Under New York law, the defendant in a criminal case has the right to waive a jury and have the charges tried before the judge, Criminal Procedure Law Section 320.10. The consent of the prosecutor is not needed for the case to be tried to a judge.

⁶ New York's sealing rule is Criminal Procedure Law Section 160.50.

a picnic cooler at Mr. Duprey's head, knocking him to the ground. Mr. Duprey died from the impact of his head hitting the pavement.

Eric Duprey was Hispanic and was 30 years old at the time of his death. The defendant was placed on modified duty by NYPD after the incident. The indictment, which was returned by the grand jury in January 2024, is here: [Erik Duran Indictment](#).

Indictments Pending Since Prior to the Last Annual Report

People v Christopher Baldner, Ulster County

The indictment charges that Christopher Baldner, who was a member of the New York State Police (NYSP), committed Murder in the Second Degree, Manslaughter in the Second Degree, and Reckless Endangerment in the First Degree when he used his trooper vehicle to cause the death of Monica Goods, who was 11 years old, and to endanger other members of her family, on December 22, 2020, in Ulster County. The indictment also charges that, in September of 2019, the defendant endangered the lives of a driver and his passengers by using his police vehicle to ram their car.⁷

On December 22, 2020, at 11:40 pm, Tristin Goods was driving on the New York State Thruway with his wife and two daughters, aged 11 and 12, on the way to visit family for Christmas. The defendant was on patrol in his marked NYSP vehicle and stopped the Goods family car for speeding. During the stop the defendant pepper sprayed Mr. Goods, and Mr. Goods sped away. During the pursuit, when both cars were traveling over 100 miles per hour, the defendant allegedly deliberately rammed his police vehicle into the rear of the Goods family car, twice. Upon the second strike, the Goods family car flipped over and came to rest upside down in the median. The impact ejected Monica Goods from the car, killing her. No one in the Goods car was armed.

The indictment is pending in Ulster County Court. A trial date has not been set. The indictment is at this link: [Christopher Baldner Indictment](#). Monica Goods was Black and was 11 years old when she died. The defendant has retired from NYSP.

⁷ This incident occurred prior to the effective date of Section 70-b, and OSI is therefore prosecuting the matter pursuant to Executive Order 147, see Footnote 1, as well as Executive Order 7, pertaining to a prior act which did not result in death. Executive Order 7 can be seen in this link: [Executive Order 7](#). On February 2, 2023, the judge presiding over the case issued a decision dismissing the count charging the defendant with Murder in the Second Degree and reducing the counts charging Reckless Endangerment in the First Degree to Reckless Endangerment in the Second Degree. The Attorney General appealed that decision, and, on September 19, 2024, the Appellate Division, Third Department, reversed the trial court and reinstated the Murder and Reckless Endangerment in the First Degree Counts.

People v Dion Middleton, Bronx County

The indictment charges that Dion Middleton, an officer in NYC DOC, committed Murder in the Second Degree and Manslaughter in the First and Second Degrees when he used his service weapon to shoot and kill Raymond Chaluisant in the Bronx on July 21, 2022.

On July 21, 2022, shortly after 1:00 am, when he was off duty and on foot near the Cross Bronx Expressway Service Road and Morris Avenue in the Bronx, the defendant allegedly shot and killed Raymond Chaluisant, who was a passenger in a car. Mr. Chaluisant was unarmed.

The trial of this indictment is in progress in Bronx County Supreme Court. The indictment is at this link: [Dion Middleton Indictment](#). Raymond Chaluisant was Hispanic and was 18 years old when he died. NYC DOC suspended the defendant after the incident pending a disciplinary process.

4. INVESTIGATION REPORTS RELEASED BY OSI IN THE PAST 12 MONTHS

OSI's Process: Published Investigation Reports

When OSI determines not to seek charges in an incident in which a police officer or peace officer caused a death, Section 70-b, Paragraph 6, requires OSI to publish an Investigation Report. Each of OSI's published Investigation Reports describes OSI's investigation in detail, as well as the legal analysis that led OSI to conclude that a prosecutor would not be able prove the officer guilty of a crime beyond a reasonable doubt at trial, or that a prosecutor would not be able to disprove the defense of justification beyond a reasonable doubt at trial. These are not conclusions that an officer's conduct was proper, only that a prosecutor would not be able to prove the officer guilty of a crime at trial under the standards required by law.⁸

⁸ In determining whether criminal charges are warranted, OSI's attorneys are ethically bound to evaluate whether the admissible evidence obtained in the investigation would carry the prosecutor's burden to prove the criminal charges beyond a reasonable doubt at trial and, where relevant, the prosecutor's burden to disprove the defense of justification beyond a reasonable doubt at trial. See the American Bar Association's Standards for the Prosecution Function, Standard 3-4.3, Minimum Requirements for Filing and Maintaining Criminal Charges: "(a) A prosecutor should seek or file criminal charges only if the prosecutor reasonably believes that the charges are supported by probable cause, that admissible evidence will be sufficient to support conviction beyond a reasonable doubt, and that the decision to charge is in the interests of justice." See also, Rule 3.8 of the New York Rules of Professional Conduct. See below, in this Section, for an explanation of the defense of justification under New York law and the prosecutor's burden to disprove the defense of justification beyond a reasonable doubt.

OSI's Investigations

OSI's investigations, each of which takes a number of months to complete, include, depending on the case:

- interviews of

- the police officers or corrections officers who are the subjects of the investigation;⁹
- other police officers and corrections officers who may be witnesses;
- civilian bystander witnesses and jail and prison witnesses;
- the medical examiner who performed the autopsy and other members of the medical examiner's staff;
- the emergency medical responders, treating physicians, and responding jail and prison medical staff; and
- other experts, such as consulting medical examiners, accident reconstruction experts, video analysts, and firearms and other forensic experts;

- and reviews of

- officers' body-worn camera (BWC) videos and dashboard camera (dashcam) videos;
- police and corrections departments' surveillance camera videos
- civilian videos from cell phones and security cameras in homes and businesses;
- recorded 911 calls, dispatch transmissions, and officer-to-officer communications;
- police departments' crime scene and other photographs, ballistics reports, DNA reports, and accident reconstruction reports;
- police and corrections departments' incident reports, interview reports, and investigative reports;

⁹ The officer-subjects of OSI's investigations often refuse OSI's requests for interviews. The same is true of officer-witnesses. As in any criminal investigation, the subjects and witnesses in OSI's investigations have the right not to talk to law enforcement, pursuant to the Fifth Amendment to the United States Constitution. OSI has civil subpoena authority, and uses it, but even when a person is civilly subpoenaed and appears for testimony, he or she has a right to refuse to answer questions. In New York criminal investigations, a prosecutor can only require a person to speak by subpoenaing the person to a grand jury and taking the person's testimony under oath, because a witness in the grand jury is granted full immunity from prosecution by operation of law, Criminal Procedure Law Article 50 and Section 190.40. Immunity is considered a complete substitute for the person's Fifth Amendment privilege. Police departments can and do compel statements from officers when conducting internal investigations of possible misconduct. However, if OSI were to become privy to such a compelled statement given by an officer who was the subject of an OSI investigation, that officer would gain use immunity and derivative use immunity with regard to the compelled statement, based on their Fifth Amendment rights. *Garrity v New Jersey*, 385 US 493 (1967). As a result, any OSI investigator or AAG with knowledge of the compelled statement would be considered "tainted" and would have to leave the investigation, and OSI would be required to bring in a new team of investigators and AAGs.

- medical and mental health records, including reports from responding EMTs and responding doctors, records from prison and jail medical services, and records from hospitals to which decedents were brought before they died; and
- autopsy reports, including photographs and toxicology reports.

New York's Law of Justification

Many of the cases OSI decides not to present to a grand jury turn on New York's law of justification, which is set forth in Article 35 of the New York Penal Law. As applied to OSI's cases, the basic idea underlying the law of justification is the right to use force to defend oneself or another from wrongful physical force.

Two provisions in Article 35 are often relevant to OSI's investigations. One is the general provision justifying all persons' (civilians' or officers') use of deadly physical force to defend themselves or others from another person's wrongful use of deadly physical force (Penal Law Section 35.15, Subdivision 2). The other is a provision specifically justifying police officers' or peace officers' use of deadly physical force to defend themselves or others from another person's wrongful use of deadly physical force when the officer is making an arrest or preventing an escape from custody for a criminal offense (Penal Law Section 35.30, Subdivisions 1 and 2).

An important difference between the general provision and the officer-specific provision concerns the duty to retreat. With limited exceptions, civilians may not use deadly physical force in defense of self or another if they know they can retreat with complete safety to themselves and others, Penal Law Section 35.15(2). However, officers who are justified in using deadly physical force under Penal Law Section 35.30 because they are making an arrest or preventing an escape for an offense are under no duty to retreat, even if they could do so with complete safety to themselves and others, Penal Law Section 35.15(2)(a)(ii).

Justification is legally a "defense," not an "affirmative defense," Penal Law Section 35.00. This means that if a case goes to trial the burden is on the prosecutor to disprove justification beyond a reasonable doubt, Penal Law Section 25.00(1). This burden of proof is often a decisive factor in OSI's determination whether or not to seek criminal charges against an officer.

Investigation Reports OSI Published in the Last 12 Months

The Investigation Reports OSI published since the last Annual Report are summarized below.

Osiris Mercado, September 23, 2021, Suffolk County

In the evening of September 23, 2021, in Port Jefferson Station, Suffolk County, a 911 caller reported a man bleeding from the head. When Suffolk County Police Department (SCPD) officers arrived, they saw Mr. Mercado bleeding from the head, screaming incoherently, and pacing the street in the rain with no shoes. Officers approached Mr. Mercado, but Mr. Mercado ran away. An ambulance arrived shortly after the officers, but the paramedics were unable to assess Mr. Mercado or render aid because they needed the officers to restrain Mr. Mercado first. The officers brought Mr. Mercado to the ground and, after a struggle, handcuffed him, but he suddenly went quiet, and limp and his vital signs dropped. The paramedics began life-saving measures, but Mr. Mercado went into cardiac arrest and died at the hospital.

The Suffolk County medical examiner determined the cause of Mr. Mercado's death to be "agitation" due to "acute drug intoxication (cocaine and fentanyl) in [a] setting of cardiomegaly [enlarged heart] and physical restraint." A second expert, retained independently by OSI, determined the cause of death to be acute drug intoxication (cocaine and fentanyl), with physical restraint having played little if any role.

Based on its investigation and legal analysis, OSI concluded that a prosecutor would not be able to prove beyond a reasonable doubt at trial that the officers who restrained Mr. Mercado had committed a crime, and closed the case with the issuance of a report.

Mr. Mercado was Hispanic and was 39 years old when he died. Although the SCPD officers were not equipped with BWC at the time of this incident, SCPD has since equipped its officers with BWC. Report: [Osiris Mercado](#).

Jason Jones, December 15, 2021, Greene County

On the evening of October 29-30, 2021, Mr. Jones became intoxicated at the Avalon Lounge, a local bar in the village of Catskill, Greene County, one block from the Catskill Police Department (CPD) stationhouse. At 1:29 am on October 30, when Mr. Jones refused to leave the Avalon, staff called CPD. Mr. Jones left the bar when the officers arrived but ran to and entered the CPD stationhouse. Video surveillance inside the stationhouse lobby showed three CPD officers speaking with Mr. Jones for the next twenty-five minutes.

Mr. Jones appeared intoxicated, pounded on windows, overturned a table, and removed his clothes. Eventually Mr. Jones picked up a gallon-jug of isopropyl alcohol-based hand sanitizer and, using the pump dispenser, doused himself. One of the officers told Mr. Jones he was

“under arrest” and going to the hospital. According to the officers, Mr. Jones refused to go voluntarily, tensed his body for a fight, and screamed at them. One officer Tased Mr. Jones, causing the hand sanitizer to ignite, engulfing Mr. Jones’s head and chest in flames for the next twenty-five seconds. The officers ran from the lobby to search, they said, for fire extinguishers. The first officer to return patted at the last of the flames on Mr. Jones’s body. Emergency medical personnel arrived, sedated Mr. Jones, and transported him to Albany Medical Center. Within hours, Mr. Jones was transferred to the Upstate Medical Burn Center in Syracuse, where he remained in a medically induced coma. Mr. Jones died on December 15, 2021, from heart and lung complications from inhaling hot gases.

Based on its investigation and legal analysis, OSI concluded that a prosecutor would not be able to prove beyond a reasonable doubt that the officer who fired the Taser at Mr. Jones had committed a crime, and closed the case with the issuance of a report.

OSI recommended that police departments and the manufacturer of the Taser device provide more complete and more detailed training for officers concerning the risks of Taser use around flammable substances.

Jason Jones was white and was 30 years old when he died. Although the stationhouse video clearly captured the incident visually, it had no audio, and the officers were not equipped with BWC. Report: [Jason Jones](#).

Billy Lee, May 13, 2022, Bronx County

In the early evening of May 13, 2022, Mr. Lee drove with a friend to a convenience store in the Bronx. Before entering the store, Mr. Lee appeared to argue with men standing outside. When Mr. Lee was in the store and paying for beer, security video, with audio, captured him saying, “I have a big gun.” What followed was captured on security video from various buildings in the area.

When Mr. Lee left the store, he again appeared to argue with men standing outside. Mr. Lee went to his parked pickup truck and began to walk back toward the store with what appeared to be a gun in his hand. Mr. Lee’s friend blocked Mr. Lee and pushed him back toward the truck. The two men got into the truck and drove off around the block. After circling the block twice, Mr. Lee parked his truck a block from the store, at the corner of Hunts Point Avenue and Seneca Avenue. When Mr. Lee got out of the truck, he took an object that appeared to be a gun, but was in fact an air pistol, from the truck and headed toward the store on foot with the pistol visible in his right hand. NYPD officers who were in the area for a narcotics operation, and in plain clothes, saw Mr. Lee with what appeared to be a gun in his hand and yelled at him to drop the gun. Mr. Lee fired the air pistol at the officers and two officers fired at Mr. Lee, striking him. Mr. Lee was taken to a hospital where he died from his wounds. The air pistol was recovered at the scene.

Based on its investigation and legal analysis, OSI concluded that a prosecutor would not be able to disprove beyond a reasonable doubt that the firing officers' actions were justified, and closed the case with the issuance of a report.

Billy Lee was white and was 51 years old when he died. NYPD officers are generally equipped with BWC. The officers involved in this case were not wearing BWC because at the time of the incident they were in plain clothes as part of a narcotics operation. Report: [Billy Lee](#).

Malick Williams, July 9, 2022, Kings County

In the late afternoon of July 9, 2022, three NYPD officers on patrol in Brooklyn pulled over a car for allegedly failing to signal turns. When the driver failed to produce valid identification, the officers directed the driver and the three passengers to get out of the car. As he got out of the front passenger seat of the car, Mr. Williams broke into a run and one of the officers ran after him. The officer's BWC and a civilian cell phone video captured the pursuit. As Mr. Williams ran up Flatbush Avenue he pulled a gun out of his waistband, turned toward the pursuing officer, and fired. Though not hit, the officer fell to the ground. He fired back four times, striking Mr. Williams once in the chest. The officer went to Mr. Williams, who lay on the sidewalk, and called for an ambulance; other officers began to render aid. Mr. Williams died of his wounds.

Based on its investigation and legal analysis, OSI concluded that a prosecutor would not be able to disprove beyond a reasonable doubt that the firing officer's actions were justified, and closed the case with the issuance of a report.

Malick Williams was Black and was 19 years old when he died. Report: [Malick Williams](#).

Raul Hardy, July 9, 2022, Queens County

On July 9, 2022, at 6:08 pm Raul Hardy called 911 and told the operator that he would shoot cops if they came to his house. He gave his name and address in Queens. Mr. Hardy called back a few minutes later, repeated his name and address, said that he was armed, that he would change the government, and threatened to kill police officers and elected officials. At 6:24 pm 10 uniformed NYPD officers went to the street in front of Mr. Hardy's address. Mr. Hardy came outside. The officers ordered Mr. Hardy to show his hands. Mr. Hardy pointed a gun at the officers. The officers ordered him to drop the gun and fired. Mr. Hardy fired four times at the officers. The officers fired 134 shots, and Mr. Hardy was struck 18 times. Mr. Hardy died from his wounds. A .380 caliber semi-automatic firearm was recovered next to Mr. Hardy's body.

Based on its investigation and legal analysis, OSI concluded that a prosecutor would not be able to disprove beyond a reasonable doubt that the firing officers' actions were justified, and closed the case with the issuance of a report.

In its report OSI recommended that NYPD train its sergeants and lieutenants annually or bi-annually for situations in which they and members they command interact with people who may be in a mental health crisis. OSI said the training should include devising and following effective tactical plans, de-escalation, and firearms deployment, and should be based on real-world scenarios. The goal should be to preserve life whenever possible.

Mr. Hardy was Black and was 62 years old when he died. Report: [Raul Hardy](#).

Elijah Muhammad, July 10, 2023, Bronx County (Rikers Island)

This incident occurred in the afternoon and evening of July 10, 2022, in an NYC DOC correctional facility on Rikers Island where Mr. Muhammad was incarcerated. At 2:56 pm surveillance video showed that Mr. Muhammad was severely disoriented and falling to the floor outside his cell, and showed that a corrections officer saw him in this condition. At 3:00 pm video showed that the corrections officer held Mr. Muhammad's cell door open while other people¹⁰ physically assisted Mr. Muhammad into his cell. Despite his training and NYC DOC rules that required him to do so, the corrections officer did not call a medical emergency for Mr. Muhammad or otherwise render aid, such as by administering Narcan. From 3:08 pm through 5:13 pm video showed that the corrections officer went to Mr. Muhammad's cell 10 times and looked inside, seeming to check on Mr. Muhammad, but also showed that from 5:13 pm to 9:43 pm the corrections officer, despite being required to do so, failed to conduct any rounds near Mr. Muhammad's cell.

Video showed that people began to gather at Mr. Muhammad's cell, apparently alarmed by his condition, beginning a few minutes after 8:00 pm. However, it was not until 9:43 pm that the corrections officer, apparently alerted by an incarcerated person, finally reappeared at Mr. Muhammad's cell, seemed to understand the gravity of his condition, and began the process of obtaining medical aid. Aid began at 9:48 pm, but Mr. Muhammad was declared dead at 10:30 pm.

The autopsy report stated the cause of Mr. Muhammad's death as "acute fentanyl intoxication" and the manner of death as "accident (substance abuse)." The medical examiner, in an interview with OSI, said that earlier medical intervention could have saved Mr. Muhammad.

¹⁰ References to a "person" or "people" in a correctional facility mean people in custody, unless otherwise specified.

New York law imposes a duty on corrections officers to make sure that prisoners receive appropriate medical care. NYC DOC's policies and training require that corrections officers obtain medical care immediately for any prisoner they observe to be "disoriented" or suffering a "loss of consciousness."

OSI concluded that the corrections officer failed to perform his duty to obtain medical care for Mr. Muhammad at the time he observed Mr. Muhammad severely disoriented and apparently about to lose consciousness. The officer's failure to call a medical emergency or otherwise render aid was legally an omission – a failure to perform a duty imposed by law – and therefore there was a substantial question whether the officer caused Mr. Muhammad's death by omission. A case is within the scope of Section 70-b when there is a "question" whether an officer has caused a death.¹¹

However, OSI concluded that a prosecutor would not be able to prove that the officer's omission caused Mr. Muhammad's death beyond a reasonable doubt at trial, and therefore would not be able to prove beyond a reasonable doubt that the officer committed a crime.

Mr. Muhammad was Black and was 31 years old when he died. NYC DOC terminated the corrections officer. Report: [Elijah Muhammad](#).

Michael Nieves, August 30, 2022, Bronx County (Rikers Island)

Michael Nieves was incarcerated in a correctional facility on Rikers Island, in a mental observation housing area, which an NYC DOC employee described to OSI as a therapeutic environment with intensive, specialized, multidisciplinary treatment, where medical and mental health clinicians provide care.

In the morning of August 25, 2022, a corrections officer gave Mr. Nieves an institutional razor before he entered the showers. Later, when the officer asked Mr. Nieves to return the razor, Mr. Nieves said he had lost it. The officer notified a captain who responded to the housing area and, with a second corrections officer, searched Mr. Nieves's cell but did not find the razor. They locked Mr. Nieves in his cell while they searched the cell of another person who had been in the showers at the same time as Mr. Nieves, but did not find the razor there, either.

The captain told a corrections officer to take Mr. Nieves to the Intake unit for a body scan to try to find the razor. According to video footage from the officer's BWC, at 11:41 am the officer went to Mr. Nieves's cell, opened the cell door, and saw Mr. Nieves leaning against a wall,

¹¹ Paragraph 1 of Section 70-b states that OSI's scope includes "any incident in which the death of a person ... is caused by an act or omission of [a defined officer] or in which the attorney general determines there is a question as to whether the death was in fact caused by an act or omission of such" officer (emphasis added).

bleeding heavily, but conscious. The captain called a medical emergency while the officer remained at the door of Mr. Nieves's cell, speaking with him as he continued to bleed. While awaiting the arrival of medical staff, the captain and two corrections officers offered a blanket and a shirt to Mr. Nieves, apparently for Mr. Nieves to put them on his wound, but he refused to take them. After watching Mr. Nieves for a few minutes, one of the officers, apparently unsure where Mr. Nieves was cut, asked him if he was bleeding from the mouth or the neck; Mr. Nieves said he was bleeding from the neck.

During the 10-minute wait for medical staff no corrections staff member applied or attempted to apply pressure to Mr. Nieves's wound.

Rikers medical staff arrived at 11:51 am and rendered aid, and EMTs arrived at 12:30 pm. At 1:00 pm the EMTs left the housing area with Mr. Nieves to take him to Elmhurst Hospital. On August 26, 2022, Mr. Nieves was determined to be brain dead and, on August 30, 2022, Mr. Nieves was removed from life support and declared dead.

The medical examiner wrote in the autopsy report that the cause of death was "incised wound of neck with injury of jugular vein" and that the manner of death was "suicide (cut self)." The medical examiner told OSI that the corrections officers' failure to immediately render aid to Mr. Nieves before the arrival of medical staff by putting pressure on his neck wound contributed to his death. She said Mr. Nieves might have survived had someone applied pressure to his wound immediately after he was discovered with the injury. Such pressure could have closed the vein, causing the blood loss to cease earlier, increasing the chance that surgical intervention could have saved Mr. Nieves's life. However, the medical examiner said that survival would not have been guaranteed even with prompt medical intervention.

OSI concluded that the failure of the corrections captain and the two corrections officers present at the cell to render aid to Mr. Nieves was legally an omission, a failure to perform a duty imposed by law, and that there was a substantial question whether this omission contributed to Mr. Nieves's death. This brought the case within the scope of Section 70-b. However, OSI concluded that a prosecutor would not be able to prove that the officers' omission caused Mr. Nieves's death beyond a reasonable doubt at trial, and therefore closed the matter with the issuance of a report.

In the course of the investigation NYC DOC training supervisors provided conflicting information to OSI as to whether NYC DOC trained corrections officers in wound care. OSI also found that NYC DOC rules and regulations did not clearly require officers to render care to people with severely bleeding wounds. Therefore, in its report on this case, OSI recommended that NYC DOC rules and regulations clearly require officers to render immediate wound care to incarcerated people experiencing severe bleeding, without waiting for the arrival of medical staff, and that NYC DOC train all officers in wound care and provide them with the equipment needed for such care.

Mr. Nieves was Hispanic and was 30 years old at the time of this death. NYC DOC brought disciplinary proceedings against the captain and the two corrections officers; the captain has resigned from NYC DOC and the charges against the two officers are pending as of the date of this Annual Report. Report: [Michael Nieves](#).

Joel Capellan, October 16, 2022, New York County

During the early morning hours of October 16, 2022, four NYPD officers drove in an unmarked car to Dyckman Street and Nagle Avenue in the Washington Heights-Inwood section of Manhattan to patrol the streets around the area's nightclubs at closing time. Shortly before the officers' arrival at the intersection, security video from a residential building and several commercial establishments showed that Mr. Capellan and his uncle were fighting with several people near the corner of Dyckman Street and Nagle Avenue. According to the videos and witness interviews, a man struck the uncle in the face and Mr. Capellan took a gun from his waist with his left hand and struck the man in the head with his left hand while holding the gun. Witnesses saw and videos showed the man bleeding from the head after Mr. Capellan struck him; medical records said the man had sustained a graze wound from a bullet.

The fight spilled into the street as the officers arrived in their car. A different man (not the one with the graze wound) was wrestling with Mr. Capellan in the street, on the ground, as other people dispersed. BWC video showed that the officers got out of their car and approached Mr. Capellan and the man he was fighting with. BWC showed that Mr. Capellan had a gun in his left hand and that the officers shouted at him to drop the gun as he was wrestling with the man. Mr. Capellan began to lift himself up from the ground with the gun in his left hand and the four officers fired 34 rounds at him. Mr. Capellan was struck 32 times and pronounced dead at a local hospital.

BWC showed a gun on the ground next to Mr. Capellan's body after he was shot and showed an officer recovering it. NYPD testing later determined it to be operable. The recovered gun had a live round in the firing chamber and three rounds in the inserted magazine. Ballistics testing of the recovered gun and a recovered shell casing indicated that the recovered gun had been discharged once. DNA testing of the recovered gun was positive for the presence of Mr. Capellan's DNA.

Based on its investigation and legal analysis, OSI concluded that a prosecutor would not be able to disprove beyond a reasonable doubt at trial that the firing officers' actions were justified, and closed the case with the issuance of a report.

Mr. Capellan was Hispanic and was 29 years old when he died. Report: [Joel Capellan](#).

Kyle Lockett, November 3, 2022, Bronx County

On the morning of November 3, 2022, Mr. Lockett was inside a convenience store near the corner of East Gun Hill Road and Hull Avenue in the Bronx. As shown by the store's internal and external security video cameras, a man holding a knife entered the store, stabbed Mr. Lockett, and ran out of the store to his parked car. Mr. Lockett ran after the man with a gun in his hand and fired four shots at him as he was getting into his car (the man was not seriously injured). Members of NYPD were conducting an unrelated operation and were in an unmarked minivan parked a few yards away from the convenience store. As Mr. Lockett was running after and firing at the man who had stabbed him, the officers got out of the minivan and shot at Mr. Lockett, striking him four times. Mr. Lockett died of his wounds.

Based on its investigation and legal analysis, OSI concluded that a prosecutor would not be able to disprove beyond a reasonable doubt that the firing officers' actions were justified and closed the case with the issuance of a report.

Mr. Lockett was Black, and was 21 years old when he died. The involved officers were not equipped with BWC at the time of the incident because they were part of an arrest warrant operation, which NYPD excepted from its BWC usage requirement. Report: [Kyle Lockett](#).

Manuel Beras Medina, November 18, 2022, New York County

On November 18, 2022, NYPD officers, working with federal officers, were conducting a narcotics operation, attempting to purchase kilograms of cocaine from a seller believed to be at an apartment in a building on Vermilyea Avenue in Manhattan. At 8:30 pm officers received information that cocaine was visible in the apartment. They entered the apartment and identified themselves as police officers. Mr. Beras Medina, who was in the apartment, pulled a firearm from his waistband, racked the slide, and fired at the officers, who returned fire 37 times. Mr. Beras Medina died of his wounds.

Another man was in the apartment with Mr. Beras Medina, and was also armed with a gun, but officers were able to grab his gun hand and prevent him from shooting. Officers quickly left the apartment after the shooting with the second man in custody, not knowing at that moment whether Mr. Beras Medina had been struck by gunfire. (The second man was arrested and later pleaded guilty to a federal narcotics crime.)

BWC from Emergency Services Unit officers who entered the apartment after the shooting showed that Mr. Beras Medina was lying on the kitchen floor and had been struck by gunfire but was still holding a gun in his hand. The recovered gun (which bore no serial numbers and was considered a "ghost gun") and ballistics evidence from the apartment showed that Mr. Beras Medina had fired three times.

Based on its investigation and legal analysis, OSI concluded that a prosecutor would not be able to disprove beyond a reasonable doubt that the firing officers' actions were justified, and closed the case with the issuance of a report.

Mr. Beras Medina was Hispanic, and was 34 years old when he died. The officers directly involved in the narcotics operation were not wearing BWC so as not to be identifiable as police officers while they staged near the apartment building. Report: [Manuel Beras Medina](#).

Miguel Romero, November 19, 2022, Nassau County

On the evening of November 19, 2022, two Nassau County Police Department (NCPD) officers were in an unmarked police car, without lights or siren activated, driving on Front Street in Uniondale, en route to help other officers with an arrest. Security camera video showed that Miguel Romero was waiting to cross the street by a parked car; he was not at a crosswalk or a traffic light. Mr. Romero looked in the direction of the approaching police car and attempted to sprint across the street, and the police car struck him. The police car was traveling 62 mph in a 40 mph zone, but there was no evidence that the driver was impaired by drugs or alcohol or that he was distracted by texting or other cell phone use.

The driver stopped the car and both officers went to Mr. Romero and called for an ambulance. Paramedics brought Mr. Romero to the hospital but he was pronounced dead soon after arrival.

OSI's legal analysis showed that, although the officer was speeding, he was operating the car under the provision of the Vehicle & Traffic Law (VTL) that allows officers responding to an emergency to exceed the speed limit (VTL Section 1104) and that, under New York case law, the speeding was not the kind of "dangerous speeding" that the courts require to be proved to find a driver guilty of a crime. Therefore, OSI concluded that a prosecutor would not be able to prove beyond a reasonable doubt at trial that the driver-officer had committed a crime and closed the investigation with the issuance of a report.

OSI's report noted that NCPD officers responding to the collision, who arrived almost immediately, failed to administer a Portable Breath Test (PBT) to the officer-driver for over two hours after the incident. Because alcohol metabolizes in the body over time, OSI recommended in the report that NCPD administer PBTs in law enforcement related collisions consistently and reliably soon after the time of collision.

Mr. Romero was Hispanic and was 47 years old at the time of his death. Report: [Miguel Romero](#).

Morris Sprachman, December 9, 2022, Nassau County

On the morning of December 9, 2022, an NCPD officer was in a marked police car on Hicksville Road, responding to a medical emergency call with emergency lights, but not siren, activated. Mr. Sprachman was in his car on Hicksville Road, in the opposite direction from the officer, waiting at a light to make a left hand turn into a shopping center. The officer was proceeding through the intersection with a green light when Mr. Sprachman made a left turn, colliding with the officer's car. Mr. Sprachman was transported to the hospital and died five days later from his injuries. The officer was traveling 62 mph in a 40 mph zone; there was no evidence that he was impaired by drugs or alcohol or that he was distracted by cell phone use. However, no responding NCPD officer attempted to administer a PBT to the driving officer.

OSI's legal analysis showed that, although the officer was speeding, he was operating the car under VTL 1104, which allows officers responding to an emergency to exceed the speed limit, and that, under New York case law, the speeding was not the kind of "dangerous speeding" that the courts require to be proved to find a driver guilty of a crime. Therefore, OSI concluded that a prosecutor would not be able to prove beyond a reasonable doubt at trial that the driver-officer had committed a crime and closed the case with the issuance of a report.

Morris Sprachman was white and was 102 years old when he died. Report: [Morris Sprachman](#).

Quayshawn Samuel, September 29, 2022, Queens County

On December 29, 2022, security video in the lobby of an apartment building in Far Rockaway, Queens County, showed a group of men in the lobby. Based on a live feed of the lobby video three NYPD officers went to the lobby to investigate potential criminal activity. Quayshawn Samuel ran out one of the rear doors of the lobby and two officers pursued him on foot through the grounds of the apartment complex and across Beach Channel Drive to Beach 56th Street. One officer was ahead of the other, but behind Mr. Samuel, and believed Mr. Samuel was holding a gun.

As the officer who was ahead ran after Mr. Samuel through the apartment grounds he dropped his radio, and his BWC fell off its mount. The second officer, whose BWC was activated, stopped to pick up the first officer's radio, which left him farther behind in the foot pursuit. (The second officer did not pick up the first officer's BWC.) As Mr. Samuel crossed Beach Channel Drive he stumbled and fell, allowing the first officer to catch up to him. On Beach 56th Street the first officer and Mr. Samuel engaged in a physical struggle on the ground, with the officer on top of Mr. Samuel, who was holding a gun. After a few seconds Mr. Samuel was able to push himself up off the ground, and, as he and the officer stood up, the officer saw a gun in Mr. Samuel's hand, which, he told OSI, Mr. Samuel was raising at him. The officer fired his service weapon at Mr. Samuel, striking him in the chest and the leg. Mr. Samuel later died of his wounds.

Surveillance video from a number of cameras captured the foot pursuit and the final struggle and shots. The second officer arrived on Beach 56th Street a few seconds after the shots were fired; his BWC showed a gun lying in the street next to Mr. Samuel's hand and captured the first officer saying that he told Mr. Samuel to drop the gun. The recovered gun had a live round in the firing chamber, and NYPD testing later determined it to be operable. The magazine from Mr. Samuel's gun was recovered from the area where Mr. Samuel stumbled and fell on Beach Channel Drive.

Based on its investigation and legal analysis, OSI concluded that a prosecutor would not be able to disprove beyond a reasonable doubt that the firing officer's actions were justified, and closed the case with the issuance of a report.

Mr. Samuel was Black and was 31 years old when he died. Report: [Quayshawn Samuel](#).

Brendon Burns, March 20, 2023, Monroe County

On March 20, 2023, officers from the Rochester Police Department (RPD), Monroe County Sheriff's Office (MCSO), and the Brighton Police Department (BPD) were looking for Mr. Burns based on reports that he had committed two shootings, one earlier that day and one a few days earlier. Officers saw Mr. Burns leave a house on foot and followed him. At one point Mr. Burns reached for his waistband and an officer thought he had drawn a handgun. Mr. Burns turned and raised his arm towards the officer and the officer fired two shots at Mr. Burns, at least one of which struck him. As Mr. Burns ran away another officer fired her gun at him.

Mr. Burns ran back to the house where the foot pursuit began, took a backpack out of a car parked in the driveway, and walked through the back yards of nearby houses, followed on foot by a number of officers. As shown on BWC, Mr. Burns stopped in one of the back yards, dug into the backpack, pulled out the stock and the barrel of a shotgun, and began to assemble them. Officers shouted to Mr. Burns to drop the gun. As Mr. Burns raised the assembled shotgun toward the officers, officers fired, striking Mr. Burns, who fell to the ground and later died of his wounds. The barrel and stock of the shotgun, a box of shotgun ammunition, and a knife were recovered near his body.

Based on its investigation and legal analysis, OSI concluded that a prosecutor would not be able to disprove beyond a reasonable doubt that the firing officers' actions were justified and closed the case with the issuance of a report.

Mr. Burns was white and was 35 years old when he died. Report: [Brendon Burns](#).

Jarrel Garris, July 10, 2023, Westchester County

July 3, 2023, at 4:31 pm a New Rochelle Police Department (NRPD) officer responded to a report of person eating food at a grocery store without paying. When the officer arrived, the store manager pointed out Jarrel Garris, who was walking away from the store. As shown by BWC, that officer and a second NRPD officer approached Mr. Garris on foot and asked him what had happened. Mr. Garris did not respond and did not stop walking. A third NRPD officer, a detective, walked over and, deciding that Mr. Garris was not complying with the first two officers, attempted to handcuff him, and a physical struggle ensued.

BWC showed that in the first few moments of the struggle, as the detective attempted to get control of Mr. Garris's arms, one officer was on the ground, attempting to control Mr. Garris's legs, and Mr. Garris was standing over her; the other officer stood a few feet away trying to line up a shot with her Taser, which, ultimately, she did not fire. A few moments later, BWC showed that Mr. Garris was on the ground with his hands on the first officer's gun and holster; the detective yelled "gun" and fired once at Mr. Garris. The shot went into the back of Mr. Garris's neck and rendered him motionless. Mr. Garris was brain-dead soon thereafter, but was kept on life support until, on July 10, 2023, life support was removed and Mr. Garris died.

Based on its investigation and legal analysis, OSI concluded that a prosecutor would not be able to disprove beyond a reasonable doubt that the detective was justified when he fired at Mr. Garris, and closed the case with the issuance of a report.

In the report OSI recommended that NRPD's training and policies make clear that officers have discretion to use physical force, or to refrain from using physical force, when attempting to obtain the compliance of a subject in response to a report of a petty, nonviolent offense. As the Garris case showed, the proper use of this discretion could mean the difference between life and death. OSI said that the decision to use physical force to obtain compliance for a petty offense, particularly where mental health may be a factor in noncompliance, should be made cautiously and should be based on objective criteria.

Mr. Garris was Black and was 37 years old when he died. Report: [Jarrel Garris](#).

Benjamin Rivers, August 3, 2023, Niagara County

On August 3, 2023, at 9:35 pm a caller to the City of Niagara Falls Police Department (NFPD) 911 line reported hearing a gunshot outside an apartment building on Niagara Avenue and hearing people yelling for others to call the police. A responding NFPD officer, with BWC activated, arrived and a woman pointed to a man, later identified as Benjamin Rivers, sitting on a low wall in front of the building, and said, "He shot in my car." The officer walked toward Mr. Rivers and told him to show his hands. When the officer saw a gun in his hand she shouted to put the gun down. Mr. Rivers stood up and began walking toward the officer, who stepped

backward and continued to yell to put the gun down. Another officer, with BWC activated, arrived and shouted to put the gun down. Mr. Rivers fired a shot at one of the officers, and the officers fired at Mr. Rivers, striking him. He died of his wounds. The officers recovered a revolver next to Mr. Rivers's feet with three live rounds and three spent casings in the cylinder.

Based on its investigation and legal analysis, OSI concluded that a prosecutor would not be able to disprove beyond a reasonable doubt that the firing officers' actions were justified, and closed the case with the issuance of a public report.

Mr. Rivers was Black and was 53 years old when he died. Report: [Benjamin Rivers](#).

Azer Ben Zitun, August 4, 2023, New York County

On August 4, 2023, in five 911 calls from 11:30 pm to 11:50 pm, members of Mr. Ben Zitun's family requested that police come to an apartment building on Roosevelt Island, saying he was mentally unstable and threatening people with a knife. Four NYPD officers arrived at 11:52 pm, activated their BWCs, and, outside the building, spoke to Mr. Ben Zitun's father and brother, who repeated that Mr. Ben Zitun had threatened them with a knife. They told the officers Mr. Ben Zitun was still in the apartment and gave them the keys.

At 11:58 pm the officers went into the building: three got into an elevator to go up to the apartment, and the fourth stayed in the lobby, outside the elevator. At the same time, as shown on security video, Mr. Ben Zitun was riding an elevator down to the lobby, holding a kitchen knife in his right hand. As shown on security video and BWC, Mr. Ben Zitun came out of his elevator and swung the knife at the officer in the lobby, who blocked the blow with his arm. Mr. Ben Zitun then turned and walked into the still-open elevator occupied by the three other officers, holding the knife in this hand. One officer attempted to fire her Taser, which did not deploy, and tried to push Mr. Ben Zitun back, and the other two officers in the elevator fired their guns, striking Mr. Ben Zitun, who died of his wounds.

Based on its investigation and legal analysis, OSI concluded that a prosecutor would not be able to disprove beyond a reasonable doubt that the firing officers' actions were justified, and closed the case with the issuance of a report.

Mr. Ben Zitun was of Middle East/North African descent, and was 21 years old when he died. Report: [Azer Ben Zitun](#).

Daniel Legler, August 6, 2023, Monroe County

On August 6, 2023, an NYSP trooper attempted to pull over a car driven by Mr. Legler on a highway in the city of Rochester for failure to signal and expired inspection. Mr. Legler fled from the trooper at a high rate of speed. During the pursuit, Mr. Legler left the highway and

crashed his car into a field in the town of Gates, in Monroe County. As recorded on BWC, Mr. Legler got out of his car and the trooper went into the field to attempt to arrest him. During a brief physical struggle, Mr. Legler fired a shot from a revolver, and the trooper quickly backed away. The trooper fired at Mr. Legler, striking him. Mr. Legler died of his wounds.

Based on its investigation and legal analysis, OSI concluded that a prosecutor would not be able to disprove beyond a reasonable doubt that the firing officer's actions were justified, and closed the case with the issuance of a public report.

Mr. Legler was white and was 35 years old when he died. Report: [Daniel Legler](#).

"CW," a Minor, November 15, 2023, Ontario County

On November 15, 2023, NYSP received an anonymous report, which read in part, "My friend is talking about killing someone next week he is 100% serious about this and he will act on it." The reporter gave an address on State Route 64 in the Town of East Bloomfield, in Ontario County. A trooper went to the address to conduct a welfare check, arrived at 6:41 pm, and activated his BWC. A woman came to the door of the house, and the trooper told her about the report he had received. The woman called over to CW, and asked him if he had called the state police. CW came to the doorway and then stepped outside onto the small porch by the door. The trooper told CW to take his hand out of his pocket. BWC showed that CW pulled out a folding tool open to a knife blade. CW came at the trooper, who moved quickly off the porch. The trooper and CW fell to the ground. CW got up and charged at the trooper, who fired six shots at CW. CW died of his wounds.

Based on its investigation and legal analysis, OSI concluded that a prosecutor would not be able to disprove beyond a reasonable doubt that the firing trooper's actions were justified, and closed the case with the issuance of a report.

CW was white and was 17 years old when he died. Report: [CW, a Minor](#).

Michael Dotel, December 23, 2023, Bronx County

On December 23, 2023, two NYPD officers responded to a call for a person who was being violent at an apartment building in the Bronx. Upon arrival, Officers activated their BWC and met with the 911 caller at the entrance to the building, who told them his stepson, Michael Dotel, was in their apartment with his (Mr. Dotel's) mother and girlfriend, was likely on drugs, had assaulted his girlfriend, and was saying he was going to hurt himself and others. The caller brought the officers upstairs to the apartment, and, along the way, the officers received a radio report that Mr. Dotel was armed with a knife. As the officers approached the apartment, they heard shouting from inside. The apartment door was locked. Just as one of

the officers banged on the door and demanded entry, Mr. Dotel's girlfriend opened the door and ran into the hallway, screaming.

As the officers entered the apartment BWC showed Mr. Dotel with his mother in a chokehold. His mother's face was bloody. Mr. Dotel screamed, "She's going to get it, she's going to get it, shoot me, shoot me right now!" The officers told Mr. Dotel to drop the knife. His mother appeared to lose consciousness. One officer fired a shot, which struck Mr. Dotel in the head, causing his death.

Based on its investigation and legal analysis, OSI concluded that a prosecutor would not be able to disprove beyond a reasonable doubt that the firing officer's actions were justified, and closed the case with the issuance of a report.

Mr. Dotel was Hispanic and was 31 years old when he died. Report: [Michael Dotel](#).

Edward Holmes, February 24, 2024, Erie County

On February 24, 2024, at 9:59 am a 911 caller said there was a man with a shotgun on a street in Buffalo, who had threatened someone and had said, "If anyone pull up on him, he's gonna shoot at them." Buffalo Police Department (BPD) officers arrived at the street at 10:02 am, activated their BWCs, and saw a man in the middle of the street, holding a long gun. The first two officers to arrive got out of their cars and repeatedly told the man, "Drop the gun. Put it down." As a third and fourth officer arrived the man fired the gun, and officers yelled their commands more forcefully. When the man pointed the gun at them two officers fired at him. The man fell, and later died of his wounds. A loaded shotgun was recovered.

Based on its investigation and legal analysis, OSI concluded that a prosecutor would not be able to disprove beyond a reasonable doubt that the firing officers' actions were justified, and closed the case with the issuance of a report. Report: [Edward Holmes](#).

5. NEW YORK CITY DEPARTMENT OF CORRECTION

Background

NYC DOC operates jails on Rikers Island and in a nearby barge, which are both in Bronx County. Persons in the custody of NYC DOC include detainees awaiting trial, detainees awaiting sentencing, and prisoners sentenced to one year or less of jail time. NYC DOC also has custody of detainees and prisoners in transit, at courthouses, and in hospitals. According to the Fact Sheet published by DCJS, the NYC DOC population in August 2024 was 6431, a 5% increase

over August, 2023. (The NYC DOC population in August 2023 was, in turn, a 10% increase over August 2022.)¹²

All jails and prisons in the state of New York are required to report deaths and other significant incidents to the New York State Commission of Correction (SCOC), an independent oversight body. SCOC issues reports describing its activities, investigations, and findings.¹³ The New York City Board of Correction (NYC BOC) is an independent oversight body for the jails in New York City. NYC BOC conducts investigations and issues reports on deaths in NYC DOC custody, jail conditions, housing density, and access to health and mental health care.¹⁴

NYC DOC's operation of the jails at Rikers Island is the subject of ongoing federal litigation, begun in 2015, which includes oversight by a court-appointed monitor and intervention by the United States Attorney for the Southern District of New York. The concerns raised in the litigation and by the monitor include detainee safety, insufficient staffing, officers' use of force, and the Department's resistance to oversight, lack of transparency, and concealment of incidents.¹⁵ Parties to the litigation, including the United States Attorney, have advocated that a receiver be appointed to take over the management of the jails from NYC DOC, and the Attorney General has filed a statement in support of the appointment of a receiver.¹⁶

Following reports and proposals by the Independent Commission on New York City Criminal Justice and Incarceration Reform, city ordinances require that the jails on Rikers Island be closed and replaced by borough-based jails by 2027.¹⁷

¹² [DCJS Jail Population by Month Report](#). A detailed description of NYC DOC's facilities can be found at [NYC DOC Facilities Overview](#).

¹³ SCOC's [Annual Reports](#) and [Incarcerated Individual Mortality Reports](#).

¹⁴ NYC [Board of Correction Reports](#).

¹⁵ The monitor, in his most recent report, dated April 18, 2024, on Page 1, provided this overview: "The jails remain dangerous and unsafe, characterized by a pervasive, imminent risk of harm to both people in custody and staff. This risk of harm is caused by pervasive dysfunction in the jails' management resulting from polycentric and interdependent issues including, but not limited to, a broad failure to utilize sound correctional security practices for even the most basic tasks, limited staff supervision and poor-quality guidance, and a persistent failure to identify misconduct and to apply appropriate accountability. These failures perpetuate a toxic culture and a system in which none of the component parts work well or together. As a result, violence and a persistent pattern and practice of the use of unnecessary and excessive force remain evident in the system." [Monitor's Report](#).

¹⁶ [New York Times \(July 17, 2023\)](#).

¹⁷ It is not clear when construction on the new jails will be finished. See the Op-Ed by the mayor and the chairman of the Independent Commission published September 9, 2024, in the Daily News: <https://www.nydailynews.com/2023/12/15/new-york-will-close-rikers-island-says-mayor-adams-and-rikers-commission-chair-lippman/>

Cause of Death under Criminal Law Principles

Section 70-b authorizes OSI to investigate whether criminal offenses have been committed and, when warranted, to seek criminal charges. Therefore, OSI members conduct investigations and reach conclusions based on the principles of criminal law.

In a criminal case concerning a death, a person may be found guilty of a homicide crime only if the person or their accomplice has caused the death. A person is deemed to cause the death of another when their “actions were an actual contributory cause of the death, ... [forging] a link in the chain of causes which actually brought about the death,” and when “the fatal result was reasonably foreseeable,” *People v Stan Xu Hui Li*, 34 NY3d 357, 369 (2019); see *People v Davis*, 28 NY3d 294, 300 (2016). Even when the defendant’s conduct was not the sole cause of death, the defendant may be deemed to have caused a death when their conduct “set in motion” or continued in motion the events which resulted in death, *People v Matos*, 83 NY2d 509, 511 (1994).

An omission or a failure to act may be the basis of criminal liability if the defendant has failed “to perform a duty imposed by law,” Penal Law Sections 15.00(3) and 15.10. The Court of Appeals has held that the state imposes a duty of care for persons in custody, *Sanchez v State of New York*, 99 NY2d 247, 250 (2002).

Under Section 70-b, OSI’s authority to investigate and prosecute is limited to incidents in which police officers or peace officers as defined, including corrections officers, cause a death.¹⁸ OSI does not have legal authority to investigate or prosecute incidents in which someone else, such as medical staff in a correctional institution, causes a death.

When OSI finds insufficient evidence to conclude that a corrections officer has caused a death, that finding is based solely on the principles of New York’s criminal law and Section 70-b, and is not necessarily a conclusion that the conduct of the involved officer was proper or that the conditions in a jail were in compliance with legal standards.¹⁹

¹⁸ OSI’s authority may also include prosecution of a person acting in concert with a defined officer. Under Paragraph 4 of Section 70-b: “The attorney general shall have criminal jurisdiction over any criminal conduct arising from any incident herein....” The language in this part of the statute is not limited to defined officers, only to “incidents.” An “incident,” under Paragraph 1 of Section 70-b, is one in which “the death of a person ... is caused by an act or omission of [a defined] officer.”

¹⁹ As explained previously, when OSI is determining whether an officer has caused a death, OSI calls the process a “preliminary assessment” – although OSI’s preliminary assessments are often in reality lengthy investigations. When OSI closes a preliminary assessment with a finding of no causation, OSI closes the matter internally.

NYC DOC Assessments Completed by OSI in the Last 12 Months

Summarized below are the assessments OSI has completed since the last Annual Report concerning deaths of persons in NYC DOC custody. See OSI's [data tables](#) for the status, as of August 31, 2024, of all NYC DOC notifications OSI has received since April 1, 2021, the effective date of Section 70-b. See Section 4, above, for summaries of two Investigation Reports OSI published since the last Annual Report concerning deaths of persons in NYC DOC custody, Elijah Muhammad and Michael Nieves.

William Brown, November 14, 2021, Anna M. Kross Center (AMKC), Rikers Island

William Brown died at AMKC on December 14, 2021. According to the medical examiner he died of a drug overdose, after smoking a substance that contained a drug called MDMB-4EN-PINACA, a synthetic cannabinoid. Surveillance video showed Mr. Brown and other people rolling and smoking cigarettes in a day room shortly after 10:00 pm. Mr. Brown fell ill, coughing violently and falling to the floor, at 10:27 pm; others also appeared to be ill. Video showed that the assigned corrections officer violated procedure by failing to conduct rounds to observe the day room after an initial round when she arrived on post at 6:55 pm. After the people began to fall ill the officer came out of the control room to observe the day room through its window and, at 10:42 pm, entered the day room and began to perform CPR. Medical staff arrived at 10:49 pm, and a doctor declared Mr. Brown dead an hour later.

The medical examiner told OSI that prompt administration of Narcan, which is effective against opioids, would not have saved Mr. Brown, as the synthetic cannabinoid that caused his death was not an opioid. Although the corrections officer did not conduct rounds as required, it is not clear that if she had done proper rounds, she would have seen the inmates using contraband in time to have taken it away before it was smoked. And although it is possible that quicker administration of CPR could have made a difference, this possibility did not seem substantial enough to say that the officer caused Mr. Brown's death by omission.

Based on its assessment, OSI did not find reason to believe that the corrections officer caused Mr. Brown's death. After a disciplinary proceeding, the corrections officer forfeited 60 compensation days and was placed on 18 months of limited probation.

Mr. Brown was Black and was 54 years old when he died.

Robert Pondexter, September 22, 2022, George R. Vierno Center (GRVC), Rikers Island

On September 17, 2022, video showed that Mr. Pondexter collapsed near a stairway in GRVC. He was taken to a clinic at the facility, where he was conscious and responding to questions. The medical staff sent him to Bellevue Hospital, where he died five days later.

In her final autopsy report, the medical examiner determined the cause of death to be pulmonary thromboembolism due to deep vein thrombosis of the lower extremities of undetermined etiology (nontraumatic) and the manner of death to be natural. The report said hypertensive cardiovascular disease was a contributory cause of death.

Mr. Pondexter entered Rikers Island on April 28, 2020 as a pretrial detainee. In 2021 and 2022 he was scheduled for weekly medical visits, though NYC DOC documentation indicates he missed (either by refusal or a failure of staff to take him) a number of visits. He had one episode prior to the incident that led to his death, when he fell down stairs in March of 2022, but the medical records of that incident do not indicate that he fainted or collapsed. Mr. Pondexter was seen by medical staff on September 16, 2022, the day before the incident that led to his death. The nursing note from that visit said his appearance, speech, mood, behavior, orientation, and cognition were within normal limits, that he was in compliance with his medication, was not in distress, voiced no complaints, ate all meals on the unit, and engaged with peers and watched TV.

Based on its assessment, OSI did not find reason to believe that a corrections officer caused Mr. Pondexter's death.

Mr. Pondexter was Black and was 59 years old when he died.

Gilberto Garcia, October 31, 2022, AMKC, Rikers Island

On October 31, 2022, at 12:17 pm, two people found Mr. Garcia unresponsive in his cell and notified corrections officers. A corrections officer and incarcerated people began to render aid, using Narcan and administering CPR, and a corrections officer called a medical emergency.²⁰ Medical personnel arrived and began to render aid at 12:29 pm, but their efforts were unsuccessful, and a doctor declared Mr. Garcia dead at 12:50 pm.

Video last showed Mr. Garcia alive at 7:37 am, when he walked into his cell. Video showed that a corrections officers did tours every half hour from 8:00 am to 12:05 pm, but also showed that the officer failed to look into Mr. Garcia's cell during many of those rounds.

The medical examiner determined the cause of death to be a fentanyl overdose and would not express an opinion as to how long Mr. Garcia might have been dead when he was found unresponsive.

²⁰ OSI sought to interview the involved corrections officers and the incarcerated persons who found Mr. Garcia unresponsive, but the requests were refused.

Based on its assessment, OSI could not conclude that the failure of corrections officers to conduct proper rounds caused or contributed to Mr. Garcia's death, and therefore did not find reason to believe that a corrections officer caused Mr. Garcia's death.

Mr. Garcia was Hispanic and was 26 years old when he died.

Marvin Pines, February 4, 2023, North Infirmery Command (NIC), Rikers Island

On February 4, 2023, at 5:18 am an incarcerated person found Mr. Pines unresponsive in a bathroom and notified corrections officers. A corrections officer went to the bathroom and administered Narcan to Mr. Pines. A second corrections officer called a medical emergency, and corrections officers and medical personnel began to arrive at the bathroom at 5:24 am.

Surveillance video from the 6th-floor medical clinic showed that at 5:30 am Mr. Pines was brought into the clinic on a stretcher and that he suffered a seizure at 5:34 am. At 5:45 am Mr. Pines became unresponsive and medical staff administered CPR, applied medical paddles to his chest, and used a bag valve mask. EMS arrived at 6:04 am and took over CPR. They pronounced Mr. Pines dead at 6:18 am.

Video last showed Mr. Pines alive at 4:12 am, when he walked into the bathroom. Video showed that a corrections officer conducted proper rounds of the housing area every half hour from 3:00 am to 5:00 am.

The medical examiner determined the cause of death to be a seizure disorder of unknown etiology and that hypertensive and atherosclerotic cardiovascular disease was a contributing factor.

Mr. Pines's medical records show that he had had seizures on several occasions prior to February 4, 2023. On August 11, 2022, he had a seizure and was transported to Bellevue Hospital; he returned to NIC the next day. On August 15, 2022, he had a seizure and fell, sustaining a head injury; he was taken to the hospital. Mr. Pines was prescribed Keppra for his seizures on August 23, 2022. Mr. Pines was treated for his head wound and headaches through January 2023; his Keppra prescription was renewed on November 22, 2022, and January 16, 2023. On January 18, 2023, Mr. Pines had a neurological examination and the doctor noted that he was stable "neurowise," and that his Keppra dose could be tapered in the future. Mr. Pines had a primary care visit the next day, the notes from which say he "always takes" his seizure medication.

Based on its assessment, OSI did not find reason to believe that a correction officer caused Mr. Pines's death.

Mr. Pines was Black and was 65 years old when he died.

Daniel Vinasco, March 22, 2023, Queens Detention Center (QDC), Queens County

On the evening of March 21, 2023, a driver on the Grand Central Parkway in Queens told NYPD officers that another car had collided with him and then crashed into the median. Officers arrived and saw Mr. Vinasco in the driver's seat of the crashed car. Officers from the Emergency Services Unit arrived and administered two doses of Narcan, which revived Mr. Vinasco. EMTs arrived and took Mr. Vinasco to a hospital; he was alert and talking in the ambulance. After blood tests and CT scans, he was discharged from the hospital and taken to a precinct stationhouse and then to QDC, which is staffed by officers of NYC DOC, for processing. Video showed that he was alert and walking under his own power. At 5:40 am another detainee told corrections officers that Mr. Vinasco was snoring and then seemed to stop breathing. Medical staff were notified and life saving measures were performed. Mr. Vinasco was taken to the hospital where he was pronounced dead.

The medical examiner found that Mr. Vinasco had died from an overdose of phencyclidine and fentanyl.

Based on its assessment, OSI did not find reason to believe that a corrections officer or a police officer had caused Mr. Vinasco's death.

Mr. Vinasco was white and was 27 years old when he died.

William Johnstone, July 15, 2023, GRVC, Rikers Island

On July 15, 2023, at 1:47 pm, after being off-post for an hour and 45 minutes, a corrections officer found Mr. Johnstone lying on the floor of his cell, unresponsive. A corrections officer administered Narcan and he and an incarcerated person performed CPR. Medical staff arrived and assumed Mr. Johnstone's care, and then EMS arrived and took Mr. Johnstone to a hospital, where he was pronounced dead at 3:50 p.m.

The medical examiner determined that Mr. Johnstone died of a heart attack caused by a blood clot in his heart, and underlying and longstanding hypertensive cardiovascular disease. The medical examiner told OSI that, because of the advanced state of Mr. Johnstone's heart disease, even prompt medical intervention would not likely have saved his life.

OSI asked the medical examiner, assuming an officer had found Mr. Johnstone unresponsive half an hour to an hour earlier than he had been found, whether the additional time would have made a difference in the attempt to save his life. He said Mr. Johnstone, prior to the final event, already had very substantial heart tissue death, that his heart issues had built up over time, and that there was evidence the blood clot had taken days if not weeks to form. The medical examiner said that in his opinion an hour or half hour was probably meaningless in view of how gravely ill Mr. Johnstone was.

Medical records show that Mr. Johnstone was placed in chronic care while at Rikers Island to monitor his hypertension and diabetes. In the days immediately preceding his death Mr. Johnstone's health began to decline. On July 8, 2023, he went to sick call complaining of pain; medical records show his vital signs were stable and that he was scheduled for a follow up sonogram, ultrasound, and labs. On July 10, 2023, Mr. Johnstone had blood drawn, on July 12, 2023 he had an ultrasound, on July 13, 2023 he had a sonogram, and on July 14, 2023 medical staff measured his vital signs, which were normal, and drew blood.

Based on its assessment, OSI did not find reason to believe that a corrections officer caused Mr. Johnstone's death.

The corrections officer who found Mr. Johnstone was suspended 30 days for leaving his post without the permission of a superior.

Mr. Johnstone was Black and was 47 years old when he died.

Donnie Ubiera, August 22, 2023, GRVC, Rikers Island

At 5:12 am on August 22, 2023, a corrections officer was performing a round, calling people to the morning meal, when he discovered Mr. Ubiera in his bed in his cell, unresponsive. The corrections officer called a medical emergency and he and other officers and responding medical personnel rendered aid, but efforts failed, and Mr. Ubiera was declared dead.

The medical examiner determined that Mr. Ubiera died of a methadone overdose. In an interview with OSI a medical examiner explained that because of the way the body absorbs methadone, it is unlikely that the administration of Narcan would have saved Mr. Ubiera's life.

Incarcerated people interviewed by NYC DOC investigators said that Mr. Ubiera had obtained and consumed methadone before he died, which is corroborated by video reviewed by OSI. Based on the degree of rigor and body temperature, it does not appear that Mr. Ubiera had been dead a long time before he was discovered. Video surveillance reviewed by OSI shows that corrections officers performed rounds as required, including pausing and looking into cells with a flashlight during overnight rounds.

Based on its assessment, OSI did not find reason to believe that an officer caused the death of Mr. Ubiera.

Mr. Ubiera was Hispanic and was 33 years old when he died.

Manish Kunwar, October 5, 2023, Eric M. Taylor Center (EMTC), Rikers Island

Mr. Kunwar entered Rikers Island on September 27, 2023. Among other medications, he was prescribed methadone. On the evening of October 4, 2023, Mr. Kunwar returned to his cell at 8:16 pm after having his blood drawn by medical staff. Video showed that corrections officers conducted rounds throughout the night, but on many occasions did not look into Mr. Kunwar's cell as required. Mr. Kunwar was found dead in his cell on October 5, 2023, at 5:41 am.

The medical examiner determined the cause of death to be an overdose of methadone. OSI interviewed the medical examiner, who said that the methadone in Mr. Kunwar's system was significantly greater than his prescribed dosage. The ME said that the toxicology report showed that Mr. Kunwar did not have time to metabolize this large dose of methadone prior to his death, which indicates that he died very quickly after ingesting it. In reviewing Mr. Kunwar's medical records, the ME noted that on the evening of October 4, 2023, at 7:40 pm Mr. Kunwar's blood was drawn and contained a methadone level consistent with his prescribed dosage. This led the ME to conclude that, after the blood draw, when Mr. Kunwar was alone in his cell, he ingested a significant amount of methadone, which killed him in a very short amount of time.

Based on its assessment, OSI did not find reason to believe that a corrections officer caused the death of Mr. Kunwar.

NYC DOC suspended the corrections officers and captain on duty the night Mr. Kunwar died for failure to conduct proper rounds.

Mr. Kunwar was South Asian and was 27 years old when he died.

6. RECOMMENDATIONS

Section 70-b directs OSI to include in the Annual Report recommendations for systemic or other reforms indicated by OSI's investigations. OSI has made a series of recommendations in its prior Annual Reports and continues to advocate for them. We add here information from the past 12 months that continues to support them. In addition, we expand on our standing recommendation on responding to mental health crises.

Video

In OSI's view, passing a law requiring the use of video – body worn cameras and dashboard cameras for all police departments in the state, and video monitoring for all the prisons and jails in the state – would quickly and effectively help address the public's concerns about policing and corrections. Video enhances transparency, and transparency enhances trust. When policing is good, video will show that. When policing is not good, video will be the key to

a meaningful response, including more reliable investigations and, as appropriate, improvements in policies and training, well-founded disciplinary decisions, and, in the most serious cases, criminal charges.

With regard to video, OSI has recommended the following in previous Annual Reports:²¹

- that the state require by law that all police departments equip their members with body worn cameras and dashboard cameras
- that the state require by law that video be used in every situation in which a police officer is likely to interact with the public, with any exceptions to be narrowly defined on the basis of clear security or privacy needs
- that the state require by law that all prisons and jails be equipped with video surveillance, and
- that the state provide the funding and other assistance smaller police and corrections agencies may need for video purchase, implementation, and training.

OSI's experience in the past 12 months strongly supports the continued need for this kind of legislation.

- There are police departments that do not equip officers with body-worn cameras²²
- There are police departments that exempt certain officers from using body-worn cameras in situations that are likely to produce interactions with the public²³
- Many of the state's jails and prisons do not have meaningful video monitoring.²⁴

²¹ Please see the prior recommendations about requiring use of video at these links: [2023 Annual Report](#), [2022 Annual Report](#), and [2021 Annual Report](#).

²² For example, the completed investigation concerning the Catskill Police Department in the Jason Jones case, summarized above in Section 4, and the in-progress investigations concerning the Johnstown Police Department in the Nathan Wood case, September 17, 2023; the Hamburg Police Department in the Lisa Haight case, February 2, 2024; and, reportedly because of a changeover in equipment, the Orchard Park Police Department in the James Cushman case, August 30, 2024, all of which are listed in the [data tables](#).

²³ For example, NYPD in the Kyle Lockett, Billy Lee, and Manuel Beras Medina cases, summarized above in Section 4, and NYPD in the Devon Allen case, April 30, 2024, which is an investigation in progress and listed in the data tables. Although police departments will exempt particular kinds of officers or assignments from their usual BWC requirements based on security or privacy considerations, there is inconsistency across the state, and, in some cases, the exemptions do not seem well founded. See for example OSI's summary of the [Roger Lynch](#) case in the 2023 Annual Report.

²⁴ Most prominently, the Sing Sing Correctional Facility, in Westchester County.

People in Crisis – Expanded Recommendation

OSI recommended in previous Annual Reports that the state improve its legal requirements for training police officers in crisis intervention, coupled with state funding for any agency that cannot otherwise pay for the improved level of training.²⁵

OSI's experience in the past 12 months strongly indicates the continuing need for better training to address people in crisis. Although OSI's members are not mental health professionals, we believe that the persons who died in the following cases were probably experiencing a mental health crisis (in some instances drug or alcohol related) when the incidents occurred: Osiris Mercado, Jason Jones, Raul Hardy, Michael Nieves, Jarrel Garris, Azer Ben Zitun, "CW" (a minor), Michael Dotel, and Edward Holmes. Making this observation does not mean that the officers in these cases were not justified in their actions under New York law, or that they committed crimes, or that better training would necessarily have changed the outcome of any specific encounter. OSI does believe, however, that better training would increase the odds of preserving life in law enforcement confrontations involving mental health crises.

OSI now expands this standing recommendation to recommend better training in tactical responses when dealing with a person in crisis, and better training in the use of discretion before deciding to go "hands on" with a person in crisis. The two cases summarized in this Report that highlight this need are Raul Hardy and Jarrel Garris (see full summaries above in Section 4).

Mr. Hardy made two 911 calls threatening to kill police. Because of these calls, his address and telephone number were known to the responding officers. However, before confronting him by taking up positions on the street directly in front of his house, no one from the police department attempted to call him and talk to him about his threats, or about whether he was armed, or about whether there were any other persons with him in his house and in danger, or about whether he might be willing to come out of his house without a gun and talk. And the supervising officer (a sergeant) in charge of the response to Mr. Hardy's house failed to create a tactical plan likely to reduce the risk of a poor outcome by creating conditions more conducive to negotiation, such as by keeping officers far from the house and in cover, closing the street to pedestrians and traffic, and designating a single, trained negotiator to speak with Mr. Hardy. Therefore, in its Investigation Report, OSI recommended that NYPD train its sergeants and lieutenants annually or bi-annually for situations in which they and members they command interact with people who may be in a mental health crisis. OSI said the training should include devising and following effective tactical plans, de-escalation, and firearms

²⁵ Please see the prior recommendations about addressing mental health crises at these links: [2022 Annual Report](#), and [2021 Annual Report](#).

deployment, and should be based on real world scenarios. The goal should be to preserve life whenever possible.

Mr. Garris ate fruit in a store without paying for it. He was unarmed and had not acted violently in the store. Two officers attempted to talk to him when he left the store, but a third decided to physically restrain him, which was when a struggle with fatal consequences ensued. Not every infraction of the law requires a physical arrest, and better training in when to refrain from physical contact, could, in some cases, save lives. Therefore, in its Investigation Report, OSI recommended that NRPD's training and policies make clear that officers have discretion to use physical force, or to refrain from using physical force, when attempting to obtain the compliance of a subject in response to a report of a petty, nonviolent offense. OSI said that the decision to use physical force to obtain compliance for a petty offense, particularly where mental health may be a factor in noncompliance, should be made cautiously and should be based on objective criteria.

OSI notes that cases described in past Annual Reports also illustrated the need for better training in tactics and in the use of discretion; see, for example, the reports concerning Jeffrey McClure and Judson Albahm.²⁶

Suicide and Overdose Prevention in Jails and Prisons

OSI recommended in a prior Annual Report a series of steps to improve prevention of suicide and overdose deaths in the state's jails and prisons,²⁷ and our updated data analysis continues to support adoption of these steps.

Based on the data set forth in Section 7 below, the number of suicides in the state's jails and prisons has increased since we made these recommendations, from 27 in the 2022 data year to 29 in the 2023 data year and to 36 in the 2024 data year. On this basis, the current suicide rate in the state's jails and prisons (72 per 100,000) is significantly higher than the last full-year rate reported for the male population of the United States (23.0 per 100,000 in 2022).²⁸

The number of overdose deaths in the state's jails and prisons has dipped slightly since we made these recommendations, from 31 in the 2022 data year to 24 in the 2023 data year

²⁶ Report: [Jeffrey McClure](#), Report: [Judson Albahm](#)

²⁷ [2022 Annual Report](#).

²⁸ The New York State Commission of Correction reports the August 2024 population of the state's local jails (county jails and NYC DOC facilities) as 16,762, [NYSCOC Report](#), and the New York State Department of Corrections and Community Supervision reports the August population of the state prisons as 33,589, [DOCCS Fact Sheet September 2024](#), for a total population of 50,351. Suicide data for the United States in 2022 are here: <https://www.cdc.gov/suicide/facts/data.html>. According to the CDC website, suicide data for 2023 are provisional at this time.

and to 29 in the 2024 data year.²⁹ However, the current rate, 58 per 100,000, remains significantly higher than the current projected annual overdose death rate in the United States of 30 per 100,000.³⁰

Portable Breath Tests for Officers Involved in Collisions

OSI recommended in the last Annual Report that police officers be held to the same standards as civilians when it comes to protocols following a serious motor vehicle collision and be breath-tested as quickly as possible following an incident.³¹ OSI's experience in the last 12 months confirms the continued need for this recommendation, as shown in the cases of Miguel Romero (breath test delayed two hours) and Morris Sprachman (no breath test administered), summarized above in Section 4.

7. OSI'S DATA

Section 70-b requires that, for each matter investigated, OSI's Annual Report state the county where the incident occurred and racial, ethnic, age, gender, and other demographic information for persons involved. This Section of the Report discusses selected data from the 12 months since OSI's last Annual Report.

Notifications OSI Received, Current Year and Prior Years

The [data tables](#) on OSI's website list every incident of which OSI has been notified from April 1, 2021, the effective date of Section 70-b, through August 31, 2024, the end of OSI's most recent data year. The data include the date of the incident, the name and demographic information of the person who died, the county in which the incident occurred, the police or corrections agency involved, and the status of the matter. If the status of a matter is "closed," the tables say whether it was closed because: there was no death; there was no defined officer; OSI did not find that an officer caused the death; OSI issued an Investigation Report; or OSI obtained an indictment. If the status of a matter is "open," the tables say whether the

²⁹ The overdose number for the 2023 data year reported here is higher than the same number reported in last year's Annual Report, as OSI has, since the last Report, received additional final autopsy reports, which raised the number.

³⁰ According to an article published September 21, 2024, in the New York Times, overdose deaths in the United States have declined. The article reports that the preliminary numbers from the Centers for Disease Control predict 101,000 overdose deaths in the United States for the 12 months ended April 2024 (the actual number of overdose deaths reported so far for that 12-month period was 97,309). <https://www.nytimes.com/2024/09/21/us/politics/drug-overdose-deaths-decrease.html?smid=nytcore-ios-share&referringSource=articleShare&ngrp=mn&pvid=F8CC80C0-5670-4869-8B50-B5EA881D8FCB> According to the Census Bureau, the population of the United States on April 1, 2024, was 336 million. https://www.census.gov/popclock/embed.php?component=pop_on_date&date=20240401). As OSI calculates it, this gives an overall United States rate of overdose deaths of 30 per 100,000.

³¹ Please see the prior recommendation about portable breath tests at this link: [2023 Annual Report](#).

matter is “pending preliminary assessment” (meaning causation is not yet clear), or “pending investigation” (meaning it is clear that an officer caused the death, but OSI has not yet determined whether to present evidence to a grand jury).

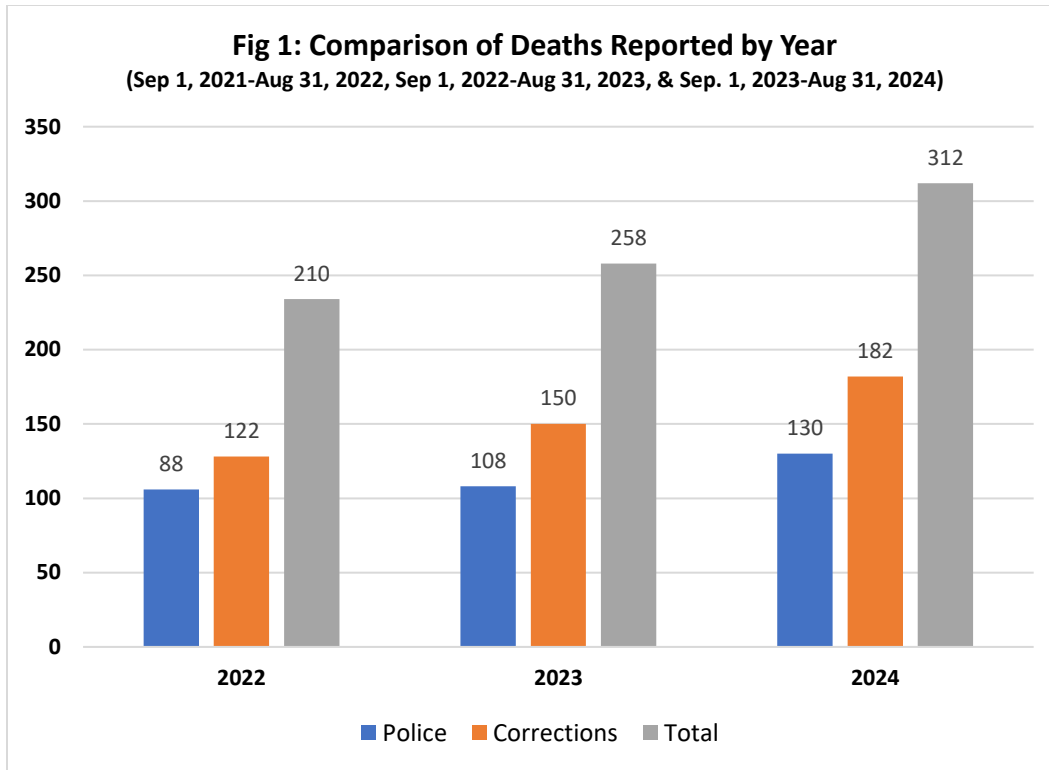
In the 12-month period ended August 31, 2024, agencies around the state notified OSI of 340 incidents potentially coming within Section 70-b, a substantial increase over prior years. The increase from 2022 to 2024 in overall reports to OSI was 45%. Of the 234 incidents reported to OSI in the 2022 data year, 5 remain open. Of the 280 incidents reported to OSI in the 2023 data year, 29 remain open. And of the 340 incidents reported to OSI in the 2024 data year, 210 remain open.

Of the 340 reported incidents in the 2024 data year, 25 did not result in a death and three did not involve a defined officer, leaving 312 *net incidents*. The number of net incidents reported to OSI increased 49% from 2022 to 2024.

All data discussed from this point on will be based on *net incidents*.

Of the 312 net incidents in the 2024 data year, 182 were incidents in jails and prisons and 130³² were incidents involving police officers. See Figure 1 for a comparison of overall net incidents in the three data years.

³² Two Police incidents from 2022 and early 2023 were not reported until this year. These incidents are included in the 2024 total.



Police Shootings

Of 130 net incidents involving police officers in the 2024 data year, 32 were shootings, but one was a murder suicide, leaving 31 net shootings. See Figures 2a through 5 for comparisons of net shootings in the current and prior data years, broken down by the gender, ethnicity, and age of the decedent, and whether the decedent was armed or unarmed.

Fig 2a: Shooting Deaths by Race
(22 incidents, Sep 1, 2021-Aug 31, 2022)

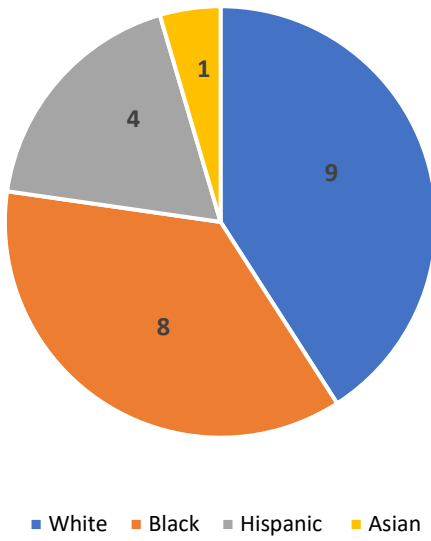


Fig 2b: Shooting Deaths by Race
(20 incidents, Sep 1, 2022-Aug 31, 2023)

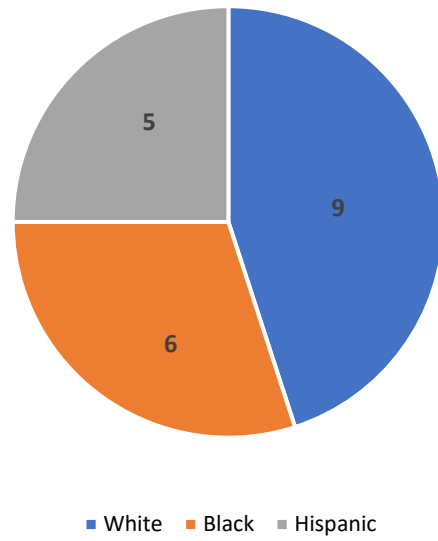
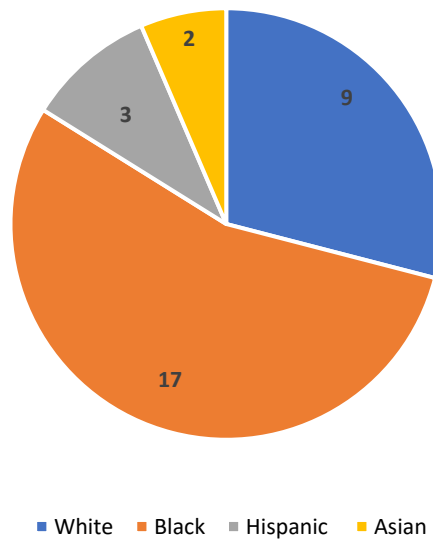
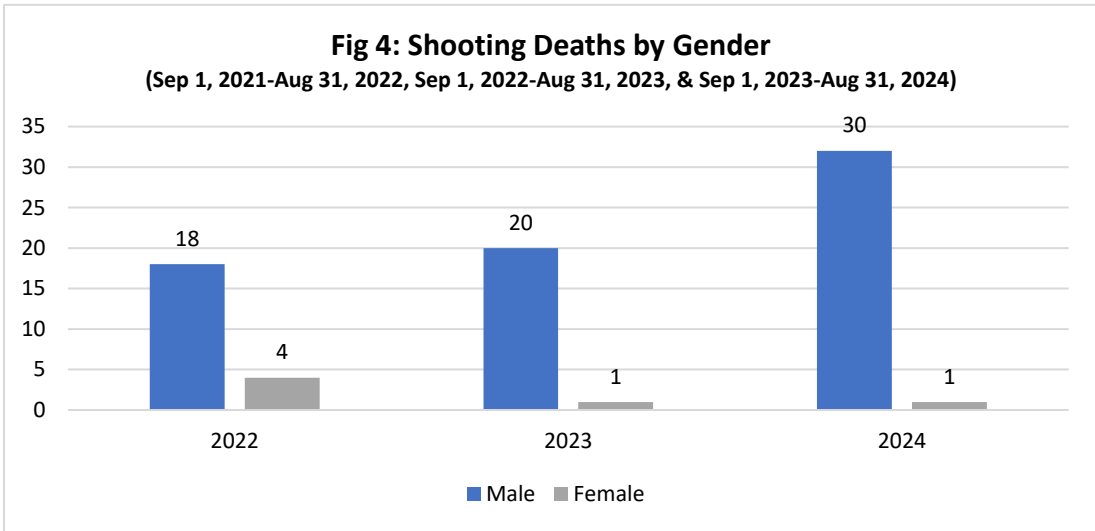
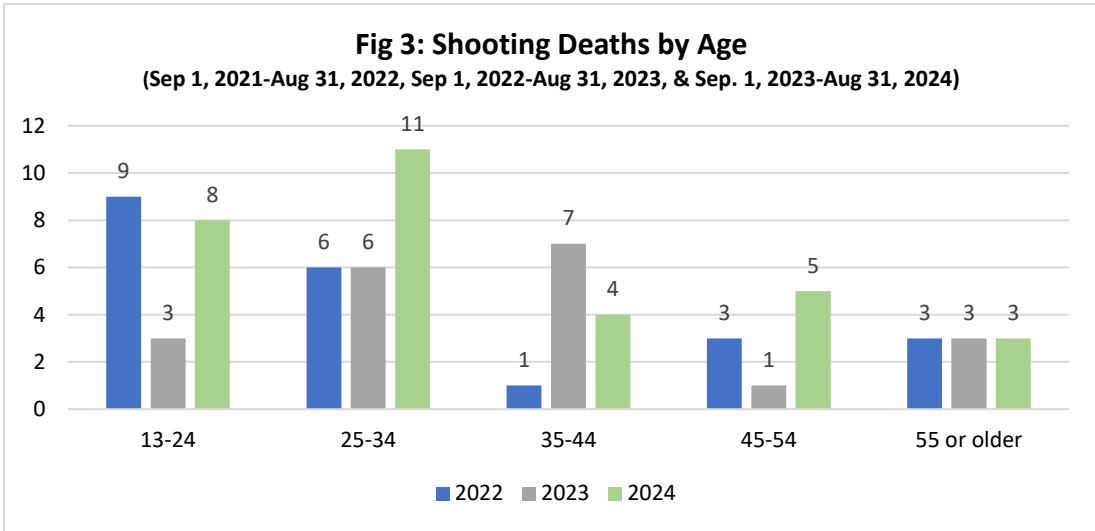
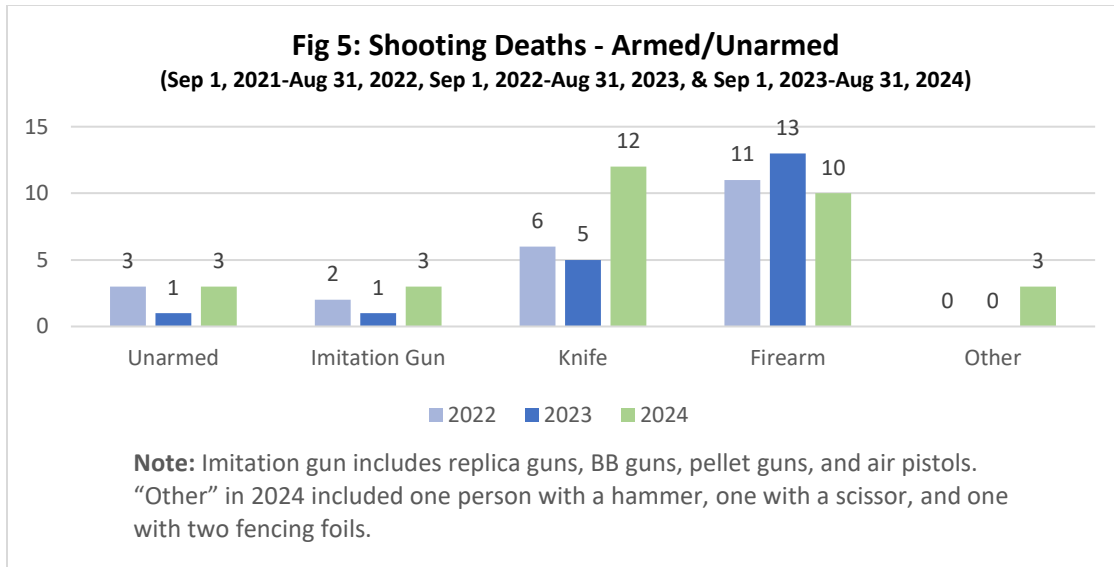


Fig 2c: Shooting Deaths by Race
(31 incidents, Sep 1, 2023-Aug 31, 2024)







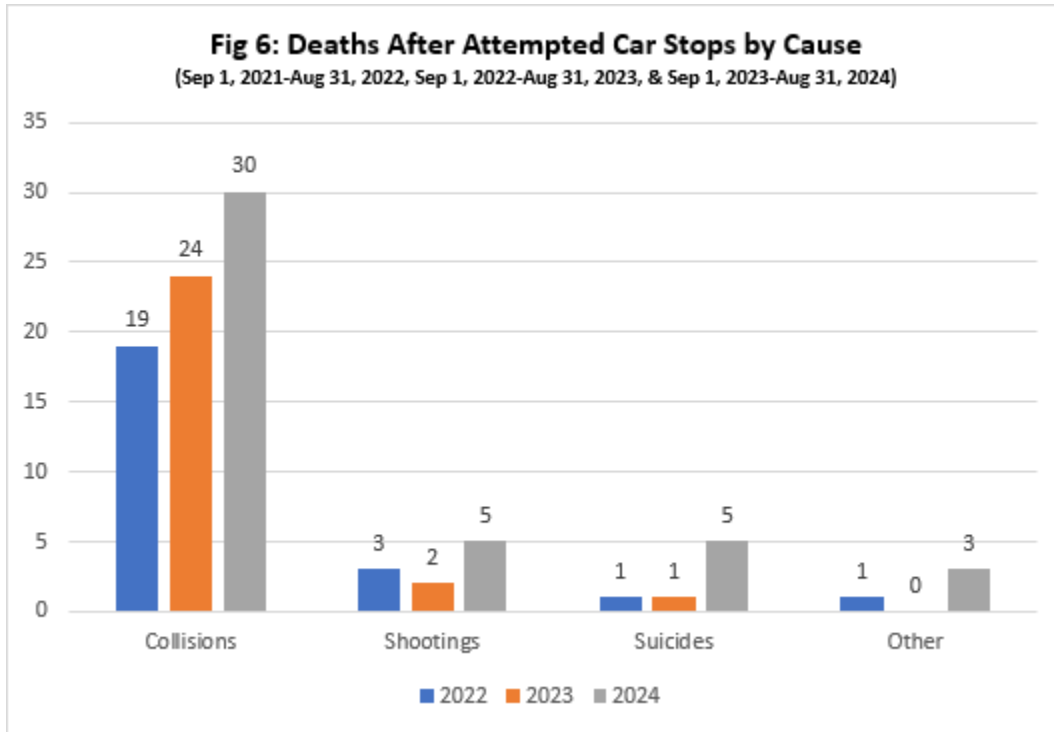
Motor Vehicle Incidents

Incidents Following Attempted Car Stops

Of the 130 net incidents involving police officers in the 2024 data year, 43 were related to attempted car stops. In 30 of those 43 incidents, the driver of the car the officer attempted to stop fled and caused a fatal collision – by killing themselves or another occupant of their car, or by killing an occupant of another car, or by killing a pedestrian.³³ In 5 of the 43 incidents, the attempted car stop led to a shooting in which an officer killed an occupant of the car the officer attempted to stop; in 5 of the 43 incidents, an occupant of the car the officer attempted to stop committed suicide;³⁴ and in 3 of the 43 incidents, death resulted in another way. These data, and the comparable data from the 2022 and 2023 data years, are shown in Figure 6 below:

³³ With regard to the civilian drivers who flee traffic stops and cause deaths, OSI “carves out” jurisdiction over them to the relevant District Attorney, under Paragraph 4 of Section 70-b.

³⁴ In one of the suicide cases in the 2024 data year the civilian driver fled the attempted car stop. After further pursuit, the civilian and the officer parked their cars and got out. The civilian fired a gun at the officer and the officer fired back. The ME determined that the driver died from a self-inflicted wound and that one of the shots from the officer wounded, but did not cause the death of, the civilian driver. Therefore, OSI counts this case as a suicide and not a shooting. Separately, two of the suicides from 2024 began when officers responded to calls concerning suicidal persons and were attempting to locate and aid those persons.



Notably, the overall number of fatal incidents following attempted car stops has increased over the three data years, from 24 to 27 to 43, a 78% increase from 2022 to 2024.

In data year 2022, one of the shooting incidents led to the indictment in Erie County, which resulted in an acquittal after trial, as summarized above in Section 2. The other two shooting incidents resulted in Investigation Reports – the report concerning Malick Williams, summarized above in Section 4, and the report concerning Brian Astarita, summarized in OSI’s 2023 Annual Report. In the 2023 data year, the shooting of Daniel Legler resulted in an Investigation Report, summarized above in Section 4; the other shooting incident is under investigation. In the 2024 data year, the five shooting incidents (one of which resulted in two deaths) are under investigation.

Incidents in which Officer-Drivers Caused Deaths

In a separate category are incidents in which officer-drivers, on duty or off duty, were directly involved in collisions that caused the death of a pedestrian or the driver or occupant of a car. These collisions occurred in many different ways, and the fact of a fatal collision does not imply that an officer committed a crime or was otherwise at fault.

Of the 88 net incidents involving police officers in the 2022 data year, there were four incidents in which officer-drivers were involved in collisions that caused the deaths of pedestrians or drivers or occupants of cars, all of which resulted in Investigation Reports.³⁵

Of the 108 incidents involving police officers in the 2023 data year, there were 11 incidents in which officer-drivers were involved in collisions that caused the deaths of pedestrians or the drivers or occupants of cars.³⁶ To date, OSI has published Investigation Reports for two of those incidents – Miguel Romero and Morris Sprachman, summarized above in Section 4 – and has obtained an indictment against the officer-driver in one other incident – the indictment of Tyler Paul, summarized above in Section 3. The other incidents remain under investigation.³⁷

Of the 130 incidents involving police officers in the 2024 data year, there were eight incidents in which officer-drivers were involved in collisions that caused the deaths of pedestrians or the drivers or occupants of cars. These incidents remain under investigation.

In New York, under VTL 1104 and case law, as described above, officer-drivers responding to emergencies may exceed speed limits and violate red lights, but remain responsible for their actions if they are reckless. In May 2024 a bill was introduced in the state Senate to address training of officer-drivers. The bill highlights that New York’s current training requirements are lower than those of other states, with only 21 hours of emergency vehicle operations training required for new officers and no mandated ongoing training. In contrast, California requires 40 hours of training for new police officers and four hours of refresher training every two years. The Senate bill would increase New York’s requirements to a minimum of 40 hours of initial training and four hours of in-service training.³⁸

Incidents in Jails and Prisons

Of the 182 deaths OSI investigated in the jails and prisons in the current data period

- 136 deaths were in facilities operated by the state Department of Corrections and Community Supervision (DOCCS)
- 6 were in facilities operated by NYC DOC, and

³⁵ [Amos Domfeh](#), [Wesley Soper](#), [Chatuma Crawford](#), and [Ronald Smith](#).

³⁶ One of the incidents counted in the 2023 data year as an officer-driver causing the death of a person in a collision is also counted in the car-stop data in the previous subsection, because the collision occurred in the course of an attempted car stop.

³⁷ One of the collisions in the 2023 data was notified to OSI a year after it occurred, and another collision in that data year was never notified to OSI – OSI learned of it through a news item.

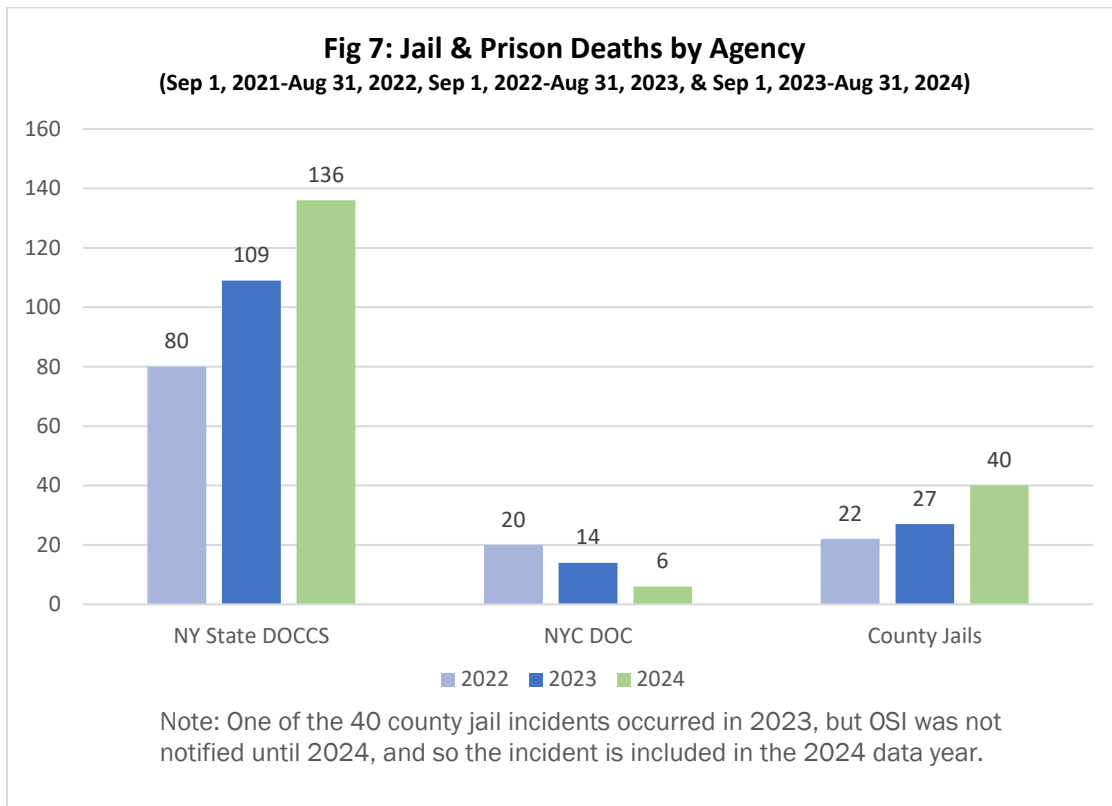
³⁸ More information about Senate Bill S9720 can be found here: <https://www.nysenate.gov/legislation/bills/2023/S9720>

- 40 were in county jails.³⁹

See Figures 7 through 10 for comparisons of jail and prison cases for the current year and the prior years, broken down by the involved agency, and by ethnicity, gender, and cause of death.⁴⁰

As Figure 7 shows:

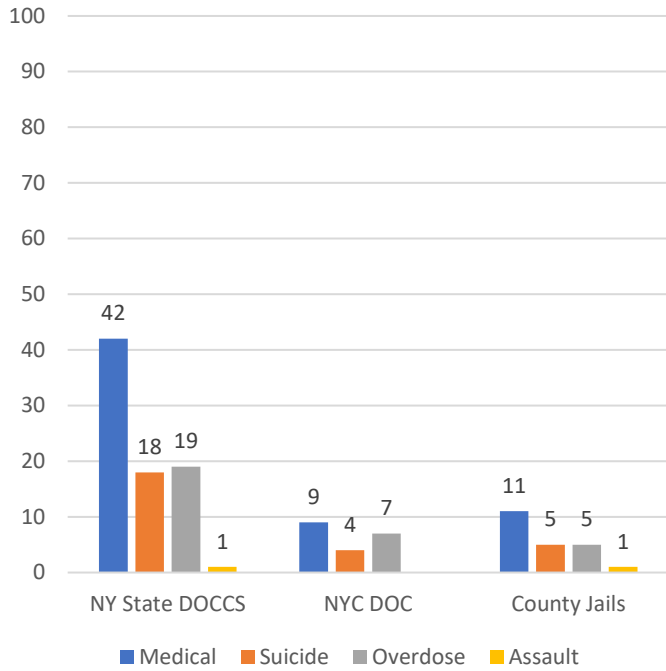
- Deaths in the DOCCS system have steadily increased, from 80 to 109 to 136 over OSI's three full data years, a 70% increase from 2022 to 2024.
- Deaths in the county jails have steadily increased, from 20 to 27 to 40 over OSI's three full data years, a 100% increase from 2022 to 2024, and
- Deaths of people in the custody of NYC DOC have steadily fallen, from 20 to 14 to 6 over OSI's three full data years, a 70% decrease from 2022 to 2024.



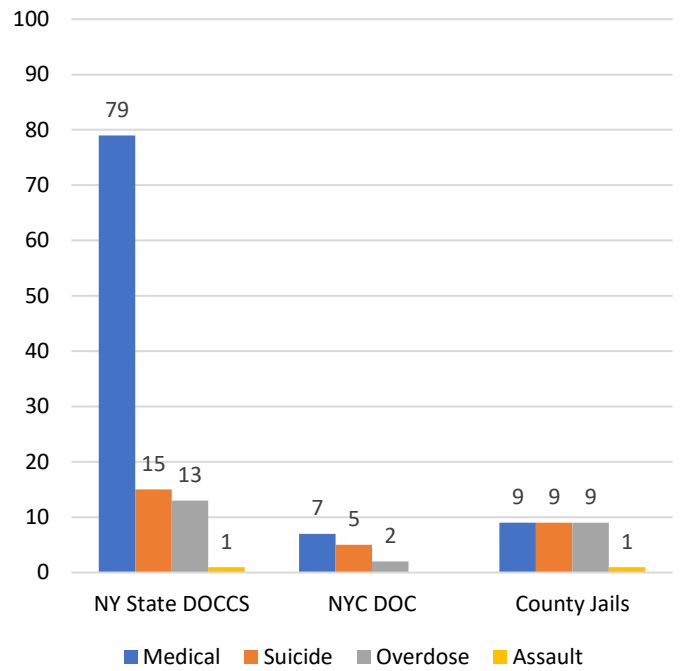
³⁹ One of the 40 county jail incidents occurred in 2023, however, OSI was not notified until 2024, therefore, the incident is included in the 2024 data year.

⁴⁰ Figs. 8a, 8b, and 8c include deaths by assault. OSI's assessments to date indicate that in those cases one or more incarcerated persons assaulted another, not that a corrections officer assaulted an incarcerated person. In Figure 8C, four of the deaths counted as overdoses are, at this time, suspected overdoses, because OSI awaits the final autopsy reports.

**Fig 8a: 2022 Jail & Prison Deaths by Cause
(122 incidents, Sep 1, 2021-Aug 31, 2022)**



**Fig 8b: 2023 Jail & Prison Deaths by Cause
(150 incidents, Sep 1, 2022-Aug 31, 2023)**



**Fig 8c: 2024 Jail & Prison Deaths by Cause
(182 incidents, Sep 1, 2023-Aug 31, 2024)**

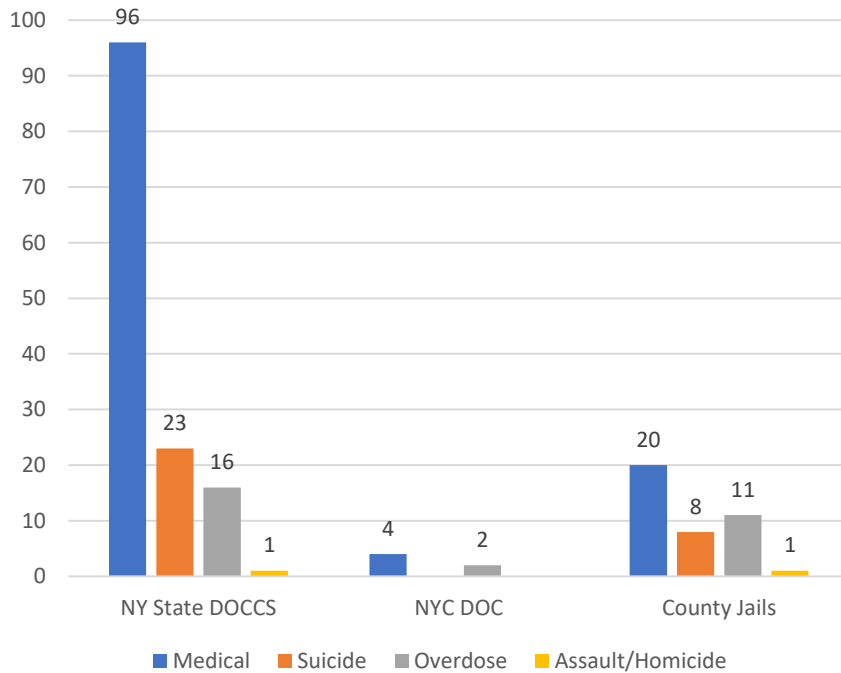
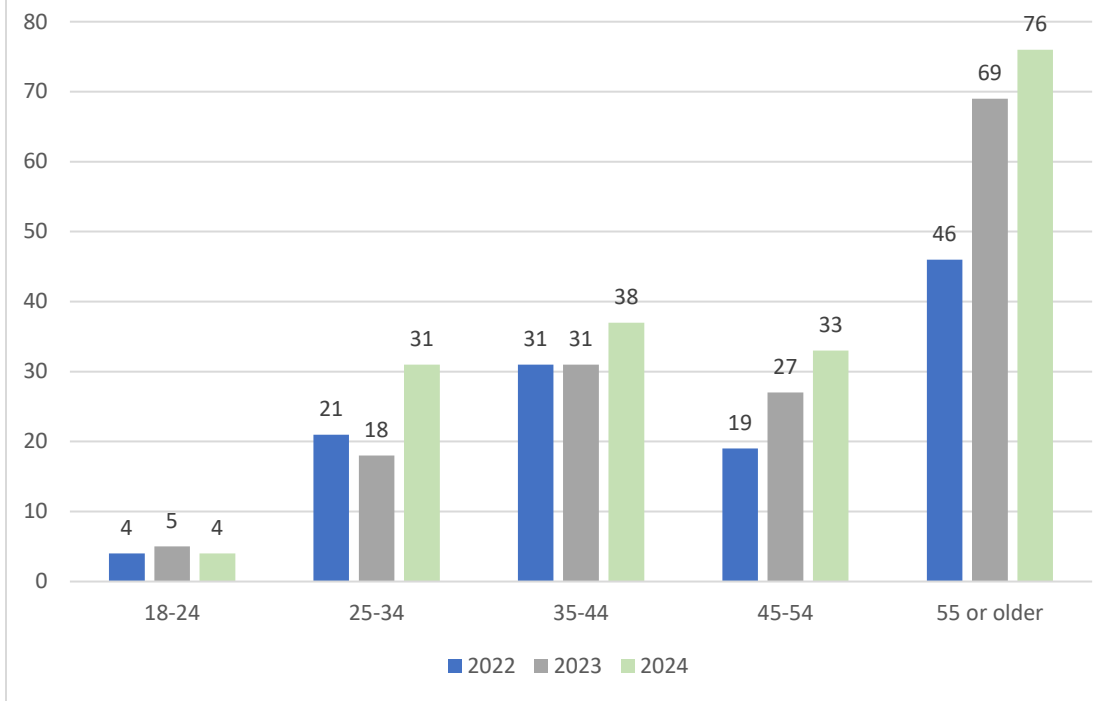
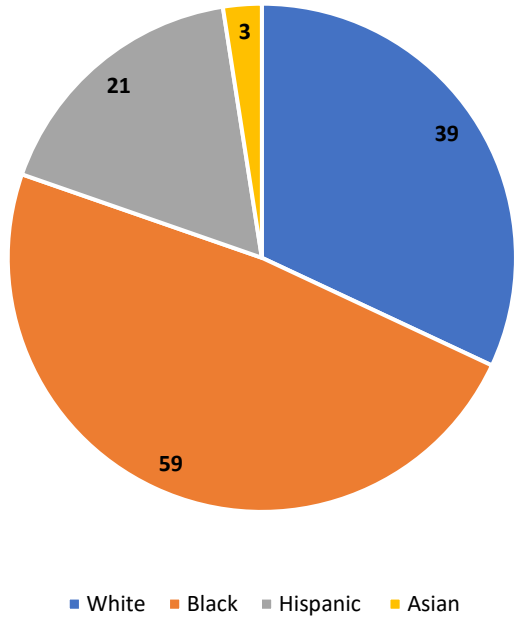


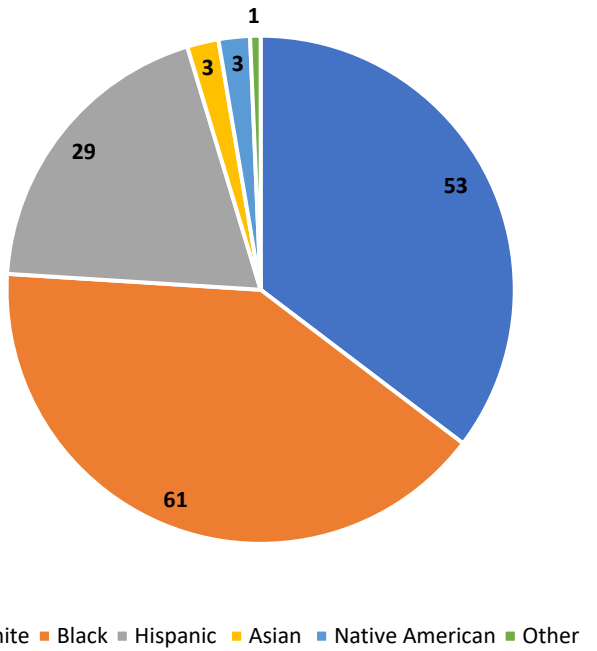
Fig 9: Jail & Prison Deaths by Age
(Sep 1, 2021-Aug 31, 2022, Sep 1, 2022-Aug 31, 2023, & Sep 1, 2023-Aug 31, 2024)



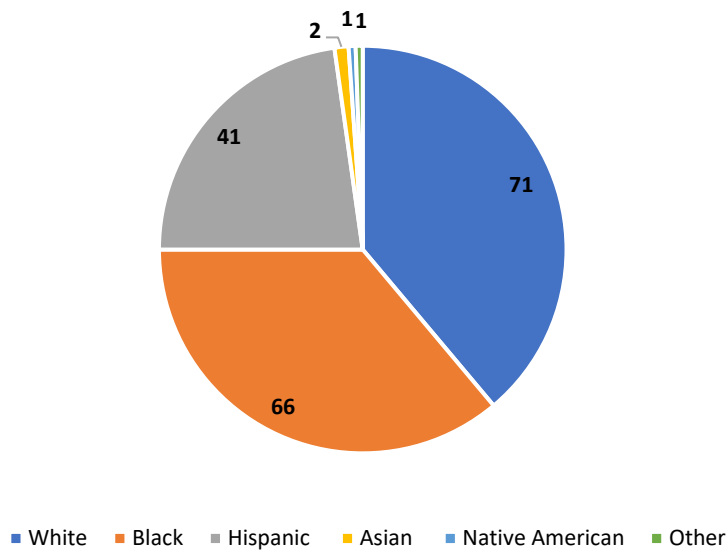
**Fig 10a: Jail & Prison Deaths by Race
(122 incidents, Sep 1, 2021-Aug 31, 2022)**



**Fig 10b: Jail & Prison Deaths by Race
(150 incidents, Sep 1, 2022-Aug 31, 2023)**



**Fig 10c: 2024 Jail & Prison Deaths by Race
(182 incidents, Sep 1, 2023-Aug 31, 2024)**



October 1, 2024