New York State Office of the Attorney General

Office of Special Investigation

October 1, 2022

Second Annual Report Pursuant to Executive Law Section 70-b

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1. Introduction

This is the second annual report of the New York Attorney General's Office of Special Investigation ("OSI"), issued October 1, 2022, pursuant to Paragraph 7 of New York Executive Law Section 70-b ("Section 70-b"). The first annual report, issued October 1, 2021, can be found here: 2021 OSI Annual Report.

Effective April 1, 2021, Section 70-b directs OSI to investigate and, if warranted, to prosecute any criminal offense that a police officer or a peace officer, as defined, may have committed in connection with any incident in which such officer caused the death of a person by an act or omission, or in which there is a question whether such officer caused the death.[1]

Section 70-b makes no distinction between on-duty and off-duty officers, nor 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).

As of the date of this report, the members of OSI include 18 assistant attorneys general, including supervisors, in eight offices around the state (Manhattan, Nassau and Westchester Counties, Albany, Rochester, Binghamton, Syracuse, and Buffalo) and 15 detectives, including supervisors, from the Attorney General's Investigation Division assigned to work with OSI. In addition, OSI has a policy analyst, who focuses on OSI's data and recommendations (including for this report); 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; and family liaisons and a community liaison, who, together with attorneys and detectives, attend meetings with family members of persons who have died in law enforcement encounters and with members of communities affected by these incidents.

Assistant attorneys general in OSI are currently prosecuting four indictments, each of which charges an officer with Murder in the Second Degree and other crimes. See Section 2 for a summary of the indictments.

[1] Under Executive Order 147, issued in 2015 and in effect through March 31, 2021, the Attorney General had 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.

In the past 12 months OSI has issued 16 public reports about incidents in which OSI found that an officer caused a death but determined that criminal charges were not warranted. Such reports are required by Paragraph 6 of Section 70-b. See Section 3 for a summary of published reports.

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.[2]

OSI investigates deaths of persons in the custody of corrections departments around the state. These include deaths of persons in the custody of the New York City Department of Correction ("NYC DOC") at Rikers Island, the jail complex operated by NYC DOC, and elsewhere. See Section 4 for summaries of the investigations OSI has completed to date of NYC DOC matters.

Section 70-b authorizes OSI to make recommendations based on its investigative work. Please see Section 5 for a series of recommendations.

On an annual basis, OSI receives notification of more than 200 incidents in which a death was caused by an officer, or in which there is a question whether a death was caused by an officer. More than half of those notifications concern incidents in jails and prisons. See Section 6 and the Tables in the Appendix for an analysis of OSI's data, including complete data for the 12-month period ended August 31, 2022 (Table A), updates on the data reported in the previous OSI annual report (Table B), and data on cases relating to persons in the custody of the New York City Department of Correction (Table C).

In the 18 months since Section 70-b went into effect, the most consistent themes in the cases investigated by OSI are mental illness and drug use. In jails and prisons, persons are dying by suicide and from drug overdoses (see Sections 5.4 and 5.5). On the street, many police responses are initiated because a person is in a mental health crisis (See Section 3, reports on the deaths of Jeffrey McClure, George Zapantis, Judson Albahm, Jess Bonsignore, Christopher Van Kleeck, Brandi Baida, and Allison Lakie; and see Section 6, subsection on "Police Shootings and Mental Health Crises"). Therefore it is critical that the state, corrections agencies in the state, and police agencies in the state, thoughtfully design, adequately fund, and effectively implement programs to reduce the risk of death due to mental illness and drug use, as described in Section 5, Recommendations.

[2] Pursuant to 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, Section 3, for an explanation of the defense of justification and the prosecutor's burden to disprove the defense of justification beyond a reasonable doubt in cases where the defense is raised.

2. Summary of Indictments

Members of OSI are prosecuting the four indicted cases described below. Indictments are accusations. Every defendant is presumed innocent unless and until a jury determines that the evidence proves the defendant's guilt beyond a reasonable doubt.

People v. Errick Allen

The indictment charges Errick Allen, who was an officer of the New York City Police Department ("NYPD"), with Murder in the Second Degree, Manslaughter in the First Degree, and Menacing, for using his service weapon to threaten and then to kill Christopher Curro on May 12, 2020, in Nassau County.[4]

Allen and Curro lived in Nassau County and were longtime friends, but text messages indicated they were in a dispute. On May 12, 2020, shortly after 8:00 pm, in a residential neighborhood in Farmingdale, Allen, who was off-duty, allegedly killed Curro by shooting him five times at close range, including twice in the head, with his NYPD service weapon. Curro was unarmed. Allen initially fled the scene but returned later in the evening.

The indictment is pending in Nassau County Court, in Mineola. A trial date has not been set. The indictment is at this link: Errick Allen Indictment. Christopher Curro was white. At the time of the incident he was 25 years old. NYPD terminated Allen after the incident.[5]

People v. Christopher Baldner

The indictment charges Christopher Baldner, who was a trooper in the New York State Police ("NYSP"), with Murder in the Second Degree, Manslaughter in the Second Degree, and Reckless Endangerment in the First Degree, for using 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.[6]

The indictment also charges that, in September of 2019, Baldner similarly endangered the lives of a driver and his passengers by using his police vehicle to ram their car.

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[4] This incident arose prior to the effective date of Section 70-b, and OSI is therefore prosecuting the matter pursuant to Executive Order 147; see Footnote 1.

[5] 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.

[6] This incident arose 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 December 22, 2020, at about 11:40 pm, Tristan 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. Trooper Baldner was on patrol in his marked NYSP vehicle and stopped the Goods family car for speeding. During the stop, Baldner pepper sprayed Mr. Goods and Mr. Goods sped away. During the pursuit, when both cars were traveling over 100 miles per hour, Baldner allegedly deliberately rammed his police vehicle into the rear of the Goods car, twice. Upon the second strike, the Goods car flipped over and came to rest upside down in the median. The impact ejected Monica Goods from the car, killing her.

Christopher Baldner was not equipped with body-worn camera or dashboard camera, and no other video captured the incident.

The indictment is pending in Ulster County Court, in Kingston. A trial date has not been set. The indictment is at this link: Christopher Baldner Indictment. Monica Goods was Black. At the time of the incident she was 11 years old. Christopher Baldner has retired from NYSP.

People v. Yvonne Wu

The indictment charges Yvonne Wu, who was an officer in the NYPD, with Murder in the First and Second Degrees, Attempted Murder in the First and Second Degrees, Assault in the First Degree, and Burglary in the First Degree, for using her service weapon to shoot and kill Jamie Liang, and to shoot and wound Jenny Li, on October 13, 2021, in Kings County.

On October 13, 2021, Yvonne Wu, while off-duty, went to the Brooklyn home of Jenny Li, whom she knew, and allegedly forced Jenny Li to let her inside, where Wu used her service weapon to shoot and kill Jamie Liang, a friend of Li's, and to shoot and wound Li.

The indictment is pending in Kings County Supreme Court, in Brooklyn. A trial date has not been set. The indictment is at this link: Yvonne Wu Indictment. Jamie Liang was Asian. At the time of the incident she was 24 years old. NYPD terminated Wu after the incident.

People v. Dion Middleton

The indictment charges Dion Middleton, an officer in NYC DOC, with Murder in the Second Degree, and Manslaughter in the First and Second Degrees, for using 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 and Morris Avenue in the Bronx, Middleton allegedly shot and killed Raymond Chaluisant, who was a passenger in a car. Middleton left the scene without reporting the incident and went to work later that morning at the firing range where he worked as a firearms instructor for NYC DOC. He was at the range when he was apprehended by NYPD in the afternoon of the same day.

The indictment is pending in Bronx County Supreme Court. A trial date has not been set. The indictment is at this link: Dion Middleton Indictment. Raymond Chaluisant was Hispanic; at the time of the incident he was 18 years old. NYC DOC suspended Middleton, pending a disciplinary process.

3. Reports Released by OSI in the Past 12 Months

When OSI determines not to seek charges in an incident in which a police officer or peace officer caused the death of a person, Section 70-b, Paragraph 6, requires OSI to publish a report detailing the investigation and explaining why OSI declined to present evidence to a grand jury. That Paragraph also authorizes OSI to include in the published report recommendations for systemic or other reforms arising from the investigation.

When OSI concludes an investigation, and prior to issuing a report, the OSI attorney and detective assigned to the investigation, as well as a family liaison and, often, the community liaison meet with family members of the person who died (and their counsel, if they wish) to explain the steps OSI took in the investigation and OSI's investigative findings and legal analysis. Members of OSI also meet with family members earlier in the course of an investigation to explain the investigative process and to show video of the incident to family members, in cases where such video exists.

OSI's Investigations

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

- interviews of
    - police officers and corrections officers;
    - civilian bystander witnesses and jail and prison inmate witnesses;
    - the medical examiner who performed the autopsy;
    - the emergency medical responders, treating physicians, and responding jail and prison medical staff;
- and reviews of
    - officers' body-worn camera ("BWC") videos and dashboard camera ("dashcam") videos;
    - police and corrections departments' surveillance camera videos and data from gunshot detection technologies;
    - civilian videos from fixed security cameras and cell phones;
    - recorded 911 calls, dispatch transmissions, and officer-to-officer communications;
    - police departments' crime scene and other photographs, ballistics reports, and accident reconstruction reports;
    - police and corrections departments' incident reports and investigative reports;
    - medical records, including physical and mental health records;
    - autopsy reports and 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 Penal Law. As applied to OSI's cases, the basic idea underlying the law of justification is the right to defend oneself or another from wrongful physical force.

There are two provisions in Article 35 most 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; and Section 35.15 Subdivision 2(a)(ii)).[7]

An important difference between the general provision and the officer-specific provision concerns the duty to retreat. 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)(a). 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).

Under the Penal Law, justification is legally a "defense," Penal Law Section 35.00, not an "affirmative defense." 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). The burden of proof is often a critical factor in OSI's decision whether or not to seek criminal charges in a case.

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[7] The general provision, Section 35.15, reads in part as follows: "1. A person may … use physical force upon another person when and to the extent he or she reasonably believes such to be necessary to defend himself, herself or a third person from what he or she reasonably believes to be the use or imminent use of unlawful physical force by such other person…. 2. A person may not use deadly physical force upon another person under circumstances specified in subdivision one unless: (a) The actor reasonably believes that such other person is using or about to use deadly physical force. Even in such case, however, the actor may not use deadly physical force if he or she knows that with complete personal safety, to oneself and others he or she may avoid the necessity of so doing by retreating…."

The provision specific to police officers and peace officers, Section 35.30, reads in part as follows: "1. A police officer or a peace officer, in the course of effecting or attempting to effect an arrest, or of preventing or attempting to prevent the escape from custody, of a person whom he or she reasonably believes to have committed an offense, may use physical force when and to the extent he or she reasonably believes such to be necessary to effect the arrest, or to prevent the escape from custody, or in self-defense or to defend a third person from what he or she reasonably believes to be the use or imminent use of physical force; except that deadly physical force may be used for such purposes only when he or she reasonably believes that: … (c) … the use of deadly physical force is necessary to defend the police officer or peace officer or another person from what the officer reasonably believes to be the use or imminent use of deadly physical force."

Reports OSI Published in the Last 12 Months

The reports OSI has published in the past 12 months are summarized below.

Jeffrey McClure, June 7, 2020, Suffolk County.[8]

On the evening of June 7, 2020, members of the Suffolk County Police Department ("SCPD") went to the McClure house in East Northport after Jeffrey McClure's father called 911 to report that his son was "going berserk," under the influence of alcohol and drugs, experiencing a mental health crisis, and wielding a BB gun. When members of SCPD arrived, they found Jeffrey McClure in the living room of the house, holding what appeared to be a rifle. He pointed it at the officers and threatened to shoot them. The officers told Mr. McClure to put the weapon down, but he ran to the basement, where family members told officers a safe held other firearms. For several minutes officers pursued Mr. McClure through the house and back yard. Two officers were looking for Mr. McClure in the back yard when he appeared on the roof of the house, pointed the rifle at the officers, and threatened to kill them. One of the officers fired and struck Mr. McClure, who died of his wounds. When officers recovered the rifle from the roof, it was found to be an air rifle, not a firearm.

None of the officers who responded to the McClure house were equipped with BWCs.

OSI concluded a prosecutor would not be able to disprove beyond a reasonable doubt that the officers' actions were justified. The evidence was that the shooting officer reasonably believed his life and the life of the other officer in the back yard to be in danger.

OSI recommended that SCPD better prepare for such situations in the future, including training more officers to handle mental health crises and improving tactics and training for emergencies when multiple officers respond. OSI recommended that the County enhance its Behavioral Health Section and 911 Mental Health Call Diversion Program. And OSI urged SCPD to expedite its rollout of BWCs to all officers, detectives, and supervisors.

Jeffrey McClure was white. At the time of the incident he was 26 years old. The McClure report can be read here: Jeffrey McClure

George Zapantis, June 21, 2020, Queens County.[9]

On the evening of June 21, 2020, members of NYPD went to a multi-family house in Whitestone, Queens, after a bystander called 911, saying people were fighting and one of them had a gun. When officers arrived neighbors told them about an argument involving Mr. Zapantis, said no gun was involved, but did say Mr. Zapantis had a sword. Officers went to the door of Mr. Zapantis's ground-floor apartment in the multifamily house to try to speak to him. They saw through a window

[8] This case was investigated pursuant to Executive Order 147. See Footnote 1.
[9] This case was investigated pursuant to Executive Order 147. See Footnote 1.

that Mr. Zapantis was dressed in gladiator attire, including a helmet, shield, and sword, and called for the Emergency Services Unit, which includes trained negotiators, to respond. Although officers had a conversation with Mr. Zapantis through the closed door for some minutes in an effort at de-escalation, he suddenly broke through the door and began to fight with the officers, who in turn attempted to restrain him with handcuffs and subdue him with Tasers. During the struggle, Mr. Zapantis went limp and became unresponsive. Despite life-saving measures attempted at the scene, Mr. Zapantis was pronounced dead less than an hour later. The Medical Examiner determined the cause of Mr. Zapantis's death to be cardiac arrest due to dilated cardiomyopathy during physical restraint by police, including conducted electrical weapon (i.e., Taser) use.

The officers involved in the physical struggle with Mr. Zapantis wore BWCs, which captured the incident.

OSI concluded that a prosecutor would not be able to disprove beyond a reasonable doubt that the officers' conduct was justified: the evidence was that the officers used reasonable physical force, and not deadly physical force, in response to physical force used by Mr. Zapantis.

George Zapantis was white. At the time of the incident he was 29 years old. The Zapantis report can be read here: George Zapantis.

Judson Albahm, March 4, 2021, Onondaga County.[10]

On the afternoon of March 4, 2021, officers from NYSP, the DeWitt Police Department, and the Onondaga County Sheriff's Office responded to a 911 call from Judson Albahm's mother, seeking help in finding her son, who had driven away from her house after a mental health crisis team arrived for a previously scheduled evaluation. Officers found Judson on foot in the woods near the house and followed him for about 30 minutes, talking to him and frequently directing him to drop what appeared to be a black pistol in his hand. Some, but not all, of the responding officers were aware that Judson suffered from mental health issues and owned air guns, but a dispatcher had told other officers that 911 callers said Judson was carrying a handgun.

When Judson stopped his flight and pointed his gun at two officers who had not been told about Judson's air guns, they and other officers fired at Judson, who died of his wounds. Later, when Judson's gun was recovered, it was found to be an air gun, without any of the legally required markings to indicate it was not a firearm.

Although some of the officers involved in the pursuit had BWCs, none of the shooting officers had a BWC, and the shooting was audibly, but not visually, captured on BWCs.

[10] This case was investigated pursuant to Executive Order 147. See Footnote 1.

OSI concluded that a prosecutor would not be able to disprove beyond a reasonable doubt that the officers' actions were justified. Judson pointed what appeared to be a black handgun at pursuing officers, who fired at him after issuing warnings to drop the gun.

OSI recommended that the agencies involved better prepare to handle such situations, including by equipping all officers with body-worn cameras, and by establishing clear protocols when multiple agencies respond to an incident, so that they effectively share information and coordinate their response. OSI also recommended that New York clarify and strengthen its laws on imitation firearms, so that no imitation gun could be mistaken for a firearm.[11]
Judson Albahm was white and Middle Eastern. At the time of the incident he was 17 years old. The Albahm report can be read here: Judson Albahm.

Tyler Green, April 6, 2021, Otsego County.

Tyler Green and his partner were the parents of a boy just under two years old. On April 6, 2021, the partner, her sister, and the child were visiting Mr. Green at his house in the City of Oneonta. Because of violent threats being made by Mr. Green, the sister slipped away, drove to the Oneonta Police Department ("OPD"), and reported the threats to them. Two OPD officers, who received a dispatch that Mr. Green had threatened to stab his partner with a knife, went to the house. Upon arriving, the officers saw Mr. Green, his partner, and the child in the front yard. Mr. Green lunged at his partner with a knife and threatened to kill her. The officers drew their guns and shouted at Mr. Green to drop the knife. Mr. Green swung at his partner's leg with the knife, cutting her, swung the knife at the officers, grabbed his son by the leg, and began to swing the knife at his son. One of the officers fired at Mr. Green, who released the child. Mr. Green later died of his wounds.

The officers' BWCs captured the incident.

OSI concluded that a prosecutor would not be able to disprove beyond a reasonable doubt that the firing officer was justified in his use of deadly force, as Mr. Green was inches away from using a knife against the child, and only the officer's use of deadly physical force prevented him from doing so.

OSI recommended that New York change its law to align with every other state to permit air ambulances to provide blood to critically injured patients.[12] Although such authority would not have

[11] After the issuance of the Albahm report, the Legislature passed a law requiring all imitation guns to be made entirely of brightly colored or transparent material: NY State Senate Bill S687 (nysenate.gov). Also see tweet and letter from the Attorney General pushing for stronger standards on imitation firearms. Separately, after Judson's death, the Onondaga County legislature provided funding for the Sheriff's Office to equip its officers with BWCs; the Sheriff's Office implemented the BWC program months later: After years without body cameras, Onondaga County deputies now get the equipment - syracuse.com.

[12] The Green report was issued on December 3, 2021. On December 22, 2021, the governor signed a law permitting air ambulances to carry, distribute, and transfuse blood. See Public Health Law Section 3003-B.

saved Mr. Green's life, due to the gravity of his injuries, the inability of the air ambulance personnel to give him blood during a medevac flight brought this flawed law to OSI's attention.

Tyler Green was white. At the time of the incident he was 23 years old. The Green report can be read here: Tyler Green.

Mark Gaskill, May 14, 2021, Monroe County.

In the early morning hours of May 14, 2021, members of the Rochester Police Department ("RPD") received alerts of gunshot activity from ShotSpotter, an automated gunshot detection technology, and could see, on RPD's street surveillance video, that a possibly involved car was driving away from the site of the shooting. When the car pulled over a few minutes later and a few blocks away from the site of the shooting, RPD officers approached and spoke to the driver and passengers. When they asked Mr. Gaskill, the rear-seat passenger, for identification, he gave a false name and date of birth. When officers tried to open the car door nearest to Mr. Gaskill, they saw him draw a gun from his waistband. The officers backed away quickly and shouted at Mr. Gaskill to drop the gun. Mr. Gaskill opened the door and began to get out of the car. The officers shouted at him to show his hands, and then fired. Mr. Gaskill died of his wounds.

Later, police recovered a loaded semi-automatic pistol from the car, near Mr. Gaskill's seat, which ballistics testing showed was the same gun used to fire the shots detected by ShotSpotter.

The officers' BWCs captured the incident.

OSI concluded that a prosecutor would not be able to disprove beyond a reasonable doubt that the officers' actions were justified. Mr. Gaskill pulled out a gun and seemed about to advance on the officers, who were aware that the car Mr. Gaskill was in had minutes before been involved in a shooting.

Mark Gaskill was white. At the time of the incident he was 28 years old. The Gaskill report can be read here: Mark Gaskill.

Jesse Bonsignore, May 20, 2021.

On the evening of May 20, 2021, in Manorville, Suffolk County, a neighborhood resident called 911 and said there was a man sleeping in the back seat of a car parked across the road from the resident's house. An SCPD officer responded and saw the man, Jesse Bonsignore, sleeping in the back seat of the parked car as reported, and knocked on the window. Mr. Bonsignore awoke, began screaming, and threatened to kill the officer. The officer told Mr. Bonsignore to remain in the car and called for backup over the radio, but Mr. Bonsignore got out of the car. The officer tried to tell Mr. Bonsignore he was not in trouble, but Mr. Bonsignore again said he was going to kill the officer.

The officer noticed a folding knife on Mr. Bonsignore's belt, which was later recovered. The officer tried to handcuff Mr. Bonsignore to prevent him from using the knife, but Mr. Bonsignore resisted and pushed backward against the officer, and both fell to the ground. In the ensuing struggle, Mr. Bonsignore tried to grab his knife and then reached for the officer's gun. The officer tried to hold Mr. Bonsignore's arms and pulled his gun from its holster to prevent Mr. Bonsignore from taking control of the gun. Mr. Bonsignore grabbed the officer's gun hand, and the officer, fearing for his life, shot Mr. Bonsignore. OSI interviewed the resident and obtained security camera footage from his home; the statements and the video were consistent with the officer's account.

OSI concluded that a prosecutor would not be able to disprove beyond a reasonable doubt that the officer's actions were justified. Mr. Bonsignore reached for his knife, tried to take the officer's gun, and threatened to kill the officer.

The officer was not equipped with BWC, and his patrol car did not have a dashboard camera.

OSI reiterated its recommendation that SCPD accelerate its implementation of BWC (see above, regarding the recommendation in the McClure report).

Jesse Bonsignore was white. At the time of the incident he was 44 years old. The Bonsignore report can be read here: Jesse Bonsignore.

Timothy Flowers, June 4, 2021, Monroe County.

Fingerprints, eyewitnesses, and other evidence established probable cause that Mr. Flowers was the gunman who had shot and injured Rochester residents in incidents on May 3, 6, and 10, 2021. RPD prepared a "wanted package" for Mr. Flowers's arrest on charges of Attempted Murder in the Second Degree, Assault in the First Degree, and Criminal Possession of a Weapon in the Second Degree. SWAT Team officers searched for and found Mr. Flowers on June 4, 2021, on foot in a parking lot in Rochester. When Mr. Flowers saw officers approaching him, he ran. Two officers followed him on foot to a residential neighborhood, where Mr. Flowers hid behind a house and fired at one of the officers, who fired back. Hearing gunfire, the second officer approached Mr. Flowers from the other side of the house. Mr. Flowers turned toward the second officer, ignored his shouts to drop the gun, and pointed his gun at him. The second officer fired at Mr. Flowers. Mr. Flowers died from his injuries.

OSI concluded that a prosecutor would not be able to disprove beyond a reasonable doubt that the officers' actions were justified. Mr. Flowers had fired at one officer and was pointing his gun at the second officer, and both officers knew that Mr. Flowers was suspected of shooting and wounding other persons in three recent incidents.

At the time of this incident, and in an exception to its general policy, RPD did not equip SWAT team officers with BWCs. So the two shooting officers did not have BWCs, and the incident was not visually captured by any other officers' BWC.

OSI recommended that RPD extend its BWC policy to all officers, including SWAT teams.[13]

Timothy Flowers was Black. At the time of the incident, he was 29 years old. The Flowers report can be read here: Timothy Flowers.

Christopher Van Kleeck, June 12, 2021, Orange County.

Mr. Van Kleeck lived with his parents in Orange County. He had a significant history of mental illness, had been in physical confrontations with police officers, and had more than once threatened violence. On June 12, 2021, when Mr. Van Kleeck was home with his parents, and after an escalating series of incidents that day, his mother called a local mental health service, whose members were familiar with Mr. Van Kleeck, to ask them to send help. Mr. Van Kleeck took the phone from his mother and threatened to "take out" any police officers who came to the house. The mental health service alerted the police, who sent officers to the house. The first officer to arrive, who was a member of the Town of Wallkill Police Department, was rolling to a stop alongside the lawn by the house, when, as civilian security video shows, Mr. Van Kleeck was running after his father across the lawn with raised knives in both hands. Within seconds of the officer's arrival, as shown in the officer's dash cam, Mr. Van Kleeck ran across the front of the officer's stopped car still holding the knives, and the officer shot through the windshield, killing Mr. Van Kleeck.

OSI concluded that a prosecutor would not be able to disprove beyond a reasonable doubt at trial that the officer was justified in using deadly physical force against Mr. Van Kleeck. Seconds before the shooting Mr. Van Kleeck appeared to be about to stab his father and, at the moment the shots were fired, still held the two knives and was running at the stopped police car, occupied by the officer.

Christopher Van Kleeck was white. At the time of the incident he was 31 years old. The Van Kleeck report can be read here: Christopher Van Kleeck.

Steven Leconte, July 8, 2021, Kings County.

On the evening of July 8, 2021, Steven Leconte, on foot, approached a group of men gathered outside a store in Bushwick, Brooklyn, and fired a gun, wounding three of them. A fourth person near the store fired a gun at Mr. Leconte, wounding him in the leg. NYPD officers patrolling nearby heard the shooting and arrived at the store within minutes; bystanders pointed them to where the shooter had fled. The officers found Mr. Leconte nearby, crouched beside a parked car, with a gun in his hand. The officers shouted at him to drop the gun, but he pointed the gun at the officers, and the officers fired. Mr. Leconte died of his wounds.

The officers' BWCs captured the incident.

[13] RPD has informed OSI it is in the process of obtaining new BWCs for the department, and that the number of devices should be sufficient to equip SWAT Team members as well as other officers with BWCs.

OSI concluded that a prosecutor would not be able to disprove beyond a reasonable doubt that the officers' actions were justified. They knew Mr. Leconte had just shot three men and saw that he still held a gun. Despite their orders to drop it, he pointed it at the officers.

Steven Leconte was Black. At the time of the incident he was 53 years old. The Leconte report can be read here: Steven Leconte.

David Wandell, August 27, Chemung County.

On August 21, 2021, David Wandell was the subject of an alert sent to members of all law enforcement agencies in Chemung County, which advised officers he was wanted for a parole violation and to use caution if they encountered him, because of his documented history of violence. On August 27, 2021, an NYSP investigator saw Mr. Wandell walking in the Eldridge Park area of the City of Elmira and radioed for assistance. An Elmira Police Department ("EPD") officer who heard the radio call passed Mr. Wandell in her cruiser and got out, intending to take him into custody. Mr. Wandell pointed what appeared to be a gun at her. The EPD officer fired shots at Mr. Wandell and then stumbled backward as Mr. Wandell fled the area. Though it does not appear that the EPD officer's bullets hit Mr. Wandell, other responding officers saw Mr. Wandell point a gun at the officer, heard gunfire, and saw the officer fall. Presuming the EPD officer had been shot, another nearby officer reported over the radio that Mr. Wandell had shot an officer. A dispatcher transmitted a call to all county units for assistance because of "shots fired at officers."

Officers from a number of agencies followed Mr. Wandell and confronted him in Woodlawn Cemetery, shouting at him to drop his weapon and show his hands. Mr. Wandell, taking cover behind a tree, raised the gun toward the officers, and five officers – an NYSP trooper, an EPD investigator, a sergeant and a deputy from the Chemung County Sheriff's Office, and a parole officer with New York State Department of Corrections and Community Supervision – fired at Mr. Wandell. Mr. Wandell died of his wounds.

Officers recovered an airsoft pistol on the ground next to Mr. Wandell's body. The orange paint on the tip, which is required by law to distinguish it from a normal firearm, had been removed.

OSI concluded that a prosecutor would not be able to disprove beyond a reasonable doubt that the officers' actions were justified. Officers saw Mr. Wandell raise what appeared to be a gun at them, had heard over the radio that he had fired at an officer near Eldridge Park minutes earlier, and had been warned in the alert that he had a history of violence.

Although the initial encounter between Mr. Wandell and the EPD officer near Eldridge Park was partially captured on that officer's BWC, not all the officers from the agencies who pursued and then shot at Mr. Wandell were equipped with BWCs, and the shooting that caused Mr. Wandell's death was audibly, but not visually, captured on BWC.

Mr. Wandell was white. At the time of the incident he was 53 years old. The Wandell report can be read here: David Wandell.

Dedrick James, September 15, 2021, Monroe County.

In December 2020, in the Wayne County Town of Marion, an NYSP investigator began an investigation to determine how Dedrick James's two-year-old son had come to be seriously injured. In July 2021, after a months-long investigation, including interviews of Mr. James and the mother of the child and review of medical and other evidence, the NYSP investigator filed a criminal court complaint charging Mr. James with Assault in the Second Degree for the injuries sustained by the child. The investigator obtained an arrest warrant from the Marion Town Justice based on the complaint.

Over the next few weeks, the NYSP investigator in Wayne County called Mr. James and visited a Rochester address Mr. James had provided but did not receive a response. The investigator referred the warrant to the United States Marshals Service ("USMS") Fugitive Task Force in Rochester to find and arrest Mr. James.

On September 15, 2021, based on observations indicating that Mr. James was then at the Rochester address he had provided, USMS Task Force officers from agencies including USMS, NYSP, and RPD went to the house to arrest Mr. James. Three officers went to the front door and knocked, and Mr. James's grandmother opened the door. Mr. James came out of a bedroom and approached the officers, but then ran into a bathroom when told he was under arrest. Officers followed him into the bathroom, where one officer attempted to restrain Mr. James from behind in a bear hug. That officer and Mr. James fell into the bathtub. Mr. James had a gun in his hand, which he pointed at the officer's head. A brief struggle over the gun ensued, and the gun went off, fatally striking Mr. James in the chest.

Mr. James's Smith & Wesson .380 pistol and an expended shell casing were recovered, along with boxes of ammunition in Mr. James's bedroom that matched the ammunition in the gun and the expended shell casing. Ballistics testing and an autopsy showed that Mr. James was killed by a single bullet discharged from the recovered firearm.

No officer fired a gun.

OSI concluded that a prosecutor would not be able to disprove beyond a reasonable doubt that the officers' actions were justified. No officer used deadly physical force, and the bear hug one officer used to restrain Mr. James was a reasonable use of physical force to effect his arrest.

No officer involved in the arrest was equipped with a BWC. At the time of the incident, the United States Department of Justice (DOJ) had recently changed its policy to permit USMS Task Force

members to wear BWCs, but full implementation had not yet occurred. OSI recommended that DOJ and USMS fully implement use of BWCs by Task Force Officers without further delay.[14]

Dedrick James was Black. At the time of the incident he was 25 years old. The James report can be read here: Dedrick James.

Brandi Baida, September 21, 2021, Cayuga County.

On the morning of September 21, 2021, callers told 911 there was an active shooter in a residential neighborhood in the City of Auburn. A neighbor told an arriving Auburn Police Department ("APD") officer that gunshots were coming from a house at 12 Wheeler Street. Officers saw and heard shots fired from a rifle aimed out of a second-floor window at that address, endangering the lives of the responding officers, nearby residents, and pedestrians. After the shooter ignored commands to stop shooting and drop the weapon, an officer fired, striking the shooter and causing her death. The shooter was later identified as Brandi Baida. Officers recovered the rifle Ms. Baida used and rounds of additional ammunition.

OSI concluded a prosecutor would not be able to disprove beyond a reasonable doubt that the officers' actions were justified. Ms. Baida was shooting a deadly weapon from a second-floor window onto a residential street, endangering the lives of police officers and civilians, and ignored commands to stop.

At the time of this incident, APD did not equip its officers with BWCs. Although APD has taken steps to obtain BWCs for its officers, OSI recommended the department accelerate its efforts.

Brandi Baida was white. At the time of the incident she was 30 years old. The Baida report can be read here: Brandi Baida.

Simran Gordon, October 6, 2021, Monroe County.

Simran Gordon walked into a Dollar Store in Rochester after 9:00 in the evening of October 6, 2021, went behind the checkout counter, showed a gun to the clerks, and told them to give him the money in the cash registers and the safe. One store employee went to a back room and called 911 to report that a man was robbing the store and holding the clerks at gunpoint. The RPD dispatcher put out the call as a gunpoint robbery.

Two RPD officers arrived at the store a few minutes later, while Mr. Gordon was still behind the counter with the clerks, waiting for the safe to open, which was on a five-minute delay. Mr. Gordon had his hands in the pocket of his sweatshirt. When one of the officers asked Mr. Gordon to show his hands, he refused and, after a slight hesitation, bolted toward the rear of the store. One officer

[14] OSI recently asked USMS about the status of its BWC implementation but has not yet received a response.

chased Mr. Gordon down the aisle and the other officer chased along a parallel aisle. Mr. Gordon fired one shot at the first officer, missing him, and that officer then fired at Mr. Gordon, killing him.

Mr. Gordon's gun and physical evidence that he had fired it were recovered at the scene. Store security video and the officers' body worn cameras captured the incident.

OSI concluded that a prosecutor would not be able to disprove beyond a reasonable doubt that the officers' actions were justified. Mr. Gordon was committing a gunpoint robbery in a store in which employees and customers were present, and, when officers arrived and began to ask questions, Mr. Gordon, attempting to flee, fired his gun at one of the officers.

After the incident, RPD issued statements alleging that Mr. Gordon was "tied to" and "connected to" prior murders of three persons. Though the public has an interest in having information about persons who die in encounters with police, statements alleging a person committed prior crimes will not only be painful to the person's surviving family members – causing them to feel that their relative's character has been assailed in an effort to justify police conduct – but could even prejudice the investigation of the person's death, by creating the erroneous impression that the alleged prior crimes are relevant to OSI's analysis. Therefore, OSI recommended that any statement by a police department about a decedent's alleged prior crimes: should be well founded; should be framed as a mere allegation, unless it is about an actual criminal conviction; and should be prominently accompanied by a caution that the alleged prior crime is not relevant to the legality of the conduct of the officers in the incident.[15]

Mr. Gordon was Black. At the time of the incident he was 24 years old. The Gordon report can be read here: Simran Gordon.

Allison Lakie, October 20, 2021, Onondaga County.

In the evening of October 20, 2021, members of the Syracuse Police Department ("SPD") responded to a house in the City of Syracuse to assist emergency medical personnel who were already present. When officers arrived, Allison Lakie was in the kitchen of the house, holding a knife and refusing to come out. Responding officers spoke to Ms. Lakie for about two hours from the front doorway, trying to persuade her to put down her knife and to come out of the house. Some of the officers speaking to Ms. Lakie had been trained in methods of dealing with people in mental health crises. Despite the attempts at de-escalation, Ms. Lakie set a fire in the kitchen, which began to grow, and several officers entered the house with a firefighter. As Ms. Lakie continued to hold a knife, the entering officers tried to subdue Ms. Lakie with Tasers (which were ineffective) as the firefighter put the fire out. Through the smoke and steam of the extinguished blaze, which

[15] RPD has not commented publicly on OSI's recommendation in the Gordon case. A news report indicates RPD recently named Simran Gordon as the shooter in a homicide and closed the case: RPD: Simran Gordon killed man on Weld Street in June 2021 - WHEC.com.

obscured what was happening, Ms. Lakie came out of the kitchen and at the officers with a knife in each hand. Four officers fired their guns at her, causing her death.

The officers' BWCs captured the incident.

OSI concluded that a prosecutor would not be able to disprove beyond a reasonable doubt that the officers' actions were justified. The officers attempted for two hours to resolve the incident without a physical confrontation, and only entered the house when a fire threatened to grow out of control, endangering the life of Ms. Lakie, and only fired when Ms. Lakie came at them with knives in both hands.

Allison Lakie was white. At the time of the incident she was 35 years old. The Lakie report can be read here: Allison Lakie.

Wesley Soper, December 17, 2021, Monroe County.

At 2:30 a.m., on December 17, 2021, a Monroe County Sheriff's deputy was on patrol on the Pittsford-Palmyra Road. As he entered the intersection with Moseley Road, the deputy, whose attention was diverted by a truck parked near an ATM, felt his car strike something. The deputy stopped, got out, and saw that he had hit a pedestrian, later identified as Wesley Soper, whose injuries were fatal.

In an interview with OSI, the deputy said he had the green light going into the intersection. There was no dash cam in his car, and his BWC was not activated prior to the impact. Security footage from a nearby Walgreen's was obtained. The deputy registered zero on an alcohol test at the scene, and a review of his cell phone indicated he was not texting or on a call at the time of the impact.

Accident reconstruction indicated the deputy had the green light, that Mr. Soper was crossing Pittsford-Palmyra Road against the light, and that the deputy's speed at the time of impact was between 49.3 and 57.4 mph, in a zone posted at 45 mph.

OSI concluded that the evidence would not have been sufficient to prove a charge of criminally negligent homicide beyond a reasonable doubt at trial. The deputy had the green light, was not impaired, and was not improperly distracted. Although he was going at least five, and possibly as much as 12.4 mph over the speed limit, New York courts do not consider speeding within that range to be serious enough to constitute criminal negligence.[16]

[16] Penal Law Section 15.05, Subdivision 4 defines criminal negligence as follows, edited to apply to the crime of criminally negligent homicide: "A person acts with criminal negligence … when he fails to perceive a substantial and unjustifiable risk that [death] will occur.... The risk [of death] must be of such nature and degree that the failure to perceive it constitutes a gross deviation from the standard of care that a reasonable person would observe in the situation." New York's highest court has held that to prove a person guilty of criminally negligent homicide in a vehicular case, the prosecutor must show "serious blameworthiness in the conduct that caused" the death, People v. Boutin, 75 N.Y.2d 692, 696 (1990), and, in a speeding case, "additional risk-creating behavior in addition to driving faster than the posted speed limit that transformed [the] speeding into dangerous speeding," People v. Cabrera, 10 N.Y.3d 370,

OSI recommended that Monroe County Sheriff's cars be outfitted with dash cam.

Wesley Soper was white. At the time of his death he was 32 years old. The Soper report can be read here: Wesley Soper.

Janet Jordan, March 14, 2022, Monroe County.

At 2:08 am on March 14, 2022, security video and other evidence show that an off-duty RPD sergeant entered Janet Jordan's home by the front door and left an hour later. When Ms. Jordan's husband came home in the morning, from his night shift as a deputy sheriff at the Monroe County Jail, he found her dead of a gunshot wound and called 911. A subsequent search for the sergeant found him dead in his car of a self-inflicted gunshot wound. On autopsy, a key to Ms. Jordan's front door was found in the sergeant's trouser pocket.

Although the murder weapon was never found, .22 caliber shell casings with a distinctive crosshair logo, and with the sergeant's DNA, were found in Ms. Jordan's house, and .22 caliber shell casings with the same logo were found in the sergeant's car. Jail video and electronic records establish that Ms. Jordan's husband was physically at the jail from the beginning to the end of his shift (10:53 pm to 6:56 am).

OSI concluded there is no reason to believe anyone other than the sergeant was responsible for Ms. Jordan's death.

Janet Jordan was Black. At the time of her death she was 35 years old. The Jordan report can be read here: Janet Jordan.

4. New York City Department of Correction

NYC DOC operates detention facilities on Rikers Island and in a nearby barge. Persons in the custody of NYC DOC are detainees awaiting trial, detainees awaiting sentencing, prisoners sentenced to one year or less of jail time, and prisoners sentenced to more than a year of prison time and awaiting transfer to a state prison. NYC DOC also has custody of persons in transit to or from an NYC DOC facility, persons at courthouses awaiting court appearances, and persons being treated in hospitals. According to the August 2022 Fact Sheet published by the New York Division of Criminal Justice Services ("DCJS"), the NYC DOC population was just under 5600.[17]

All jails and prisons in New York are required to report deaths and other significant incidents to the New York State Commission of Correction ("SCOC") for review. SCOC is an independent oversight body, which sees that jails and prisons throughout the state uphold minimum standards under the

377 (2008) [inner quotation marks omitted].

[17] See the DCJS Jail Population by Month Report. A detailed description of NYC DOC's facilities can be found at NYC DOC Facilities Overview.

state's constitution, statutes, and regulations. SCOC issues an annual report,[18] describing its activities and findings, and issues reports on deaths in NYC DOC facilities.[19]

The New York City Board of Correction ("NYC BOC") is an independent oversight body for the jails in New York City, which sees that they comply with minimum standards in conditions of confinement and health and mental health care. 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.[20]

Conditions at Rikers Island have been the subject of innumerable news stories.[21] In June, 2015, United States District Judge Laura Taylor Swain appointed a monitor to oversee reforms to NYC DOC facilities, including reducing unnecessary uses of force, increasing video monitoring, and addressing staffing concerns.[22] Since that time the monitor has issued 12 reports on conditions at Rikers Island, with dozens of recommendations for improvement.[23] The United States Department of Justice has intervened in the litigation.[24] Judge Swain recently held hearings on whether to remove NYC DOC from managerial control of the jails and to give that control to a receiver.[25]

The Independent Commission on New York City Criminal Justice and Incarceration Reform, chaired by Jonathan Lippman, the former Chief Judge of the State of New York, published reports about inhumane conditions at Rikers Island, including violence, environmental hazards, and preventable mortality.[26] In its July 2021 report, the Commission proposed a plan to close the jails on Rikers Island and to transition NYC DOC to a borough-based system of jails.[27]

In this section OSI summarizes investigations it has completed to date into the deaths of persons in NYC DOC custody, occurring since April 1, 2021, the effective date of Section 70-b. If not described in this section, OSI's investigations into the deaths of persons in the custody of NYC DOC remain active. Table C in the Appendix has data on all NYC DOC notifications OSI received from April 1, 2021 through August 31, 2022. In Section 5 below, OSI makes recommendations concerning suicide prevention and drug overdose prevention in the state's jails and prisons. The investigation summaries are below:

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[18] See SCOC Annual Reports.
[19] See SCOC Incarcerated Individual Mortality Reports.
[20] See NYC Board of Correction Reports.
[21] See, e.g., news articles from: New York Times (February 22, 2015); Daily News (April 6, 2017); New York Times (January 1, 2022); New York Times (January 13, 2022); New York Times (February 2, 2022); New York Times (May 18, 2022).
[22] See the Consent Judgment for the Nunez Monitorship and Politico (June 20, 2015) for more details
[23] Monitor's reports can be found here: Nunez Monitor Reports
[24] See United States Department of Justice August 6, 2020 press release and Rikers Island Remedial Order addressing NYC DOC non-compliance.
[25] See NBC New York (April 20, 2022); NYC Public Advocate Press Release (2022); AMNY (May 16, 2022); Politics NY (May 24, 2022); and Gothamist (June 28, 2022).
[26] See Commission Reports.
[27] See Closing Rikers Island – A Roadmap for Reducing Jail in New York City.

Thomas Braunson, April 19, 2021.

Thomas Braunson was arrested for a parole violation on April 16, 2021 and housed at the Eric M. Taylor Center ("EMTC") on Rikers Island. Prior to his transport to Rikers Island, a corrections officer assessed Mr. Braunson for suicide risk, mental health risk, and substance use history at the Queens Detention Complex. Mr. Braunson denied drug use at that time.

On the morning of April 19, 2021, according to handwritten logs and inmate interviews, a fight broke out between two incarcerated persons in the area of EMTC where Mr. Braunson was housed. Later that morning, a corrections officer conducting rounds saw Mr. Braunson lying unresponsive in his bed. The officer called a medical emergency, and staff attempted life-saving measures. Mr. Braunson was pronounced dead 15 minutes later by an urgent care doctor. Heroin and heroin residue were later found on Mr. Braunson and in his cell.

The medical examiner determined the cause of death to be acute intoxication from combined effects of fentanyl, heroin, and phencyclidine; the medical examiner's report also noted evidence of chronic substance use. Two incarcerated persons housed near Mr. Braunson said in interviews that they observed him swallow a quantity of apparent heroin before his death. One said Mr. Braunson "got scared and swallowed everything" when officers entered the housing area following the fight earlier that morning.

Based on the investigation, OSI did not find reason to believe that a corrections officer caused Mr. Braunson's death.

Mr. Braunson was Black. At the time of his death he was 35 years old.

Richard Blake, April 30, 2021.

Richard Blake was arrested for criminal possession of a controlled substance on February 11, 2021 and housed in the Otis Bantum Correctional Center ("OBCC") on Rikers Island.

On April 27, 2021, Mr. Blake had a seizure, was treated in a medical unit, and was returned to his housing. On April 30, 2021, at 10:47 pm, several persons housed near Mr. Blake summoned a corrections officer because Mr. Blake appeared to be having a medical emergency. The responding officer called for assistance from the medical unit but did not directly try to assist Mr. Blake until the arrival of a second officer seven minutes later. When the second officer arrived at 10:54 pm Mr. Blake was no longer breathing. The second officer and an incarcerated person moved Mr. Blake to the floor, where the officer performed chest compressions until the medical unit arrived at 10:56 pm. (Mr. Blake's housing unit lacked an automated external defibrillator.) Mr. Blake never regained consciousness.

The medical examiner determined the cause of death to be hypertensive and atherosclerotic cardiovascular disease. In an interview with OSI the medical examiner said Mr. Blake had

significant cardiovascular disease, which obstructed adequate supply of blood to his heart, and that, due to the severity of Mr. Blake's heart disease, he would have needed to be on an operating table almost immediately to have survived his cardiac arrest.

Based on the investigation, OSI did not find reason to believe that a corrections officer caused Mr. Blake's death.

Mr. Blake was Black. At the time of his death he was 45 years old.

Brandon Rodriguez, August 10, 2021.

Brandon Rodriguez was arrested on August 4, 2021, for Strangulation in the Second Degree and other crimes, and housed at OBCC.

On August 5, 2021, at OBCC, a corrections officer assessed Mr. Rodriguez for suicide risk and found no suicide risk. Mr. Rodriguez was held in an overcrowded OBCC Intake holding pen for the next two and a half days, until, on August 8, at 9:45 am, he was assaulted by other incarcerated persons (captured on video) and removed for medical care. Mr. Rodriguez was initially treated at a clinic on Rikers Island and was later taken to Elmhurst Hospital for treatment of a broken bone around his eye; he was returned to OBCC in the morning of August 9.

Later on August 9 a doctor and a social worker assessed Mr. Rodriguez's physical and mental condition; neither found him to be a suicide risk, though both indicated he needed mental health follow-up. Mr. Rodriguez's medical records, from prior stays on Rikers Island, indicated he had attempted suicide previously. It is not clear whether the two professionals who evaluated Mr. Rodriguez on August 9 saw or had access to those records at the time of the evaluations.

On the same day, after the evaluations, Mr. Rodriguez assaulted an incarcerated person (captured on video) and corrections officers took him to the Segregation Intake housing area; when he physically resisted transport to the area, corrections officers used force to handcuff him and place him on a gurney to take him to the area (captured on video). Upon arrival in the Segregation area, shortly before 4:00 pm, corrections officers put Mr. Rodriguez in a shower cell, explaining that the regular cells had not been cleaned.

According to an officer's incident report, at about 7:20 pm, corrections officers came to Mr. Rodriguez, still in the shower cell, told him they were going to take him to a medical clinic to be evaluated because of the earlier use of force, and began to place handcuffs on him through a cuffing port. However, with only one wrist cuffed, Mr. Rodriguez pulled his arms back and refused to allow his other wrist to be cuffed. The corrections officers demanded that he allow them either to cuff the other wrist or to take their cuffs back, but Mr. Rodriguez refused. Some, though not all, nearby incarcerated persons said in investigative interviews that Mr. Rodriguez said he would kill himself and that one of the officers responded, I don't care if you kill yourself, I need my cuffs back.

Video surveillance (which does not have audio) confirms that officers arrived about 7:20 pm, spoke to Mr. Rodriguez in the cell, and appeared (from a vantage point behind the officers) to attempt to cuff him and then struggle with him. One of the officers involved in the cuffing incident refused, via her attorney, OSI's request for an interview; the other officer has left NYC DOC employment and OSI has not succeeded in locating and interviewing him.

After the cuffing incident, video shows that Mr. Rodriguez spoke often with other incarcerated persons, and that a corrections officer frequently checked on Mr. Rodriguez. Video also captured Mr. Rodriguez appearing to prepare to take his own life, taking off his shirt, twisting it, putting it around his neck, and tying it to something in the cell. There are moments in the video, especially after midnight, when it appears that Mr. Rodriguez ceased his preparatory actions because another person was nearby and might have been able to see him. Although the video does not capture an incarcerated person or the corrections officer noticing these actions, one incarcerated person, in a later interview, said he saw these actions but did not realize Mr. Rodriguez was going to hang himself.

Video shows that at 12:03 am, the corrections officer assigned to the Segregation Intake housing area looked directly into Mr. Rodriguez's cell for 20 seconds, from the gallery above and across from the cell, and then left the area. Video shows that at 12:33 am the officer re-entered the gallery above and across from Mr. Rodriguez's cell, looked into the cell, went down to the cell, opened it, moved Mr. Rodriguez, used his radio, and began chest compressions on Mr. Rodriguez. The NYC DOC incident report states that the officer found Mr. Rodriguez hanging at 12:30 am. Based on recorded transmissions, the officer made three radio calls for medical to come ASAP while he continued to perform chest compressions. Medical staff arrived at 12:43 am and continued attempts to resuscitate Mr. Rodriguez. Medical staff declared Mr. Rodriguez dead at 1:08 am. The medical examiner determined the cause of death to be hanging.

The officer who found Mr. Rodriguez refused, via his attorney, OSI's request for an interview.

Despite the many failures that preceded Mr. Rodriguez's death, OSI did not find reason to believe that a corrections officer caused his death. The excessive time he spent in the Intake pens, during which he was assaulted, was a systemic failure; more than 40 incarcerated persons were in a similar situation, apparently the result of a staffing shortage when OBCC corrections officers called in sick.[28] The doctor and the social worker who failed to recognize Mr. Rodriguez's suicide risk were not corrections officers; even if they could be considered to have contributed to the cause of Mr. Rodriguez's death by failing to put him on suicide watch, Section 70-b does not authorize OSI to investigate or prosecute their conduct. And the evidence is not conclusive whether a corrections officer said, "I don't care if you kill yourself." Assuming such a statement was made, and as harsh

[28] See New York City Board of Corrections report on suicides and drug-related deaths, Gothamist (August 12, 2021) news article, and The City (August 26, 2021) news article.

and improper as it would have been, it is hard to conclude that the statement would have caused Mr. Rodriguez to take his own life.

However, the failures in Mr. Rodriguez's case were significant, and they are part of the basis for a recommendation, detailed in Section 5.4 below, on reducing suicide risk in New York's jails and prisons.

Brandon Rodriguez was Hispanic. At the time of this death he was 25 years old.

Segundo Guallpa, August 30, 2021.

Segundo Guallpa was arrested on August 18, 2021, for Strangulation in the Second Degree and was housed in the West Facility on Rikers Island.

A corrections officer performed a standard screening for suicide risk, which the officer assessed as zero. Mr. Guallpa was initially assigned to medical housing, due to the heightened Covid risk presented by his asthma; during his time in medical housing he was seen a number of times by medical staff, who noted no apparent physical or mental health issues in their records before clearing him, on August 29, for transfer to regular housing.

Shortly after 1:00 am on August 30, corrections officers conducting a round failed to get a response from Mr. Guallpa when they turned on the light in his cell and knocked on the door. Upon entering the cell, corrections officers found Mr. Guallpa hanging, in a seated position, from a ligature made of socks and attached to the bed frame. Correctional and medical staff were unable to revive him, and medical staff declared Mr. Guallpa dead shortly after 1:30 am. Mr. Guallpa was in early-stage rigor mortis when he was found. The medical examiner determined the cause of death to be hanging but would not opine on how long Mr. Guallpa was dead before he was found.

OSI requested interviews with the corrections officers assigned to Mr. Guallpa's housing area during the time in question, and, through their lawyers, each refused to speak with us.

Based on the investigation, OSI did not find reason to believe that a corrections officer caused Mr. Guallpa's death. Although video shows that corrections officers assigned to Mr. Guallpa's housing area on the night of August 29 and the early morning hours of August 30 missed scheduled rounds (the officers falsely reported having done those rounds, and four officers – including two captains – were disciplined), OSI could not conclude that Mr. Guallpa's death would have been prevented had all rounds been properly conducted. Based on interviews with medical examiners in a number of cases, it appears that brain death can occur within a few minutes when a person begins to hang.[29] Based on OSI's review of a number of suicides in jails and prisons, even in cases where video shows officers made regular rounds, incarcerated persons were able to hang themselves in the space of a few minutes, without being noticed, between those rounds. (See, later in this section,

[29] Goldstein, S. (2020, December 3). Hanging Injuries and Strangulation. *Medscape.* Retrieved from: https://emedicine.medscape.com/article/826704-overview?reg=1.

the case of Antonio Bradley.) Therefore, even if the officers in the case of Mr. Guallpa had made regular rounds, OSI cannot conclude they would have prevented Mr. Guallpa's death.

Segundo Guallpa was Hispanic. At the time of his death he was 58 years old.

Esias Johnson, September 7, 2021.

Esias Johnson was arrested on August 6, 2021, for Menacing in the Second Degree, and housed at the Anna M. Kross Center on Rikers Island.

On September 7, 2021, corrections officers found Mr. Johnson in his bed and unresponsive at 9:11 am. When medical staff arrived they saw that Mr. Johnson was not breathing and in early-stage rigor mortis; they declared him dead at 9:43 am. The medical examiner determined the cause of death to be acute methadone intoxication.

Video shows that Mr. Johnson went to bed a few minutes after 1:00 am and appeared to stop breathing about 6:00 am. The medical examiner opined that, assuming Mr. Johnson had taken a fatal dose of methadone shortly before going to bed, it might have been possible to save him with Naloxone if administered soon after, with the chances of success decreasing over time; if corrections officers had noticed that he stopped breathing at 6:00 am, it would probably have been too late to save him.[30]

OSI examined allegations that prior to his death Mr. Johnson was denied medical care for digestive problems but could not substantiate them. Rikers medical records indicate medical staff saw Mr. Johnson on August 11, 19, and 26, and September 1, and that on August 17 and September 6 Mr. Johnson refused medical care; the medical notes do not indicate Mr. Johnson complained of digestive problems.

Video shows that the corrections officer assigned to conduct rounds every 30 minutes in Mr. Johnson's housing area from at 3:15 am to 9:15 am on September 7 only conducted four rounds (three of which were incomplete) and failed to conduct seven rounds; the officer falsely noted in the logbook that "active supervision" was conducted every 30 minutes as required. (Under NYC DOC rules, active supervision requires, among other things, checking each incarcerated person individually for signs of life.) Three corrections officers (including a captain) were reassigned pending disciplinary proceedings. OSI requested interviews with four officers, each of whom refused, via counsel.

Based on the investigation, OSI did not find reason to believe that a corrections officer caused Mr. Johnson's death.

Esias Johnson was Black. At the time of his death he was 24 years old.

[30] Naloxone is an opioid antagonist used to rapidly reduce the effects of opioid overdose by attaching to opioid receptors, blocking the effects of other opioids, and quickly restoring normal breathing if administered quickly enough. Naloxone has no known adverse effects if administered on someone who does not have opioids in their system. See National Institute on Drug Abuse – Naloxone Drug Facts

Karim Isaabdul, September 19, 2021.

Karim Isaabdul was arrested on August 18, 2021 on a parole warrant and was housed in Dorm 3 of the North Infirmary Command on Rikers Island, a housing area for persons needing special medical attention. Mr. Isaabdul had been on parole from a state prison sentence for Criminal Sale of a Controlled Substance in the Third Degree.

On September 19, 2021, as captured on video, Mr. Isaabdul, who was wheelchair-bound, was in a common area, speaking with other incarcerated persons, when, at 6:37 pm, he seemed to slump and suffer pain. At 6:42 pm a medical response team arrived and, at 6:48 pm, took Mr. Isaabdul on a gurney to an adjacent clinic. Medical records show that medical staff administered Narcan and epinephrine to Mr. Isaabdul at the clinic, but failed to revive him. He was pronounced dead at 7:35 pm.

OSI looked into allegations that Mr. Isaabdul complained of feeling ill and failed to get treatment, but could not substantiate them. According to the Correctional Health Service ("CHS")[31] medical records, Mr. Isaabdul was seen by medical and mental health staff on 25 of the 32 days he was incarcerated, and, on many of those days, was seen more than once.

According to medical records, medical staff evaluated Mr. Isaabdul on August 21, 2021 and diagnosed him with asthma, spinal fusion, seizure disorder, hypertension, diabetes, and schizoaffective disorder. Staff developed a treatment and medication plan for each diagnosis, including a diet and follow-up lab work for diabetes, medication for hypertension and seizure disorder, an inhaler for asthma, medication and regular appointments with mental health professionals for schizoaffective disorder, and a wheelchair to assist with mobility. Medical staff reevaluated Mr. Isaabdul several times to assess his medications; on three occasions Mr. Isaabdul told a physician he was non-compliant with his medication. On August 25, 2021, Mr. Isaabdul tested positive for Covid-19 and was quarantined before moving to Dorm 3. When medical staff saw Mr. Isaabdul on September 16, 2021, he complained of pain to his arm and chest, and they ordered a chest x-ray for September 20, the day after he died. Medical staff saw Mr. Isaabdul the next day, September 17, 2021.

The medical examiner found that Mr. Isaabdul died of "pulmonary emboli due to right lower extremity deep vein thrombosis complicating Covid-19 in a person with decreased mobility due to degenerative spine disease."

Based on the investigation OSI did not find reason to believe that a corrections officer caused Mr. Isaabdul's death.

Records vary as to whether Mr. Isaabdul was Black or Hispanic. At the time of his death he was 41 years old.

[31] CHS is part of the New York City Health & Hospitals Corporation, not NYC DOC. https://www.nychealthandhospitals.org/correctionalhealthservices/

Steven Khadu, September 22, 2021.

Stephen Khadu was arrested on December 19, 2019 for Murder in the Second Degree and was housed at the Vernon C. Bain Center ("VCBC"), a jail barge docked at the southern shore of the Bronx.

On July 6, 2021 Mr. Khadu suffered a seizure and was treated at Lincoln Hospital from July 6 to July 12. On September 22, 2021, as captured on video, Mr. Khadu suffered another seizure, at 8:15 am; medical staff arrived at 8:25 am, brought him to the infirmary and treated him with medication; his condition seemed to improve, but then he suffered another seizure. According to medical records, a team from Emergency Medical Services arrived at the infirmary at 9:39 am and a second team of emergency medical technicians, who were trained in advanced life support, arrived at 9:42 am. The two teams of EMTs moved Mr. Khadu out of the clinic at 9:52 am and took him by ambulance to Lincoln Hospital. Mr. Khadu suffered a heart attack en route and, despite the EMTs' efforts in the ambulance, including intubating Mr. Khadu and performing cardiopulmonary resuscitation, he was pronounced dead at 10:55 am, five minutes after arrival at the hospital.

The medical examiner determined that Mr. Khadu died of complications of lymphocytic meningitis. In an interview with OSI, the medical examiner said that meningitis increases the risk of seizure because it causes inflammation of the brain, and that any prolonged seizure can lead to difficulty breathing, which in turn can lead to cardiac arrest and death, as happened to Mr. Khadu.

OSI examined allegations that Mr. Khadu did not receive adequate medical care but could not confirm them. According to medical records, upon Mr. Khadu's return to VCBC after his hospital stay for the July seizure, he saw medical staff on July 12, July 14, August 4, August 12, and August 14, 2021. From September 15 to September 20, 2021, Mr. Khadu made eight recorded phone calls, which OSI reviewed; he did not say he was being denied medical care.

Based on the investigation OSI did not find reason to believe that a corrections officer caused Mr. Khadu's death.

Mr. Khadu was Black. At the time of his death he was 24 years old.

Victor Mercado, October 15, 2021.

Victor Mercado was arrested on July 21, 2021 for Criminal Possession of a Controlled Substance in the Third Degree and Criminal Possession of a Weapon in the Second Degree. After testing positive for Covid-19 on October 8, 2021, he was transferred from the North Infirmary Command to the Communicable Disease Unit ("CDU") of the West Facility, on Rikers Island.

On the day he tested positive, Mr. Mercado did not have a high fever or difficulty breathing. On the next day, October 9, according to medical records, he had a fever of 102.1, which dropped after he took Tylenol. From October 10 through 13, Mr. Mercado's temperature did not exceed 100.5 degrees, and his blood oxygen level did not drop below 95%. Medical records show that medical

staff in the CDU checked on Mr. Mercado at least twice a day on October 9, 10, 11, 12, and 14, and once on October 13.

On the morning of October 14, 2021, according to a logbook entry, Mr. Mercado complained of difficulty breathing at 9:45 am. Medical records show corrections officers made an emergency medical call for Mr. Mercado at 10:05 am, and that a doctor and a nurse responded, examined Mr. Mercado, and determined he should go to the hospital. Video shows that oxygen and an IV drip were brought to Mr. Mercado's cell at 10:17 am, that Emergency Medical Services arrived at 10:40 am, and that EMS left with Mr. Mercado for the hospital at 10:55 am. Medical records show that Mr. Mercado arrived at Elmhurst Hospital at 11:36 am and was immediately intubated. He was pronounced dead at the hospital the next day, at 12:39 pm.

The medical examiner determined that Mr. Mercado's Covid-19 infection caused lung consolidation, which in turn caused sepsis, renal failure, and death. Mr. Mercado had a number of underlying medical conditions that put him at a higher risk for severe Covid-19 outcomes.

Based on the investigation, OSI did not find reason to believe that a corrections officer caused Mr. Mercado's death.

Mr. Mercado was Hispanic. At the time of his death he was 64 years old.

Malcolm Boatwright, December 10, 2021.

Malcolm Boatwright was arrested on November 11, 2021 for Sexual Abuse in the First Degree and was housed in the PACE Unit of the Anna M. Kross Center ("AMKC"), on Rikers Island. PACE stands for Programs to Accelerate Clinical Effectiveness and is a unit for persons with significant mental health or behavioral issues.

Video shows that Mr. Boatwright was playing a card game with other incarcerated persons in the PACE Unit on December 8, 2021 when, at 1:14 pm, he had a seizure, which lasted for three to four minutes. A nurse was present and called a medical emergency. Medical staff brought Mr. Boatwright to a clinic, where he was examined by a doctor, who sent him to Elmhurst Hospital for evaluation and testing. In the hospital, at midnight, as he was about to have an X-ray, Mr. Boatwright had another seizure. After further evaluations, doctors sent Mr. Boatwright to Bellevue Hospital for a further testing; he arrived at Bellevue midday on December 9. (Mr. Boatwright was in the prison wards of both hospitals.) At Bellevue, on the 9th and into the 10th, video shows corrections officers made regular rounds of the ward where Mr. Boatwright was housed. At 4:15 am on the 10th, corrections officers summoned medical staff to Mr. Boatwright's room after finding him unresponsive on the floor. Medical staff arrived at 4:18 am, but their efforts failed, and Mr. Boatwright was declared dead at 5:36 am.

Although Mr. Boatwright had no history of seizure disorder before December 8, he had been taking medications for mental illness. On December 4, under the guidance of physicians at AMKC, Mr. Boatwright finished tapering off Clozapine, and had not started any new medications. On autopsy, the medical examiner found no evidence of external trauma, or of meningitis or Covid-19; the

cardiac pathologist did not find indications of disease; neuropathology was negative; and microscopic genetic analysis was negative for abnormality that could explain death. In an interview with OSI, the medical examiner said that the medical taper of Clozapine could have been a contributing factor to Mr. Boatwright's seizures. The final autopsy report said the cause of death was complications of non-traumatic seizure disorder of undetermined etiology (origin), and that the manner of death was "natural."

Based on the investigation, OSI did not find reason to believe that a corrections officer caused Mr. Boatwright's death.

Mr. Boatwright was Black. At the time of his death he was 28 years old.

Antonio Bradley, June 18, 2022.

Antonio Bradley was arrested on October 13, 2021 for Criminal Possession of a Weapon in the Second Degree and was housed at the Anna M. Kross Center on Rikers Island.

On the morning of June 10, 2022, Mr. Bradley was transported from Rikers Island to a holding cell in the Bronx courthouse to await a scheduled court appearance. A recorded phone call between Mr. Bradley and his father, from earlier in the morning of the same day, indicated that Mr. Bradley hoped to be released as a result of the court appearance. The appearance, however, was postponed, which Mr. Bradley learned in a conversation with his lawyer at about 12:15 pm, while he was still in the holding cell in the courthouse. Video shows that corrections officers spoke with Mr. Bradley at 4:18 pm and 4:22 pm, while he was in the holding cell. At 4:23 pm, video shows Mr. Bradley began to twist his sweatshirt into a ligature; he tied it around his neck and to the cell bars and knelt down; he repositioned himself and knelt down again. At 4:25:13 pm his body went limp. At 4:33 pm corrections officers came to take Mr. Bradley back to Rikers Island but found him hanging. A corrections officer opened the cell door and officers used an automated external defibrillator and performed cardiopulmonary resuscitation. Emergency Medical Services arrived at 4:52 pm and took Mr. Bradley to Lincoln Hospital where he continued to receive emergency treatment. Brain death began on June 13, and a doctor pronounced Mr. Bradley dead on June 18, 2022.

Based on the investigation, OSI did not find reason to believe that a corrections officer caused Mr. Bradley's death.

Antonio Bradley was Black. At the time of his death he was 28 years old.

5. Recommendations

Section 70-b directs OSI to include in the annual report recommendations for systemic or other reforms indicated by OSI's investigations. OSI makes five recommendations in this report, as follows:

5.1 Body Worn Cameras and Dashboard Cameras

RECOMMENDATION

The Legislature and the Governor should require by statute that all police and sheriff's departments deploy and use body-worn cameras ("BWCs") and dashboard cameras ("dashcams") and should provide smaller departments with related funding from the state and training by the Department of Criminal Justice Services ("DCJS").

In the 2019 Biennial Report under Executive Order 147, OSI's predecessor unit recommended, and in the 2021 Annual Report under Section 70-b, OSI recommended that all police agencies in New York outfit their officers with BWCs and dashcams so that encounters between police and the public would be captured on video.[32]

Although seven states – Colorado, Connecticut, Illinois, Maryland, New Jersey, New Mexico, and South Carolina – now mandate statewide use of body-worn cameras by law enforcement officers,[33] there is no law in New York requiring police agencies in New York to deploy BWCs or dashcams. Of the 89 deaths involving police agencies reported to OSI from September 1, 2021, to August 31, 2022, agencies in 27 cases were not equipped with BWCs or dashcams.[34]

The absence of video has the potential to hinder thorough investigation of such matters and to diminish trust in law enforcement.

> For example, in the cases of Timothy Flowers and Dedrick James in Rochester, no BWCs visually captured the incidents. In the case of Mr. Flowers, the absence of BWC was due to the Rochester Police Department's policy against SWAT Team use of BWC; in the case of Mr. James the absence of BWC was due to the US Marshals Service's failure to implement a then-recent policy allowing use of BWC during arrests.[35]
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> In the cases of Judson Albahm, in Onondaga County, and David Wandell in the City of Elmira, Chemung County, members of multiple police agencies pursued and fired guns at the two

[32] See 2019 Biennial Report, pp. 48-49, https://ag.ny.gov/OSI. See 2021 OSI Annual Report, pp. 16-17, https://ag.ny.gov/OSI

[33] See National Conference of State Legislatures Body-Worn Camera Laws Database.

[34] OSI received 106 notifications on a gross basis involving police agencies. However, 14 of those matters did not involve a death and 3 of those matters did not involve an officer as defined by Section 70-b, leaving 89 matters net. See Section 6 for more detail.

[35] See above, Section 3 for summaries of the Flowers and James cases and links to the full reports.

persons who died. The members of some of those agencies had BWCs and the members of other agencies did not. As a result, neither shooting was visually captured on video.[36]

In the cases of Jeffrey McClure and Jesse Bonsignore, both in Suffolk County, the officers involved were not equipped with BWCs. Although Suffolk County has committed to equipping officers with BWCs, implementation does not appear to be complete.[37]

Body-worn and dashboard cameras increase transparency and accountability, in addition to potentially reducing unnecessary uses of force.[38] Cameras also assist in gathering evidence and providing an objective account of incidents, which benefits civilians, communities, and police departments.[39]

Because funding and training could be difficult for smaller departments, we recommend that the state provide the funding, and, through DCJS, the training to such departments so that they are able to implement a BWC and dashcam mandate.[40]

5.2 Video in Jails and Prisons

RECOMMENDATION

The Legislature and the Governor should require by statute that all agencies in the state that operate jails and prisons outfit them with surveillance video, equip the corrections officers staffing them with body worn cameras, and should provide smaller corrections agencies with related state funding and, through DCJS or the New York Department of Corrections and Community Supervision ("DOCCS"), training.

Section 70-b directs OSI to investigate, and, if warranted, to prosecute deaths caused by peace officers, including all corrections officers in the state. The Attorney General's Office did not have this authority prior to April 1, 2021, the effective date of Section 70-b.

[36] See above, Section 3 for summaries of the Albahm and Wandell cases and links to the full reports.
[37] See above, Section 3 for summaries of the McClure and Bonsignore cases and links to the full reports.
[38] See the Benefits of Body-worn Cameras: New Findings from a Randomized Control Trial at the Las Vegas Metropolitan Police Department.
[39] New York State Division of Criminal Justice Division Services – Municipal Police Training Council. (2015). Body-worn Camera Model Policy.
[40] DCJS has issued a model BWC policy with guidance for modification based on the varying capacities of local police departments. See DCJS Body-Worn Camera Model Policy. Similar federal guidance is available from the US Department of Justice, see Bureau of Justice Assistance, Body-Worn Camera Frequently Asked Questions. Storage and preservation of video from BWCs and dashcams can also be a significant cost, and funding from the state for smaller departments should cover those costs as well. Separately, some BWC systems automatically activate an officer's camera when the officer draws a gun; this and other automated features address the possibility that an officer will forget to activate the camera in moments of stress.

There are about 46,600 persons incarcerated in New York.[41] From April 1, 2021, through August 31, 2022, OSI examined 120 incidents in jails and prisons.[42] Facilities in 50 of those investigations were equipped with surveillance video that captured relevant images, and corrections officers in 22 of those investigations were equipped with BWCs. Remarkably, even certain large prisons in the state prison system, including Sing Sing, in Westchester County, do not have surveillance video.

Police departments throughout the state are expanding their use of body-worn cameras to increase transparency in police encounters with civilians; use of BWCs could advance the same goal in jails and prisons. An increasing number of state prison systems are outfitting corrections officers with body-worn cameras, even in settings where fixed surveillance cameras are already in use. For example, California began expanding the use of body-worn cameras in prisons following allegations of abuse of people with disabilities within the correctional system.[43] Similarly, Ohio expanded the use of body-worn cameras in correctional settings following the death of an incarcerated person amid a use of force incident.[44]

Body-worn cameras in correctional settings have the potential to reduce violence and hold incarcerated persons or officers accountable in appropriate cases. Fixed surveillance cameras in correctional settings are important, but they have blind spots that prevent incidents occurring outside the view of cameras from being recorded and are generally aimed away from private areas, including cell interiors and bathrooms. Although procedures for use of body-worn cameras in jails and prisons should provide for avoiding infringements of privacy, employment of body-worn cameras during uses of force, cell extractions, emergencies requiring forced cell entry, and mortality incidents would add to the available body of evidence in many investigations.

5.3 Training Police for Behavioral Health Emergencies

RECOMMENDATION

The Legislature and the Governor should require by statute that all police and sheriff's departments meaningfully train all officers in crisis intervention, both at the academy and on an ongoing basis, and should provide smaller departments with related state funding and, through DCJS, training.

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[41] According to DCJS, as of August 2022 the NYC DOC population is just under 5600 and the aggregate county jail population outside New York City is just over 10,000. See DCJS Monthly Population Report. According to the Fact Sheet issued by NY DOCCS as of September 1, 2022, the population of the DOCCS system is just over 31,000. See DOCCS Factsheet.

[42] OSI received notification of 126 incidents in the jails and prisons on a gross basis. However, 3 of those incidents did not involve a death, 2 of those incidents did not involve an officer as defined by Section 70-b, and 1 person who died was an employee of the agency, not an incarcerated person, leaving 120 incidents, net. See Section 6 for more detail.

[43] Sheeler, A. (July 26, 2021). CA correctional officers to wear body cameras in state prisons. *The Sacramento Bee.* Retrieved from: https://www.sacbee.com/news/politics-government/the-state-worker/article252906793.html

[44] Walsh-Higgins, A. (2021, October 29). Prison system adding body-worn cameras to security plans. *ABC News.* Retrieved from: https://abcnews.go.com/US/wireStory/prison-systems-adding-body-worn-cameras-security-plans-80856281

OSI's first annual report recommended that police officers and other members of police departments be trained to respond to persons experiencing mental health crises, whether drug-induced or otherwise, including training for 911 operators and dispatchers to accurately record and transmit the facts conveyed to them, and training for responding officers in de-escalation methods.[45]

OSI is not staffed with medical or mental health professionals, but among the cases for which OSI issued public reports during the last 12 months, the following cases involved persons who seemed to be undergoing mental health crises (see Section 3 above for fuller summaries and links to the full reports):

> Jeffrey McClure died in Suffolk County in June of 2020. Officers responded to a 911 call about a person who was under the influence of alcohol and drugs and experiencing a mental health crisis. When officers arrived, Mr. McClure threatened to kill them while holding a realistic-looking pellet rifle, which resulted in his death when an officer, believing he was holding a firearm, responded with gunfire.
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> George Zapantis died in Queens County in June of 2020. When police arrived they quickly realized Mr. Zapantis might be undergoing a mental health crisis, and called for assistance from the Emergency Services Unit, which has trained negotiators, while they attempted to de-escalate on their own. The situation quickly deteriorated and led to Mr. Zapantis's death in a physical struggle, including Taser use, when he became increasingly agitated and physically came at the officers gathered outside his door.
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> Judson Albahm died in Onondaga County in March of 2021. A team of mental health providers had come to Judson's house for a previously scheduled evaluation, but his mother requested police intervention after he fled by car. Some responding officers, but not all, were aware that Judson had a history of mental health issues and possessed an imitation gun. When Judson stopped fleeing and pointed a realistic-looking gun at some officers, officers shot and killed him.
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> Jesse Bonsignore died in Suffolk County in May of 2021. When an officer tapped on the window of the car in which Mr. Bonsignore was sleeping, he screamed incoherently and then said, repeatedly, I'm going to kill you. When Mr. Bonsignore got out of the car, against the officer's direction, the officer physically engaged him, which led to a struggle involving Mr. Bonsignore's attempt first to get at a folding knife on his own belt and then to get at the officer's gun. The officer responded by shooting Mr. Bonsignore.
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> Christopher Van Kleeck died in Orange County in June of 2021. He had a history of hospitalization and other treatment for mental illness. After a series of escalating threats, family members called a mobile mental health team through the County crisis center, but

[45] See 2021 OSI Annual Report. Retrieved from: https://ag.ny.gov/OSI. A similar recommendation was made in the Biennial Report issued by OSI's predecessor unit in 2019 at pages 43-44. https://ag.ny.gov/uploads/biennial-report-office-attorney-generals-special-investigations-prosecutions-unit-2019

the center called on the police to intervene. The first responding officer had seconds to decide whether to shoot Mr. Van Kleeck, who came at his father, and then toward the officer's car, with knives raised in both hands.

Allison Lakie died in the City of Syracuse, in Onondaga County, in October of 2021. Officers, some of whom were trained in crisis intervention, all understood that Ms. Lakie was undergoing a mental health or drug or alcohol induced crisis and spoke with her for two hours, attempting to persuade her to put down her knife and come out of her mother's house. In the end, because Ms. Lakie had set a fire, which was growing, the officers entered the house to put out the fire and shot Ms. Lakie when she came at them with knives in each hand.

See also Section 6, below, concerning OSI's data on 22 police shootings, in which 10 of the persons who died appeared to be in the midst of a mental health crisis or a drug induced mental health crisis.

As these cases illustrate, persons undergoing apparent mental health crises often present significant danger to others – including any mental health professionals who might respond to such a crisis. It is therefore inevitable that police officers will need to respond to such cases.

Although many jurisdictions in New York have mental health professionals who respond to reports of persons undergoing mental health crises, availability is often limited – for example, professionals may not be not available seven days a week, 24 hours a day, or may not be available to cover all sectors of a county, or may not be numerous enough to respond to more than one emergency at a time.[46] Moreover, many situations may not be recognized initially as mental health emergencies at all – as when the 911 caller does not describe what appears to be a mental health crisis or the 911 dispatchers do not transmit the relevant information. Therefore, even in jurisdictions which have mental health responders, police will often respond to mental health emergencies without the assistance of mental health professionals. When mental health professionals do respond, in many cases they will need to wait until the police officers have made the situation safe enough for the mental health professionals to take action. And, finally, though many police departments have specialized units with members trained in crisis intervention, those units generally deploy only when the first responders call them and so they do not arrive on scene until crucial minutes have passed.

Therefore, it is essential that all officers in all departments in the state receive meaningful training in handling mental health emergencies. It simply will not be possible for officers to await the arrival of specialized police units or mobile mental health teams in every case.

Several police departments in New York have introduced crisis intervention training to assist responding officers in better addressing cases in which persons show signs of mental illness or drug use. DCJS offers Fundamental Crisis Intervention Skills for Law Enforcement in collaboration

[46] For example, as OSI learned in the investigation of the McClure case, summarized in Section 3, above, Suffolk County has a civilian crisis intervention program whose members, at the time, were available to respond to crises only at certain times and in certain sectors.

with the New York State Office of Mental Health, as well as a mental health section in the Basic Course for Police and Peace Officers.[47]

However, New York law on crisis intervention training for police officers does not assure effective training. Under Section 840(4)(d)(2)(vii) of the Executive Law, the Municipal Police Training Council ("MPTC") must promulgate a model use of force policy, including "training mandates on … conflict prevention, conflict resolution and negotiation, de-escalation techniques and strategies, including, but not limited to, interacting with persons presenting in an agitated condition…." Under Section 840(3) all police agencies in the state must, at minimum, adopt the model policy. It is not clear how effective this is. MPTC's model policy provides for crisis training is a word-for-word repetition of the statutory provision just quoted. And the use of force policy adopted by the New York State Police, for example, is a word-for-word repetition of the model policy. Given the inadequate response of some police agencies to apparent mental health crises in the cases investigated by OSI, questions remain about whether high quality, meaningful behavioral health curriculums are being delivered to all police officers.

When responding to behavioral health emergencies, law enforcement personnel must balance public safety concerns with the complex needs of persons with mental illness. The new 988 Suicide and Crisis Hotline [48] offers an alternative to 911 and has the potential to divert many behavioral health emergencies from law enforcement to local mental health providers, but safety concerns inevitably arising in many of these scenarios will continue to require police involvement. This makes crisis intervention training necessary for all police officers.

Partnerships between law enforcement, mental health providers, and emergency medical professionals could figure prominently in improving community responses to behavioral health emergencies and alleviating the burden placed on responding officers. Various models, such as Crisis Intervention Team programs,[49] Mental Health First Aid[50] curriculum, and various Police Mental Health Collaboration[51] programs have shown promise in their potential to mitigate risk and yield favorable outcomes for persons who are experiencing mental health crises amid police encounters.

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[47] The NYPD implemented crisis intervention training in 2021, consisting of a four-day course that trained over 16,000 police officers on how to recognize signs of mental illness and assist people in crisis as part of a partnership between the Mayor's Office of Community Mental Health and the NYPD. Several law enforcement officers in Chautauqua County completed Crisis Intervention Team Training in April, 2022. See also DCJS training material: New York State Division of Criminal Justice Services (2022), Police and Peace Officer Training, https://www.criminaljustice.ny.gov/ops/training/calendar.htm

[48] See U.S. Department of Health and Human Services – Substance Abuse and Mental Health Services Administration (SAMHSA): https://www.samhsa.gov/find-help/988

[49] See Crisis Intervention Training International for more information on de-escalation and crisis response: https://www.citinternational.org/

[50] Mental Health First Aid is a course that teaches participants how to identify, understand, and respond to signs of mental illness and substance use disorders. For details see: https://www.mentalhealthfirstaid.org/about/

[51] The U.S. Department of Justice Bureau of Justice Assistance offers training and toolkits on Police Mental Health Collaboration programs to support law enforcement agencies in collaborating with mental health providers and advocates to improve overall safety. For details see: https://bja.ojp.gov/program/pmhc

Therefore, we urge the Legislature and the Governor, by statute, to mandate that all police and sheriff's departments in the state provide meaningful crisis intervention training to all officers to improve responses to persons presenting with mental health emergencies. All officers should be introduced to such a curriculum as new recruits and be given regular, ongoing training throughout their careers. We recommend that the Legislature authorize financial and administrative support to make possible the universal implementation of such training across all municipal police and sheriff's departments in the state.

5.4 Suicide Prevention in Jails and Prisons

RECOMMENDATION

New York's jail and prison personnel should take, at minimum, four common-sense steps to improve suicide prevention.

OSI received notification of 120 deaths in jails and prisons between September 1, 2021, and August 31, 2022.[52] Of those, 27 deaths were by suicide (or, pending autopsy, apparent suicide).[53] Based on medical records obtained by OSI in the course of its investigations, 19 of the persons who died by suicide had a mental health history.[54]

Two things stand out about these 27 deaths.

First, though the sample size is small, the suicide rate in New York's jails and prisons appears to be more than twice as high as the suicide rate in the United States. There are about 46,600 persons incarcerated in New York in 2022.[55] For that population, 27 suicides in a year would be a rate of about 57.9 per 100,000. All the suicides were men. According to the website of the National Institutes of Mental Health, the age-adjusted suicide rate for men in the United States in 2020 was 21.9 per 100,000.[56]

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[52] See the recommendation for video in jails and prisons, above, and Section 6, below, for how this number is calculated.

[53] OSI is not notified of an event unless a death results, but, based on statistics OSI obtained from the New York State Commission on Correction, there were 166 attempted suicides in New York jails and prisons from September 2021 to August 2022 that did not result in death. OSI does not have data showing how many persons were involved in the 166 attempts (we assume some persons made more than one attempt), nor how many of the persons making an attempt later "succeeded" and died.

[54] For the purposes of this report, mental health history is defined as documentation of mental health treatment, confirmed diagnosis of mental illness as defined by the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, history of psychiatric hospitalization, and/or documentation of prescribed psychotropic medication for the purposes of managing mental health symptoms. An absence of documented mental health treatment does not necessarily indicate that incarcerated persons were not experiencing mental health challenges, as many cases are undiagnosed, under-reported, and inadvertently untreated.

[55] According to DCJS, as of August 2022 the NYC DOC population was just under 5600 and the aggregate county jail population outside New York City was just over 10,000. See DCJS Monthly Population Report. According to the Fact Sheet issued by DOCCS as of September 1, 2022, the population of the DOCCS system is just over 31,000, DOCCS Factsheet.

[56] See NIMH Suicide Statistics. Despite being the first year of the Covid pandemic, the suicide rate reported by NIMH for 2020 was actually lower than the rate for 2019. According to NIMH, the suicide rate for men is almost five times the

Second, of the 27 persons who died by suicide in New York's jails and prisons in the 12 months ended August 31, 2022, the institutions identified 8 as persons at risk of suicide, but failed to prevent their deaths, and failed to identify the other 19 persons as at risk of suicide.

It is not surprising that incarcerated persons would take their own lives at a greater rate than non-incarcerated persons, and no one expects that New York's jail and prison personnel will identify all persons at risk of suicide or prevent all deaths from suicide. However, based on OSI's investigations, there do appear to be, at minimum, four common-sense steps New York's jail and prison personnel could take to reduce suicide risk.

First, professionals with relevant training should conduct the initial suicide risk screenings upon a person's arrival at a jail or prison. Although initial screenings for suicide risk were done in all of the 27 cases examined by OSI for the 12-month period ended August 31, 2022, those in the county jails and the NYC DOC jails were done by corrections officers, not medically trained personnel, such as a nurse, a social worker, or a doctor, using simple questionnaires that relied on the officer's observations and the person's responses to determine suicide risk.[57] OSI urges the jails to require that initial suicide screenings be conducted by professionals who are trained to take inmates' histories and make nuanced observations.

Second, personnel conducting inmates' initial screenings must have and take account of inmates' mental health histories. According to medical and behavioral health records obtained by OSI in the course of its investigations, 19 of the 27 persons who died by suicide in the 12 months ended August 31, 2022 had a documented history of mental health treatment, including 11 diagnosed with a serious mental illness (SMI), such as schizophrenia, bipolar disorder, or major depression,[58] and 10 with histories of self-harm, including prior suicide attempts.[59]

For example, Brandon Rodriguez died by suicide in a jail on Rikers Island on August 10, 2021 (prior to the 12-month period ended August 31, 2022). Although he was seen by a doctor and a social worker after his initial suicide risk screening, neither of them rated him a suicide risk. Despite the existence of medical records showing Mr. Rodriguez had a history of mental illness and had previously attempted suicide, it is not clear that either professional had access to, or if they did, read those records. (See a description of Mr. Rodriguez's case in Section 4 above.)[60]

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rate for women.

[57] For example, NYC DOC corrections officers use a questionnaire that includes the questions, "Detainee is thinking about killing self (If yes, notify supervisor)," and "Detainee is expressing feelings of hopelessness (nothing to look forward to) (If yes, notify supervisor)."

[58] According to the Substance Abuse and Mental Health Services Administration, a mental illness that interferes with a person's daily life and ability to function is defined as a serious mental illness (SMI).

[59] The 11 persons diagnosed with SMIs and the 10 persons with history of self-harm were in some instances the same person.

[60] It is also critically important that corrections officials take note of directions from medical professionals and of orders from courts. In the case of an incarcerated person on Rikers Island who took his own life in the summer of 2022, there was a note on his securing order stating "suicide watch ordered by judge," but jail personnel failed to put him on suicide watch. OSI's investigation of this matter is ongoing.

Third, whether or not jail and prison personnel initially rate a person as a suicide risk, they should regularly follow up on the incarcerated person's mental health. For example, based on OSI's investigations, 2 of the 27 suicides in the period seemed to follow adverse events in an incarcerated person's life, such as denial of the appeal in his criminal case, or a wife saying she wanted a divorce.[61] Also, certain kinds of criminal convictions and sentences seem to increase risk: 13 persons who died by suicide had been charged with serious crimes or sentenced to long terms of imprisonment, including 8 persons charged with or convicted of murder or manslaughter, and 5 charged with or convicted of sex offenses.

Fourth, corrections officers must enforce simple rules of good order that already exist. For example, in 2 of OSI's investigations into the 27 suicides, corrections officers failed to enforce a rule prohibiting incarcerated persons from obstructing the view into their cells, such as by using cardboard to cover door windows, or sheets to cover open-bar cell doors. In those cases incarcerated persons were able to hang themselves out of view of corrections officers, even when the corrections officers were conducting rounds and, theoretically, looking into each cell.[62] Similarly, in 3 of OSI's investigations into the 27 suicides, corrections officers failed to conduct rounds as required. As shown by video, officers either completely missed required rounds, or, though they walked a corridor, failed to look carefully into the cells of the incarcerated persons.[63]

For example, in the case of Segundo Guallpa, an incarcerated person on Rikers Island who took his own life on August 30, 2021 (before the 12-month period ended August 31, 2022), corrections officers were supposed to conduct rounds every 30 minutes but allowed two periods – one of an hour and a quarter, and another of an hour and a half – to go by without making a round when Mr. Guallpa might have hung himself. (Officers in that case also falsified the logbooks to make it appear that the missing rounds had been done. Four corrections officers were disciplined after Mr. Guallpa died.)

It is an unfortunate fact that when an incarcerated person hangs himself, he can often accomplish the act in a matter of minutes, and, once hanging, become brain dead within a few minutes more.[64] Therefore, there is no guarantee that enforcing these simple rules of good order would necessarily

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[61] In some of OSI's investigations, fellow inmates told OSI's or other investigators they were aware of adverse events affecting the person who took his own life, or of other severe distress expressed by the person. Although these after-the-fact statements are to be taken with a grain of salt, having corrections officers simply talk to incarcerated persons on a regular basis could surface potential issues and put personnel on alert for suicide risk.

[62] OSI is investigating the case of an incarcerated person on Rikers Island who took his own life in the spring of 2022 and who had covered the window of the door to his cell before hanging himself. It is unknown how long he had been hanging before he was found.

[63] After a death, review of surveillance video, where it exists, will show whether corrections officers made the rounds they indicated in their logbooks. However, OSI does not know how often jail and prison supervisors review the accuracy of logbook entries in the absence of a death and take disciplinary action where logbook entries are falsified. If supervisors do not do such reviews or take such action, a culture of missing rounds and falsifying logbooks could take root, which in turn would endanger inmate safety.

[64] See, for example, the case of Antonio Bradley, described above in Section 4. See Goldstein, S. (2020, December 3) Hanging Injuries and Strangulation, *Medscape,* https://emedicine.medscape.com/article/826704-overview?reg=1.

have saved any specific life, but OSI believes that consistent enforcement would change the odds and over time would save lives.

5.5 Drug Overdose Prevention in Jails and Prisons

RECOMMENDATION

New York's jail and prison personnel should, at minimum, take five common-sense steps to improve drug overdose prevention.

Of the 120 persons who died in jails and prisons from September 1, 2021 through August 31, 2022, 31 died from drug overdoses (including 8 suspected overdoses, pending final autopsy reports). Of the 23 cases in which a final autopsy report was produced, the medical examiner found intoxication by fentanyl to be the cause of death in 17 cases (including 7 cases where other drugs contributed to the fatal intoxication), methamphetamine to be the cause of death in 3 cases, synthetic marijuana to be the cause of death in 2 cases, and methadone to be the cause of death in 1 case.[65]

Two things stand out.

First, the rate of death from drug overdoses in New York's jails and prisons appears to be more than double the rate for the overall United States population. According to the website of the Centers for Disease Control, the age-adjusted death rate from drug overdoses in the United States in 2020 was 28.3 per 100,000. (This was a marked increase from the prior year, which the CDC attributes at least in part to the Covid-19 pandemic.) As mentioned, the total population of New York's jails and prisons is about 46,600. Although the sample size is small, 31 overdose deaths in that population is a rate of about 66.5 per 100,000.

Second, of the 23 cases where a final autopsy report is available, opioids caused the deaths in 18 (17 involving fentanyl, and 1 involving methadone). The effect of opioids, even in large amounts, is reversible when Naloxone, also known as Narcan, is timely administered.[66]

It is not surprising that the overdose death rate in jails and prisons exceeds that in the general population of the country, and no one expects New York's jail and prison personnel to find and seize all illicit drugs that enter their institutions nor to detect and prevent all potential overdose events. However, OSI recommends that New York's jail and prison personnel, at minimum, take five common-sense steps to reduce the risk of death from drug overdoses.

First, professionals with relevant training should perform an initial screening of incarcerated persons to look for signs of drug abuse. Generally, in the county jails and NYC DOC jails the initial screening procedure for suicide risk and for drug use or history are one and the same, and, as

[65] OSI does not have data concerning overall drug use or possession in the jails and prisons, nor concerning overdoses that do not result in death, as OSI receives notifications only when an event results in a death.
[66] See National Institute on Drug Abuse – Naloxone Drug Facts.

mentioned above in connection with suicide screening, corrections officers rather than medical staff generally perform the drug use screenings based on simple questionnaires.[67]

Second, the professionals who perform the initial screenings should have and take account of medical records showing any history of drug abuse and other mental health issues. According to records obtained by OSI in the course of its investigations, 14 of the 23 persons who died of confirmed drug overdoses had documented histories of behavioral health treatment, and many were dually diagnosed with mental illness and substance use disorders.

Although drug abuse programs in the jails and prisons are generally voluntary, thorough initial screenings could enable staff to identify persons at risk and make focused efforts to encourage them to attend those programs. In addition, the agencies in charge of the jails and prisons should consider assigning those at risk of serious drug abuse to protective or supportive housing, similar to the programs already in place for persons with serious mental illness.[68]

Third, whether or not a person is initially identified as likely to abuse drugs, personnel must follow up and, where indicated, take appropriate action. For example, in 10 cases in the 12 months ended August 31, 2022, persons who died of overdoses had previously overdosed or were found with contraband in the course of the same term of incarceration, but the institution failed to take effective action, such as putting them on enhanced watch or housing them in a supportive unit.

Fourth, corrections officers should be equipped with Narcan for immediate use when they find an incarcerated person unresponsive. In 14 of the 31 overdose cases in the 12 months ended August 31, 2022, corrections officers needed to await the arrival of medical staff before Narcan was administered to persons who had overdosed. Narcan is extremely effective in reversing the effects of an opioid overdose, but the passage of time can reduce effectiveness – and no harm is done if Narcan is administered to a person who is not overdosing on opioids.[69]

Fifth, corrections officers must enforce simple rules of good order that already exist. For example:

> In a case still under investigation by OSI, an incarcerated person died of a methadone overdose on Rikers Island in spring of 2021. Video appears to show at least one corrections officer observing the person in an obviously intoxicated state hours before he died. Apparently in violation of a rule, the corrections officer failed to call a medical team to the scene. Because

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[67] NYC DOC corrections officers use the same questionnaire for drug use screening as they use for suicide screening, which includes the questions, "Detainee is displaying unusual behaviors and is acting and/or talking in a strange manner," and "Detainee is apparently under the influence of alcohol or drugs."

[68] Information on substance use treatment programs is available at https://doccs.ny.gov/programs?f%5B0%5D=filter_term%3A126

[69] DOCCS issued a directive authorizing officers to use Narcan in instances where an overdose is suspected: https://doccs.ny.gov/system/files/documents/2022/09/4058.pdf. Based on OSI's investigations, it is not clear this authorization has been fully put into practice, as in many cases administration of Narcan awaited the arrival of the medical team. According to the New York City Board of Correction ("NYC BOC"), corrections officers and incarcerated persons in NYC DOC jails are supposed have Narcan available for their use whenever they suspect a person is suffering from an overdose, but NYC BOC notes many corrections officers are not aware of the program; see pages 23-24 of https://www1.nyc.gov/assets/boc/downloads/pdf/Reports/BOC-Reports/2021-suicides-and-drug-related-deaths-report-and-chs-response.pdf.

methadone is an opioid, and because Naloxone/Narcan can be very effective at reversing an opioid overdose, it is possible that a timely call to medical could have saved the person.

In another case still under investigation by OSI, a person died of a methamphetamine overdose in fall of 2021 at the Albany County Jail. Officers there may have failed to perform an adequate search of the person before putting him in a cell, and his death may have been caused by drugs he brought into the cell.

In another case under investigation by OSI, a person died of an overdose on Rikers Island in fall of 2021, from a drug called MDMB-4EN-PINACA, a synthetic cannabinoid. Video shows the person and others rolling and smoking cigarettes in plain sight in a common area. Corrections officers may have violated a rule by failing to seize obvious contraband from them.

6. OSI Data

Section 70-b requires that OSI's annual report include, among other things, the county of each matter investigated, and racial, ethnic, age, gender, and other demographic information concerning persons involved. This section, and Tables A, B, and C in the Appendix provide these and other data.

OSI's Data Period

Section 70-b requires that OSI's annual report be published on October 1 every year. OSI takes 30 days to collate and analyze data before the publication date, and so uses a data period ending on August 31. The data for the current 12-month period, from September 1, 2021, through August 31, 2022, are discussed in this section and are presented in Table A in the Appendix. OSI's first annual report, issued October 1, 2021, analyzed data for the five-month period from April 1, 2021, the effective date of Section 70-b, through August 31, 2021. See 2021 OSI Annual Report. An update of the data from the first annual report is in Table B in the Appendix. Table C shows data for New York City Department of Correction matters arising from the date Section 70-b took effect, April 1, 2021, through August 31, 2022.

OSI's Procedures

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 a causal relationship between an officer's act or omission and the death – are present.

Regarding the first element, 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, 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, but the presence of the third element – the causal relationship between an officer's act or omission and the death – is not clear. In those cases, OSI does a thorough investigation to determine whether there is reason to believe the officer caused the death. Because the third element – causation – is not initially clear, OSI calls these 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 ("omission") 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 based on the absence of 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, in effect, 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, then, pursuant to Section 70-b, OSI must do one of two things: (a) present evidence to a grand jury and obtain an indictment, or (b) issue a public report explaining why OSI chose not to present evidence to a grand jury.[70]

Accordingly, Table A in the Appendix indicates the status of every matter for which OSI received a notification in the current data period. If a matter is closed, Table A indicates 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 a published report; or OSI obtained an indictment. If a matter is open, Table A indicates whether the matter is "pending preliminary assessment" (meaning causation is not yet clear), or "pending investigation" (meaning causation is clear, but OSI has not yet determined whether to present evidence to a grand jury).

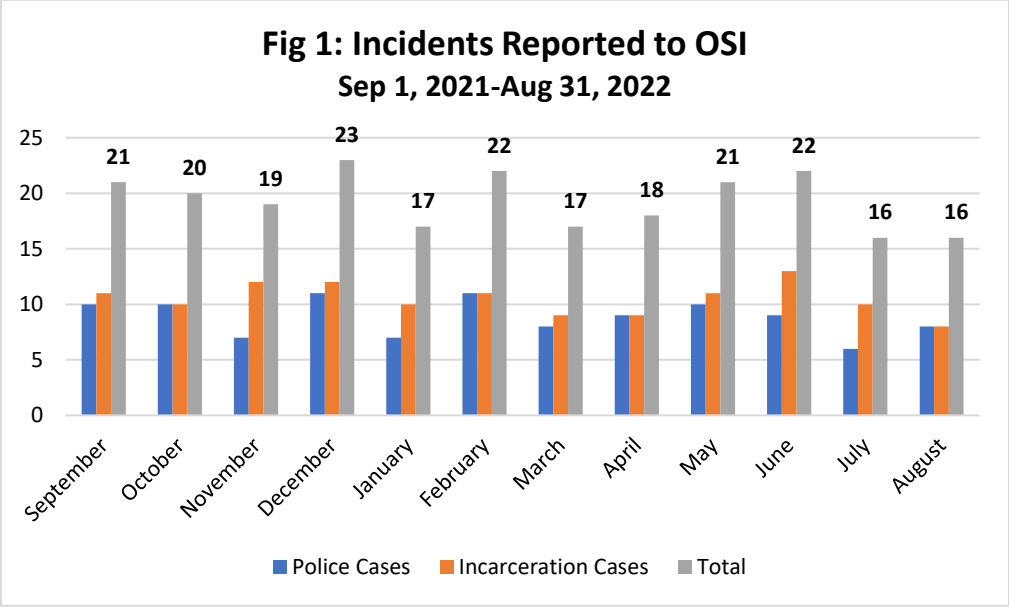
Table B shows complete (including updated) data from the five-month period from April 1 through August 31, 2021. Table C shows data from all NYC DOC matters from April 1, 2021 (the effective date of Section 70-b) through August 31, 2022.

[70] OSI is also required to issue a report explaining the investigation and the outcome if OSI does present evidence to a grand jury but the grand jury declines to indict.

Selected data are discussed below.

Notifications Received and Status, Current Year and Prior Year

In the 12-month period ended August 31, 2022, agencies around the state notified OSI of 232 incidents potentially coming within Section 70-b. This is an average of close to 20 notifications per month, which is similar to the monthly average reported in OSI's first annual report. Of those 232 incidents, 126 were incidents in jails and prisons and 106 were incidents involving police officers.[71] See Figure 1.



Of the 106 incidents involving police agencies, OSI closed 67 prior to August 31, 2022, including the closure of

- 42 because, after a preliminary assessment, OSI did not find reason to believe that an officer caused the death
- 14 because there was no death
- 3 because an officer as defined by Section 70-b was not involved
- 6 by issuing a report[72]
- 2 by presenting evidence to grand juries and obtaining indictments, which members of OSI are now prosecuting.[73]

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[71] One incident occurred in a holding cell operated by police rather than a corrections agency, and we classify it as a police case.

[72] The six published reports for incidents arising in the current data period concern the deaths of Dedrick James, Brandi Baida, Simran Gordon, Allison Lakie, Wesley Soper, and Janet Jordan. Summaries are in Section 3 above.

[73] See Section 2 above for a summary of the indictments. Two indictments OSI is now prosecuting, People v. Wu and People v. Middleton, arise from incidents in the current data period. The two other indictments, People v. Allen and People v. Baldner, arise from incidents in 2020, which predate the effective date of Section 70-b.

Of the 126 incidents involving jails and prisons, OSI closed 71 prior to August 31, 2022, including the closure of:

- 65 because, after a preliminary assessment, OSI did not find reason to believe that an officer caused the death
- 3 because there was no death
- 2 because an officer as defined by Section 70-b was not involved
- 1 because the person who died was an employee of a jail, not an incarcerated person.

See Table A, which includes additional detail for every case in the current period, such as date of death, county of occurrence, the agency involved, the type of case, and the decedent's name, race or ethnicity, and age.

For cases arising in the 12 months ended August 31, 2022, 27 remain open pending investigation and 67 remain open pending preliminary assessment.

As set forth in OSI's prior annual report, OSI received 95 notifications in the five-month period ended August 31, 2021 and closed 70 of those matters in that period. An additional incident occurring during that period was reported to OSI following the issuance of the first annual report, for a total of 96 incidents in the prior reporting period. Since September 1, 2021, for matters arising from April 1 through August 31, 2021, OSI closed an additional:

- 12 matters because, after a preliminary assessment, OSI did not find reason to believe that an officer caused the death and
- 7 matters by issuing a published report.[74]

See Table B for details on every matter arising in the prior data period.

For cases arising in the five months from April 1, 2021, through August 31, 2022, 6 remain open pending investigation, and 1 remain open pending preliminary assessment.

Two cases remain open, pending investigation, from the period prior to April 1, 2021, when OSI's predecessor unit conducted investigations under Executive Order 147, and OSI closed three incidents from that period in the past 12 months with published reports.[75]

Police Shootings

Of the 106 notifications involving police officers in the year ended August 31, 2022, 40 were shootings. In 12 of those incidents there was no death, in 2 incidents there was no officer defined by Section 70-b, in 3 incidents an off-duty officer killed a person and then killed himself (murder-suicide), and in 1 incident a bystander was caught in crossfire involving police and others and it is

[74] See Section 3 for summaries of the published reports; the seven reports on incidents in the prior data period are those on the deaths of Tyler Green, Mark Gaskill, Jesse Bonsignore, Timothy Flowers, Christopher Van Kleeck, Steven Leconte, and David Wandell.

[75] The three published reports from the period prior to the effective date of Section 70-b concern the deaths of Jeffrey McClure, George Zapantis, and Judson Albahm, and are summarized above in Section 3.

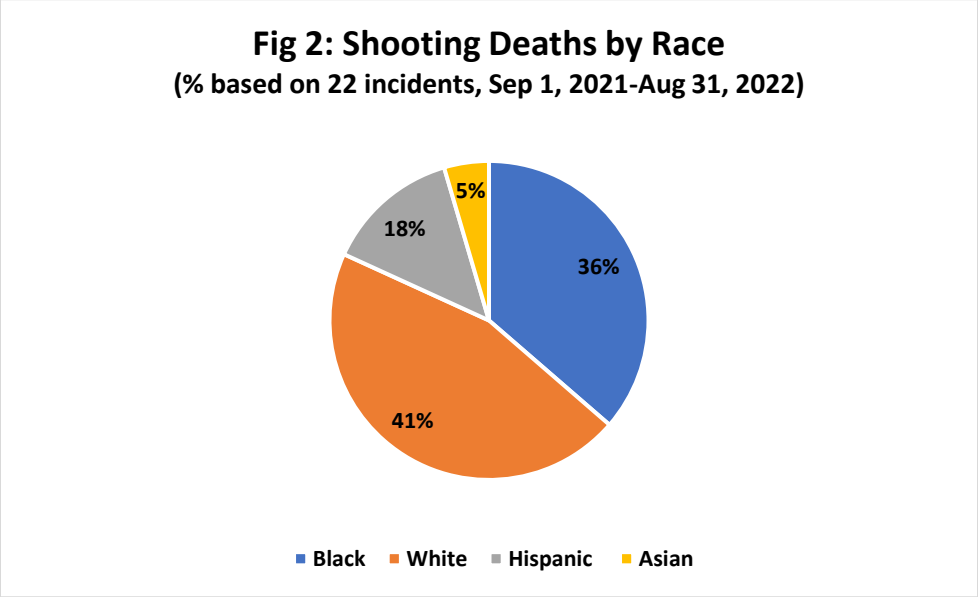
unclear at this time whether he was killed by a police bullet – leaving 22 incidents in which an officer shot and killed another person.

Of these 22 shooting incidents, OSI closed 4 by issuing a report (Dedrick James, Brandi Baida, Simran Gordon, and Allison Lakie, see Section 3 above), and 2 by obtaining indictments (People v. Wu and People v. Middleton, see Section 2 above), which members of OSI are prosecuting. The other 16 shooting incidents remain under investigation.

Of the 22 shooting incidents:

- 18 persons killed were male and 4 were female
- 9 persons killed were white, 8 were Black, 4 were Hispanic, and 1 was Asian
- 19 of the persons killed had a weapon (11 had firearms, 6 had knives, 2 had realistic BB or pellet guns) and 3 of the persons were unarmed
- 15 of the persons killed were 18 to 34 years old
- 11 incidents involved officers of the New York City Police Department, and 11 involved officers of other police agencies.

See Figures 2, 3, 4, and 5, below.



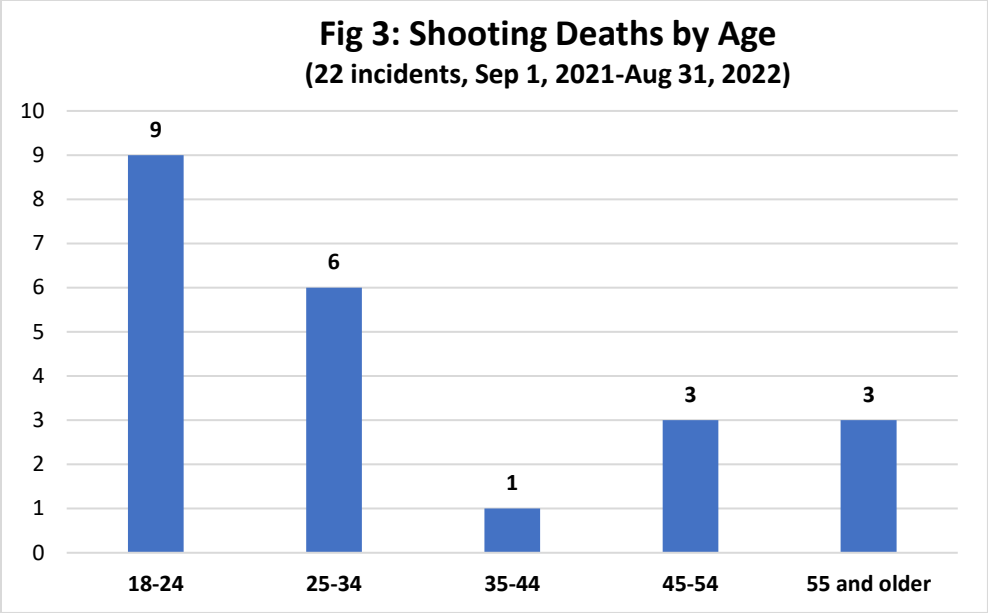


Fig 3: Shooting Deaths by Age
(22 incidents, Sep 1, 2021-Aug 31, 2022)
10
9
8
7
6
5
4
3
2
1
0
9
6
1
3
3
18-24
25-34
35-44
45-54
55 and older

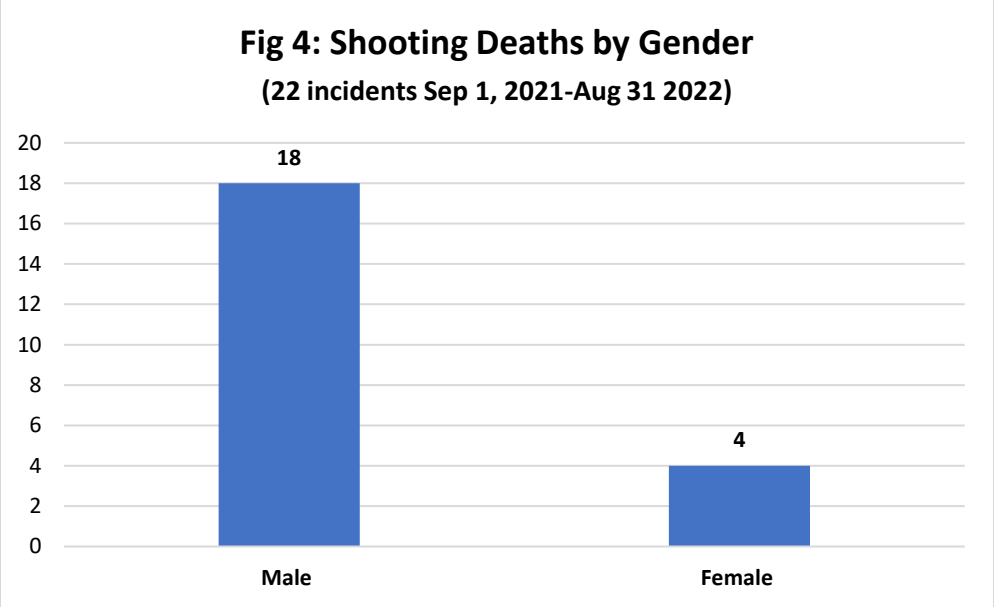
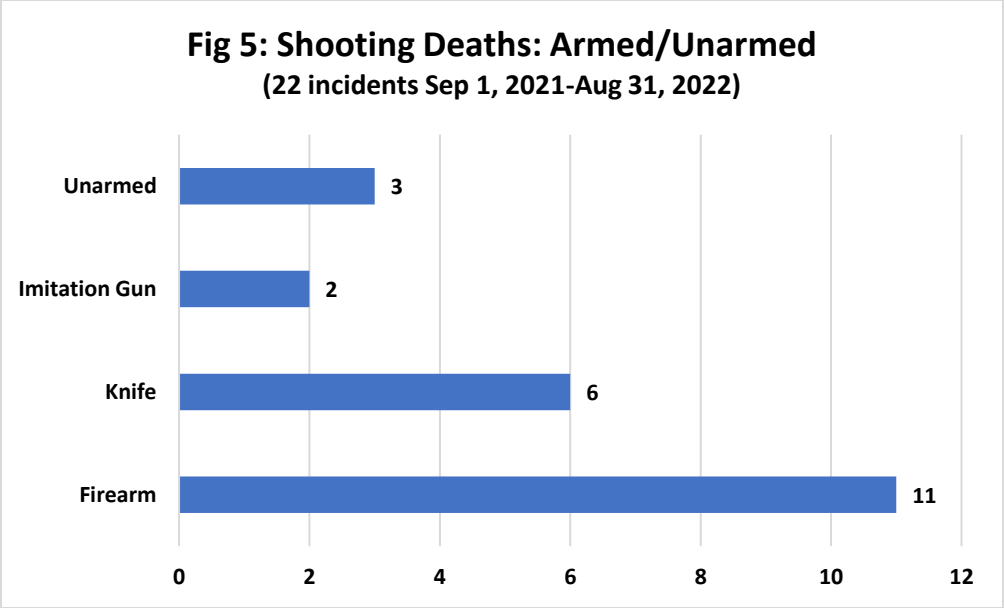


Fig 4: Shooting Deaths by Gender
(22 incidents Sep 1, 2021-Aug 31 2022)
20
18
16
14
12
10
8
6
4
2
0
18
4
Male
Female



Police Shootings and Mental Health Crises

OSI's personnel do not include mental health professionals, but, as laypersons, our perception is that at least 10 of the 22 persons who died in police shootings in the 12 months ended August 31, 2022 may have been undergoing a mental health crisis (or a drug or alcohol induced crisis) at the time of the incident, including:

- A person shooting a rifle from the window of a house in a residential neighborhood for no apparent reason (see the description of the Brandi Baida case, in Section 3)
- A person who called for police assistance and pointed a gun at the officer who responded[76]
- A person setting fires in her mother's house, who came at officers with knives in both hands after two hours of attempted negotiation (see the description of the Allison Lakie case, in Section 3)
- A person who got out of his car, got a realistic looking BB or pellet gun from the car, and took a shooting stance, pointing the gun officers who had stopped him for speeding
- A person who called 911 to report a man with a knife, and who was the same person who came at responding police officers with a knife, after officers attempted to negotiate with him
- A person who, after injuring his mother, came at officers with a knife and a sword, after officers attempted to negotiate with him
- A person who put a knife to his own chest, indicating he would kill himself, and then tossed the knife in the direction of a responding officer

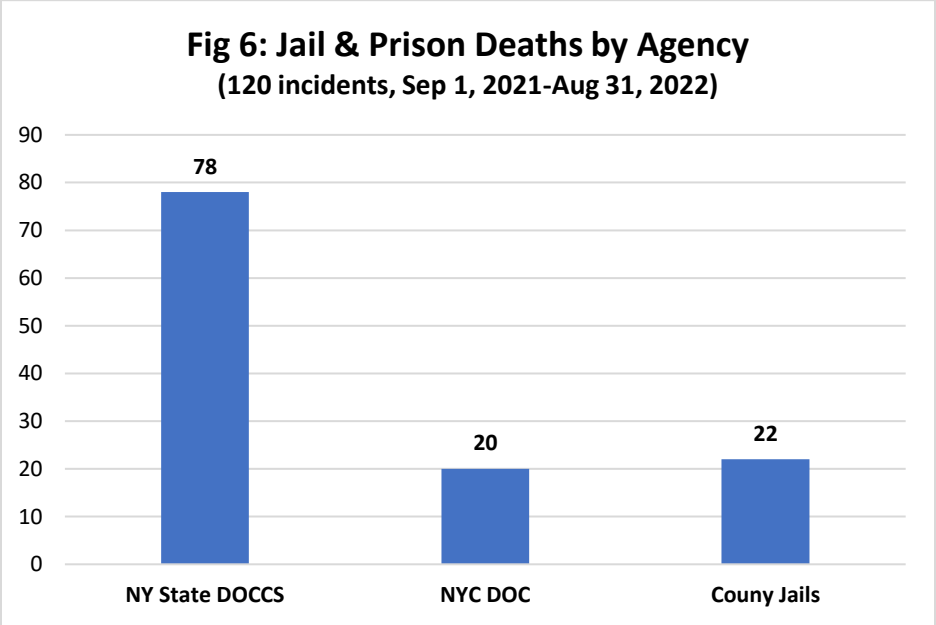
[76] Unless there is a cross reference to a report described in the earlier sections of this report, the case remains under investigation. The descriptions here of cases still under investigation should not be considered indications of the conclusions OSI will come to when the investigations are finished.

- A person who pulled out a knife as an officer, who had responded to her call for assistance with a domestic incident, was talking with her
- A person who had injured a mental health worker with a knife and pulled out a knife and came at an officer responding to the earlier incident, and
- A person who called 911 and said he wanted to kill police officers.

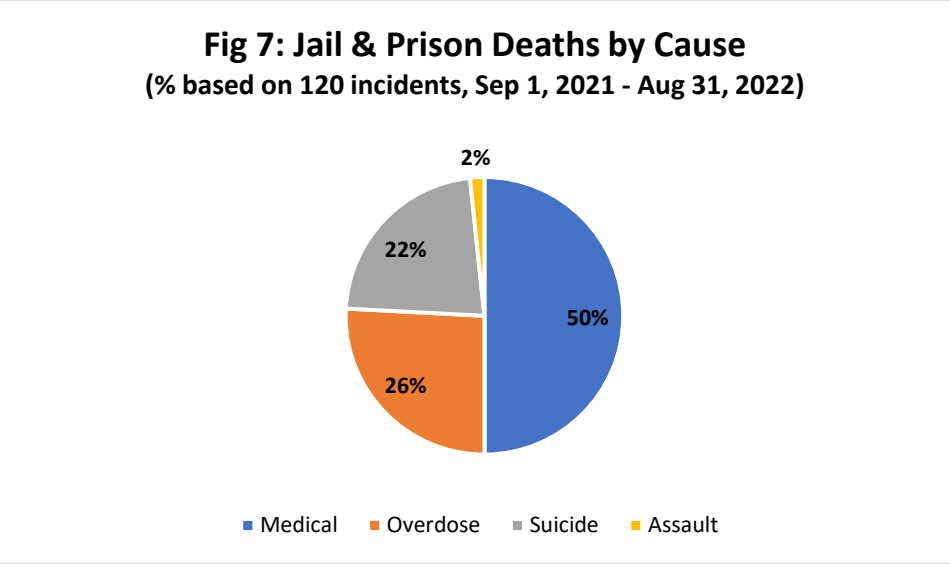
Please see OSI's recommendation, above, in Section 5, concerning the need to train police officers to respond to mental health crises.

Incidents in Jails and Prisons

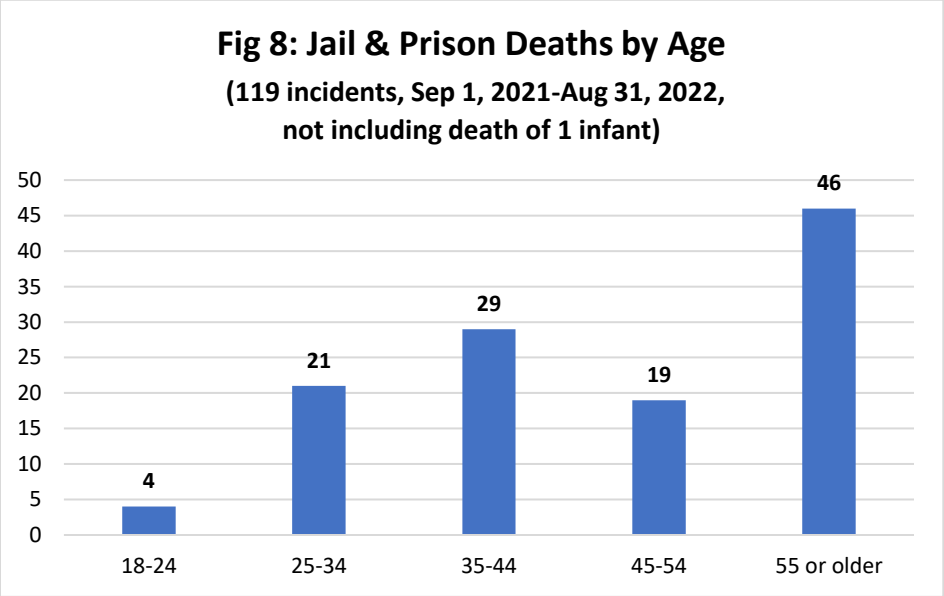
Of the 120 deaths OSI investigated in the jails and prisons in the current data period, 78 incidents related to DOCCS, 20 related to NYC DOC, and 22 related to county jails. See Figure 6.



Of the 120 deaths, 27 were by suicide or apparent suicide, 31 were by drug overdose or suspected overdose, 60 were due to medical emergencies, and 2 were due to violence between incarcerated individuals. See Sections 5.4 and 5.5 above for a discussion of these data and recommendations on suicide and overdose prevention. See Figure 7.



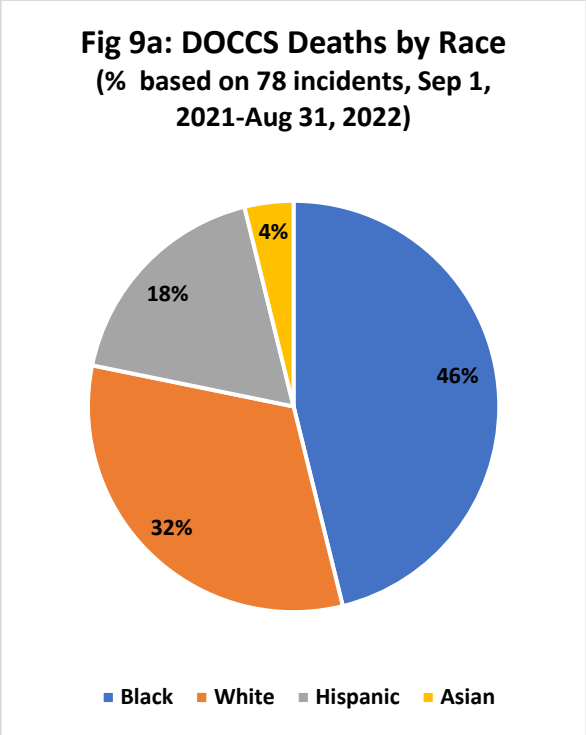
Of the 120 persons who died in jails and prisons, 117 were male and 3 were female. None identified as transgender or nonbinary; 4 were 18 to 24 years old, 21 were 25 to 34 years old, 29 were 35 to 44 years old, 19 were 45 to 54 years old, and 46 were 55 or older. One person was an infant: the incident involved an incarcerated woman who gave birth.[77] See Figure 8.

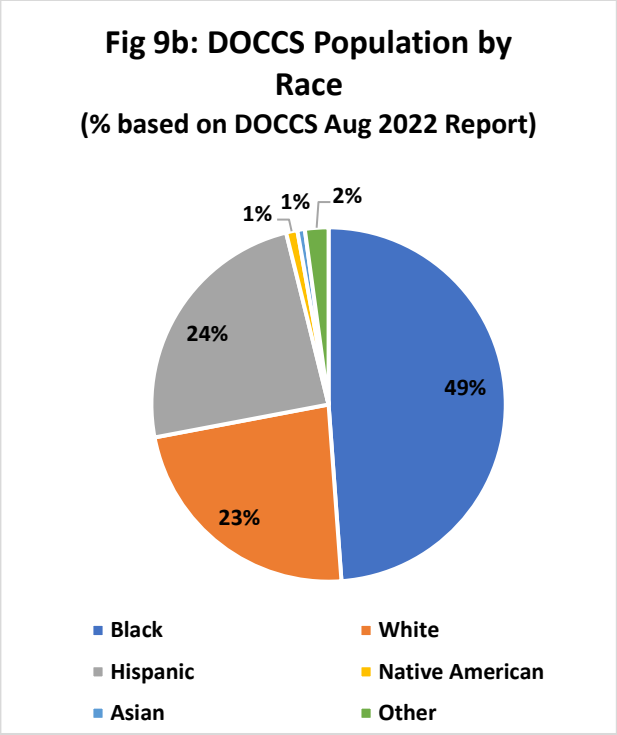


[77] The incident involving the infant who died during birth is not captured in the Figure 8.

DOCCS Deaths by Race

Of the 78 persons who died in the DOCCS system from September 1, 2021 to August 31, 2022, 36 were Black, 25 were white, 14 were Hispanic, and 3 were Asian. See Figure 9a; see Figure 9b for overall DOCCS population by race for comparison.[78]

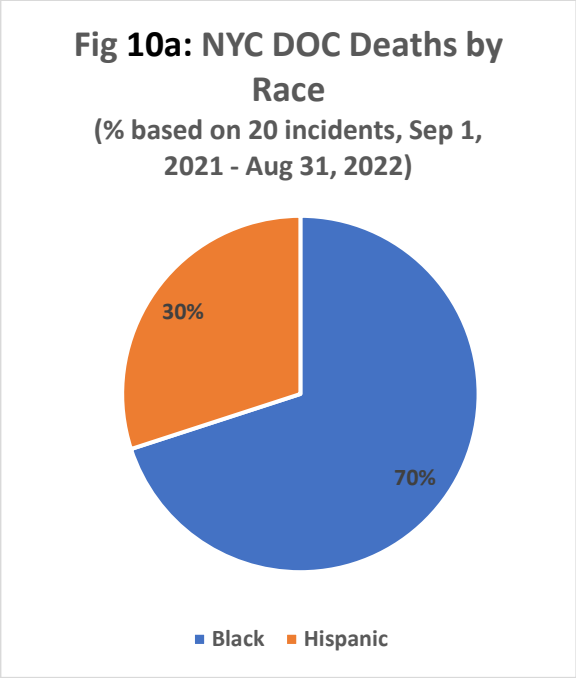


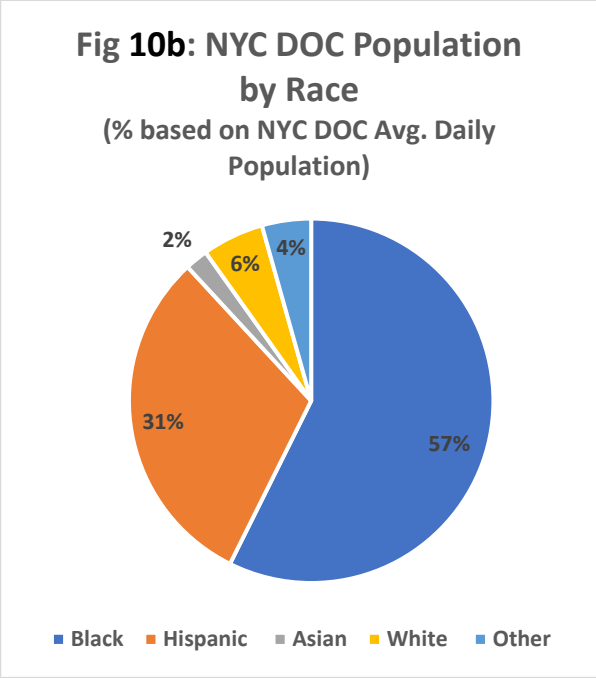


NYC DOC Deaths by Race

Of the 20 persons who died in NYC DOC custody from September 1, 2021 to August 31, 2022, 14 were Black and 6 were Hispanic. See Figure 10a; see Figure 10b for overall NYC DOC population data by race.[79]

[78] DOCCS population data is based on the DOCCS Incarcerated Profile Report from August 2022.
[79] NYC DOC population data is based on the FY22 Q4 Population Demographics Report.





Of the 22 persons who died in county jails outside of New York City, 10 were Black, 11 were white, and 1 was Hispanic. Population data for county jails is maintained on the local level and therefore not available for comparison.

7. Conclusion

In the 18 months since Section 70-b went into effect, the most consistent themes in the cases investigated by OSI are mental illness and drug use. In jails and prisons, persons are dying by suicide and from drug overdoses. On the street, many police responses are initiated because a person is in a mental health crisis. Therefore it is critical that the state, corrections agencies in the state, and police agencies in the state, thoughtfully design, adequately fund, and effectively implement programs to reduce the risk of death due to mental illness and drug use, including

- Effective evaluation, monitoring, and treatment of persons in jails and prisons at risk of suicide and drug use
- Effective enforcement of the rules of good order in jails and prisons
- Meaningful and continuous training of police officers, 911 operators, and dispatchers to handle cases involving persons undergoing mental health crises.

No program or combination of programs will reduce to zero the number of deaths in jails and prisons and in police encounters due to mental illness and drug use. But the risk and the numbers can and should be reduced. Persons – even persons committing crimes or convicted of committing crimes – should not have to die because they are mentally ill.

8. Appendix

Table A. Incidents Notified to the Attorney General Under Section 70-b, September 1, 2021 through August 31, 2022												
A	B	C	D	E	F	G	H	I	J	K	L	M
#	Date of Death	County	Agency	Name	Age	Race/Ethnic Group	Gender	Incarcerated	Incident Type	Agency Video	Status	Comments
1	9/2/2021	Westchester	DOC (Westchester County)	**Anthony Jacobs**	53	Black	Male	Yes	Medical	Yes	Closed	Officer did not cause death
2	9/5/2021	Oneida	Village of Yorksville PD	**Nathaniel Harvey**	45	Black	Male	No	Vehicular	No	Closed	Officer did not cause death
3	9/6/2021	Onondaga	Onondaga County Sheriff	**Angela Peng**	27	Asian	Female	No	Suicide	Yes	Closed	Officer did not cause death
4	9/7/2021	Chautauqua	Chautauqua County Jail	**Jose Luis Rivera Perez**	31	Hispanic	Male	Yes	Suicide	Yes	Closed	Officer did not cause death
5	9/7/2021	Bronx	NYC DOC	**Esias Johnson**	24	Black	Male	Yes	Overdose	Yes	Closed	Officer did not cause death
6	9/7/2021	Washington	DOCCS (Great Meadows)	**Shakim J. Allah**	61	Black	Male	Yes	Medical	Yes	Closed	Officer did not cause death
7	9/7/2021	Fulton	Fulton County Sheriff	**Edward Fletcher**	50	White	Male	No	Suicide	No	Closed	Officer did not cause death
8	9/8/2021	Orange	Orange County Jail	**Michael Stevenson**	41	Black	Male	Yes	Medical	Yes	Closed	Officer did not cause death
9	9/10/2021	Clinton	Clinton County Sheriff	**Steven D. Murray**	62	White	Male	Yes	Medical	Yes	Closed	Officer did not cause death
10	9/11/2021	Kings	NYPD	**Apolline Mong-Guillemin**	3 mos.	Hispanic	Female	No	Vehicular	Yes	Closed	Officer did not cause death
11	9/13/2021	Greene	DOCCS (Coxsackie)	**Mark Williams**	54	Black	Male	Yes	Medical	Yes	Closed	Officer did not cause death
12	9/14/2021	Erie	DOCCS (Wende)	**Robert Hill**	60	Black	Male	Yes	Medical	No	Closed	Officer did not cause death
13	9/15/2021	Monroe	Rochester PD	**Dedrick James**	24	Black	Male	No	Shooting	No	Closed	Report issued
14	9/16/2021	Dutchess	Dutchess County Sheriff	**Amos Domfeh**	57	Black	Male	No	Vehicular	Yes	Open	Pending investigation

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#	Date of Death	County	Agency	Name	Age	Race/Ethnic Group	Gender	Incarcerated	Incident Type	Agency Video	Status	Comments
15	9/18/2021	Kings	Federal Parks Police	**Joshua Cooper**	31	Unknown	Male	No	Shooting	No	Closed	No defined officer
16	9/19/2021	Bronx	NYC DOC	**Karim Isaabdul**	41	Black	Male	Yes	Medical	Yes	Closed	Officer did not cause death
17	9/21/2021	Cayuga	Auburn PD	**Brandi Baida**	30	White	Female	No	Shooting	Yes	Closed	Report issued
18	9/22/2021	Bronx	NYC DOC	**Stephen Khadu**	24	Black	Male	Yes	Medical	Yes	Closed	Officer did not cause death
19	9/23/2021	Suffolk	Suffolk County PD	**Osiris Mercado**	39	Hispanic	Male	No	Medical	No	Open	Pending investigation
20	9/26/2021	Bronx	NYPD	**Adrian Golding**	42	Black	Male	No	Vehicular	Yes	Closed	No death
21	9/30/2021	Seneca	DOCCS (Five Points)	**Joseph Ambrosio**	60	White	Male	Yes	Medical	Yes	Closed	Officer did not cause death
22	10/4/2021	Delaware	Walton PD	**Paul Weeden**	66	White	Male	No	Shooting	Yes	Open	Pending investigation
23	10/6/2021	New York	NYPD	**Antonio Armstrong**	23	Black	Male	No	Suicide	Yes	Closed	Officer did not cause death
24	10/6/2021	Monroe	Rochester PD	**Simran Gordon**	24	Black	Male	No	Shooting	Yes	Closed	Report issued
25	10/8/2021	Westchester	DOCCS (Sing Sing)	**Corey Slattery**	33	White	Male	Yes	Suicide	No	Closed	Officer did not cause death
26	10/11/2021	Kings	NYPD	**Peter Tse**	35	Asian	Male	No	Vehicular	No	Closed	Officer did not cause death
27	10/13/2021	Kings	NYPD	**Jamie Liang**	24	Asian	Female	No	Shooting	Yes	Closed	Indictment issued
28	10/15/2021	Cayuga	DOCCS (Auburn)	**Kareem Bryan**	38	Black	Male	Yes	Medical	No	Closed	Officer did not cause death
29	10/15/2021	Bronx	NYC DOC	**Victor Mercado**	64	Hispanic	Male	Yes	Medical	Yes	Closed	Officer did not cause death
30	10/17/2021	Kings	NYPD	**James Lopez**	42	Hispanic	Male	No	Vehicular	Yes	Closed	Officer did not cause death
31	10/17/2021	Dutchess	DOCCS (Downstate)	**Michael Wisdom**	45	Black	Male	Yes	Suicide	No	Closed	Officer did not cause death

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#	Date of Death	County	Agency	Name	Age	Race/Ethnic Group	Gender	Incarcerated	Incident Type	Agency Video	Status	Comments
32	10/19/2021	New York	NYC DOC	**Anthony Scott**	58	Black	Male	Yes	Suicide	Yes	Open	Pending preliminary assessment
33	10/19/2021	Suffolk	Suffolk County PD	**Starling Diaz-Felipe**	19	Hispanic	Male	No	Vehicular	Yes	Closed	Officer did not cause death
34	10/20/2021	Onondaga	Syracuse PD	**Allison Lakie**	33	White	Female	No	Shooting	Yes	Closed	Report issued
35	10/20/2021	Orange	DOCCS (Otisville)	**Marco Ayuso**	61	Hispanic	Male	Yes	Overdose	No	Closed	Officer did not cause death
36	10/22/2021	Dutchess	DOCCS (Fishkill)	**Juan Roman**	61	Hispanic	Male	Yes	Medical	No	Closed	Officer did not cause death
37	10/23/2021	Niagara	Niagara County Jail	**Jeffrey Joyes**	51	White	Male	Yes	Suicide	Yes	Closed	Officer did not cause death
38	10/24/2021	Seneca	DOCCS (Five Points)	**Tyrone Williams**	41	Black	Male	Yes	Suicide	Yes	Closed	Officer did not cause death
39	10/26/2021	Queens	NYPD	**Christopher Auriemma**	28	Asian	Male	No	Suicide	Yes	Closed	Officer did not cause death
40	10/29/2021	Orange	NYSP, Walden and Montgomery PD	**Joanne Schields & Elizabeth Bello**	52 & 35	Unknown	Female	No	Vehicular	Yes	Closed	Officer did not cause death
41	10/31/2021	Albany	Albany County Sheriff	**Brian Bishop**	43	White	Male	Yes	Overdose	Yes	Open	Pending investigation
42	11/1/2021	Chemung	DOCCS (Elmira)	**Timothy Bush**	56	White	Male	Yes	Suicide	No	Closed	Officer did not cause death
43	11/1/2021	Queens	NYPD	**Christian Gomez**	33	Hispanic	Male	No	Suicide	Yes	Closed	Officer did not cause death
44	11/3/2021	Kings	NYPD	**Unknown**	Unknown	Unknown	Unknown	No	Shooting	N/A	Closed	No death
45	11/4/2021	Ontario	Ontario County Sheriff	**John Fontaine**	38	White	Male	No	Suicide	Yes	Closed	Officer did not cause death
46	11/8/2021	Dutchess	DOCCS (Fishkill)	**Bernard Hatch**	81	White	Male	Yes	Medical	No	Closed	Officer did not cause death
47	11/10/2021	Nassau	Nassau County Jail	**James Campbell**	57	White	Male	Yes	Medical	No	Closed	Officer did not cause death

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48	11/11/2021	Kings	NYPD	**Brian Astarita**	65	White	Male	No	Shooting	Yes	Open	Pending investigation
49	11/12/2021	Rockland	Spring Valley PD	**Paul Waddell**	65	Black	Male	No	Medical	No	Closed	Officer did not cause death
50	11/15/2021	Chemung	DOCCS (Elmira)	**Adam Perham**	38	White	Male	Yes	Overdose	No	Closed	Officer did not cause death
51	11/15/2021	Chemung	Chemung County Sheriff	**Rickey Wells**	53	Black	Male	Yes	Medical	Yes	Closed	Officer did not cause death
52	11/16/2021	Dutchess	DOCCS (Green Haven)	**Robert Durso**	52	White	Male	Yes	Overdose	No	Closed	Officer did not cause death
53	11/16/2021	Onondaga	Onondaga County Sheriff	**Daniel Gibson**	36	American Indian	Male	No	Overdose	Yes	Closed	Officer did not cause death
54	11/19/2021	Queens	DOCCS (Queensboro)	**Joseph Rodriguez**	62	Hispanic	Male	Yes	Medical	No	Closed	Officer did not cause death
55	11/21/2021	Chemung	DOCCS (Elmira)	**Ronald McCarthy**	59	White	Male	Yes	Suicide	No	Closed	Officer did not cause death
56	11/24/2021	Oneida	Marcy Psychiatric Hospital	**Anthony Diaz**	Unknown	Unknown	Male	Yes	Other	N/A	Closed	No defined officer
57	11/24/2021	Nassau	Nassau County Sheriff	**Unknown**	Unknown	Unknown	Unknown	Yes	Medical	N/A	Closed	No death
58	11/26/2021	Saratoga	Saratoga County Sheriff	**John Cranfield**	68	White	Male	No	Suicide	No	Closed	Officer did not cause death
59	11/28/2021	Chemung	DOCCS (Elmira)	**Saroeun Muon**	33	Asian	Male	Yes	Suicide	No	Open	Pending preliminary assessment
60	11/30/2021	Erie	Erie County Sheriff	**James Ellis**	58	Black	Male	Yes	Medical	Yes	Closed	Officer did not cause death
61	12/3/2021	Erie	DOCCS (Collins)	**Antonio McCarty**	55	Black	Male	Yes	Medical	Yes	Closed	Officer did not cause death
62	12/7/2021	Franklin	NYSP	**Aaron Stark**	41	White	Male	No	Overdose	Yes	Closed	Officer did not cause death
63	12/7/2021	Westchester	DOCCS (Sing Sing)	**Steven Alleyne**	56	Black	Male	Yes	Overdose	No	Closed	Officer did not cause death

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64	12/7/2021	Bronx	NYC DOC	**Thamar Francois**	Unknown	Unknown	Unknown	No	Medical	N/A	Closed	Not an inmate
65	12/10/2021	Bronx	NYC DOC	**Malcolm Boatwright**	28	Black	Male	Yes	Medical	Yes	Closed	Officer did not cause death
66	12/14/2021	Bronx	NYC DOC	**William Brown**	37	Black	Male	Yes	Overdose	Yes	Open	Pending preliminary assessment
67	12/15/2021	Greene	Catskill PD	**Jason Jones**	29	White	Male	No	Taser	Yes	Open	Pending investigation, incident 10/30/2021
68	12/16/2021	Queens	NYPD	**Raymierik Lopez**	20	Hispanic	Male	No	Shooting	No	Open	Pending investigation
69	12/16/2021	Onondaga	Onondaga County Sheriff	**Paul Watkins**	38	White	Male	Yes	Suicide	No	Closed	Officer did not cause death
70	12/17/2021	Monroe	Monroe County Sheriff	**Wesley Soper**	32	White	Male	No	Vehicular	No	Closed	Report issued
71	12/17/2021	Onondaga	Town of Cicero PD	**Chatuma Crawford**	20	Black	Male	No	Vehicular	No	Open	Pending investigation
72	12/19/2021	Chemung	Chemung County Sheriff	**James Thigpen**	36	White	Male	No	Vehicular	No	Closed	Officer did not cause death
73	12/20/2021	Kings	NYPD	**Eudez Pierre**	26	Black	Male	No	Shooting	Yes	Open	Pending investigation
74	12/22/2021	Otsego	NYSP	**Mark Beilby**	24	White	Male	No	Shooting	Yes	Open	Pending investigation
75	12/22/2021	Seneca	DOCCS (Five Points)	**Henry Maldonado**	61	Hispanic	Male	Yes	Suicide	No	Closed	Officer did not cause death
76	12/24/2021	Oneida	DOCCS (Mohawk)	**Lawrence Harris**	69	Black	Male	Yes	Medical	No	Closed	Officer did not cause death
77	12/24/2021	Herkimer	NYSP	**Carson Dobson**	24	White	Male	No	Shooting	Yes	Open	Pending investigation
78	12/24/2021	Clinton	DOCCS (Clinton)	**Bryan Ashline**	35	White	Male	Yes	Overdose	Yes	Closed	Officer did not cause death

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#	Date of Death	County	Agency	Name	Age	Race/Ethnic Group	Gender	Incarcerated	Incident Type	Agency Video	Status	Comments
79	12/25/2021	Wyoming	DOCCS (Attica)	**Tyrone Chaneyfield**	25	Black	Male	Yes	Medical	No	Closed	Officer did not cause death
80	12/27/2021	Bronx	NYPD	**Sergio Guzman**	52	Hispanic	Male	No	Vehicular	Yes	Closed	Officer did not cause death
81	12/27/2021	Clinton	DOCCS (Clinton)	**Justin Odell**	28	Black	Male	Yes	Overdose	Yes	Closed	Officer did not cause death
82	12/30/2021	Wyoming	DOCCS (Attica)	**Alvin Yates**	64	Black	Male	Yes	Medical	No	Closed	Officer did not cause death
83	12/31/2021	Oneida	DOCCS (Mohawk)	**Derrick Lewis**	65	Black	Male	Yes	Medical	No	Closed	Officer did not cause death
84	1/3/2022	Chemung	DOCCS (Southport)	**Terrol Massey**	32	Black	Male	Yes	Medical	Yes	Closed	Officer did not cause death
85	1/4/2022	Erie	Erie County Sheriff	**Edward Bald**	65	White	Male	Yes	Medical	No	Closed	Officer did not cause death
86	1/7/2022	Monroe	Rochester PD	**Benji Martinez**	46	Hispanic	Male	No	Vehicular	Yes	Closed	Officer did not cause death
87	1/7/2022	Queens	NYC DOC	**Sean Sarker**	Unknown	Unknown	Male	Yes	Stabbing	No	Closed	No defined officer
88	1/9/2022	Bronx	NYPD	**Abdul Jallow**	55	Black	Male	No	Shooting	Yes	Open	Pending preliminary assessment. Incident was 4/3/2021.
89	1/10/2022	Chenango	Chenango County Sheriff	**Brian Lambrecht**	51	White	Male	No	Suicide	Yes	Closed	Officer did not cause death
90	1/13/2022	Sullivan	Sullivan County Jail	**James Slater**	36	Black	Male	Yes	Overdose	No	Open	Pending preliminary assessment
91	1/13/2022	Washington	DOCCS (Great Meadows)	**Anthony Rivaldo**	42	White	Male	Yes	Suicide	Yes	Closed	Officer did not cause death
92	1/15/2022	Oneida	NYSP	**Joshua Doyle**	Unknown	Unknown	Male	No	Shooting	N/A	Closed	No death

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93	1/16/2022	Orange	Orange County Sheriff	**Ricky Mack**	66	Black	Male	Yes	Medical	Yes	Open	Pending preliminary assessment
94	1/17/2022	Oneida	DOCCS (Mohawk)	**Roger Stein**	59	Black	Male	Yes	Medical	No	Closed	Officer did not cause death
95	1/20/2022	Bronx	NYPD	**Yoskar Feliz**	27	Hispanic	Male	No	Shooting	Yes	Open	Pending investigation
96	1/21/2022	Greene	DOCCS (Greene)	**Ronald Drabman**	64	White	Male	Yes	Medical	Yes	Open	Pending preliminary assessment
97	1/21/2022	New York	NYPD	**Lawshawn McNeil**	47	Black	Male	No	Shooting	Yes	Open	Pending investigation
98	1/24/2022	Albany	Albany PD	**Jordan Young**	32	Black	Male	No	Shooting	Yes	Closed	No death
99	1/25/2022	Seneca	DOCCS (Five Points)	**Willie Dancy**	45	Black	Male	Yes	Overdose	Yes	Open	Pending preliminary assessment
100	1/28/2022	Seneca	DOCCS (Five Points)	**Jermaine Stewart**	32	Black	Male	Yes	Overdose	Yes	Closed	Officer did not cause death
101	2/1/2022	Cattaraugus	Cattaraugus County Jail	**Brett Abrams**	32	White	Male	Yes	Overdose	Yes	Open	Pending preliminary assessment
102	2/2/2022	St. Lawrence	NYSP	**Robert LaRock Jr**	38	White	Male	No	Vehicular	Yes	Open	Pending preliminary assessment. Incident was 2/2/2022; death was 6/2/2022.
103	2/3/2022	Kings	NYPD	**Clarence Little**	46	Black	Male	No	Shooting	Yes	Open	Pending investigation
104	2/6/2022	New York	NYPD	**Joley Aristhee**	29	Black	Male	No	Suicide	Yes	Closed	Officer did not cause death
105	2/6/2022	Kings	NYPD	**Jada Rollins**	18	Black	Female	No	Vehicular	No	Closed	Officer did not cause death

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106	2/7/2022	Onondaga	Onondaga County Sheriff	**Isaac Eames**	48	White	Male	No	Murder-suicide	No	Open	Pending investigation
107	2/8/2022	Dutchess	DOCCS (Fishkill)	**Andrew Harrington**	31	White	Male	Yes	Suicide	No	Open	Pending preliminary assessment
108	2/9/2022	Queens	NYPD	**Jose Rodriguez**	33	Hispanic	Male	No	Suicide	Yes	Closed	Officer did not cause death
109	2/12/2022	Erie	NYSP	**James Huber**	38	White	Male	No	Shooting	Yes	Open	Pending investigation
110	2/12/2022	Jefferson	Watertown PD	**Robert Breckenridge**	40	White	Male	No	Suicide	No	Open	Pending preliminary assessment
111	2/14/2022	Washington	Washington County Jail	**Kenny Mallory**	37	White	Male	Yes	Medical	No	Closed	Officer did not cause death
112	2/16/2022	Bronx	NYC DOC	**Ullah Rahm**	Unknown	Unknown	Male	Yes	Suicide	N/A	Closed	No death
113	2/23/2022	Niagara	Lockport PD/ NYSP	**Derrick Holmes**	21	White	Male	No	Vehicular	Yes	Closed	Officer did not cause death
114	2/23/2022	Erie	DOCCS (Wende)	**Cecil Alves**	43	Hispanic	Male	Yes	Suicide	No	Closed	Officer did not cause death
115	2/23/2022	Westchester	DOCCS (Sing Sing)	**Steve Johnson**	54	Black	Male	Yes	Suicide	No	Open	Pending preliminary assessment
116	2/24/2022	Sullivan	DOCCS (Sullivan)	**Keith Woolridge**	52	Black	Male	Yes	Overdose	Yes	Open	Pending preliminary assessment
117	2/24/2022	Erie	DOCCS (Wende)	**Eric Sykes**	44	Black	Male	Yes	Medical	No	Closed	Officer did not cause death
118	2/26/2022	Dutchess	DOCCS (Green Haven)	**Cory McCollum**	53	Black	Male	Yes	Medical	Yes	Open	Pending preliminary assessment
119	2/27/2022	Niagara	Niagara County CF	**Leroy Cheek**	35	Black	Male	Yes	Suicide	Yes	Closed	Officer did not cause death

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120	2/27/2022	Bronx	NYC DOC	**Tarz Youngblood**	38	Black	Male	Yes	Overdose	Yes	Open	Pending preliminary assessment
121	2/27/2022	Bronx	NYPD	**Maxie Suber**	35	Black	Male	No	Suicide	Yes	Closed	Officer did not cause death
122	2/27/2022	Dutchess	Dutchess County PD	**Michael Becerril**	23	Unknown	Male	No	Shooting	N/A	Closed	No death
123	3/3/2022	St. Lawrence	DOCCS (Riverview)	**Alexander Williams**	54	Black	Male	Yes	Medical	No	Closed	Officer did not cause death
124	3/4/2022	Dutchess	DOCCS (Green Haven)	**Gregory Diaz**	43	Hispanic	Male	Yes	Overdose	Yes	Open	Pending preliminary assessment
125	3/6/2022	Bronx	NYPD	**Luis Monsanto**	19	Hispanic	Male	No	Shooting	No	Closed	No death
126	3/6/2022	Orange	Orange County Sheriff	**Steven Cox**	60	Unknown	Male	No	Medical	N/A	Closed	Officer did not cause death
127	3/7/2022	Queens	NYPD	**Michel Marvens**	24	Black	Male	No	Vehicular	N/A	Closed	No defined officer. Incident was 2/26/22.
128	3/8/2022	Dutchess	NYSP	**Robin Alverez**	59	White	Female	No	Vehicular	Yes	Closed	Officer did not cause death
129	3/14/2022	Monroe	Rochester PD	**Janet Jordan**	35	Black	Female	No	Murder-suicide	Yes	Closed	Report issued
130	3/14/2022	Queens	NYPD	**Mohamed Diallo**	30	Black	Male	No	Medical	Yes	Open	Pending preliminary assessment
131	3/17/2022	Bronx	NYC DOC	**George Pagan**	48	Black	Male	Yes	Medical	No	Open	Pending preliminary assessment
132	3/18/2022	Bronx	NYC DOC	**Herman Diaz**	52	Hispanic	Male	Yes	Medical	No	Open	Pending preliminary assessment
133	3/19/2022	Herkimer	Herkimer County Jail	**Marie Soldato**	39	White	Female	Yes	Medical	Yes	Closed	Officer did not cause death

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134	3/20/2022	Dutchess	DOCCS (Green Haven)	**Kenneth Brown**	65	Black	Male	Yes	Medical	Yes	Open	Pending preliminary assessment
135	3/21/2022	Dutchess	DOCCS (Green Haven)	**Miguel Abarentos**	35	Asian	Male	Yes	Overdose	Yes	Open	Pending preliminary assessment
136	3/24/2022	Wyoming	DOCCS (Attica)	**Troy Cartwright**	57	Black	Male	Yes	Overdose	Yes	Closed	Officer did not cause death
137	3/27/2022	Dutchess	DOCCS (Green Haven)	**Cedric Darrett**	56	Black	Male	Yes	Overdose	Yes	Closed	Officer did not cause death
138	3/29/2022	Erie	Erie County Sheriff	**Arthur Basher**	Unknown	Unknown	Male	No	Medical	N/A	Closed	Officer did not cause death
139	3/31/2022	Wayne	Wayne County Sheriff	**Vincent Mitchell**	60	White	Male	No	Shooting	Yes	Closed	No death
140	4/4/2022	Albany	Albany PD	**Tea'Shawn Walker**	13	Black	Male	No	Vehicular	Yes	Closed	Officer did not cause death
141	4/6/2022	Wyoming	DOCCS (Attica)	**Thomas Lasher**	56	White	Male	Yes	Medical	Yes	Open	Pending preliminary assessment
142	4/7/2022	Kings	NYPD	**Ronald Smith**	53	Black	Male	No	Vehicular	Yes	Open	Pending investigation
143	4/10/2022	Kings	NYPD	**Unknown**	Unknown	Unknown	Unk	No	Shooting	N/A	Closed	No death
144	4/11/2022	Dutchess	DOCCS (Fishkill)	**Joseph Clarke**	37	Black	Male	Yes	Suicide	Yes	Open	Pending preliminary assessment
145	4/11/2022	Queens	NYPD	**Eduardo Andrade**	Unknown	Unknown	Unk	No	Shooting	N/A	Closed	No death
146	4/12/2022	Dutchess	DOCCS (Greenhaven)	**Brian Sohtz**	47	White	Male	Yes	Overdose	Yes	Closed	Officer did not cause death
147	4/14/2022	Chemung	DOCCS (Elmira)	**Jingzh Li**	58	Asian	Male	Yes	Suicide	No	Closed	Officer did not cause death
148	4/15/2022	Tioga	Tioga County Jail	**David Jones**	58	White	Male	Yes	Overdose	No	Closed	Officer did not cause death

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149	4/18/2022	Warren	Warren County Correctional	**Dennis Ford**	66	White	Male	Yes	Medical	No	Closed	Officer did not cause death
150	4/18/2022	Orange	Village of Suffern PD	**Ahkem Chu**	23	Hispanic	Male	No	Vehicular	No	Closed	Officer did not cause death
151	4/20/2022	Westchester	FBI	**Bryant Jackson Jr.**	28	Black	Male	No	Shooting	No	Closed	No defined officer
152	4/24/2022	Dutchess	DOCCS (Fishkill)	**James Pallonetti**	62	White	Male	Yes	Medical	No	Closed	Officer did not cause death
153	4/26/2022	Oneida	DOCCS (Mohawk)	**Tomas Berroa**	40	Hispanic	Male	Yes	Medical	No	Closed	Officer did not cause death
154	4/28/2022	Oneida	DOCCS (Mohawk)	**Ricardo Maisonet**	59	Hispanic	Male	Yes	Medical	No	Closed	Officer did not cause death
155	4/29/2022	Dutchess	NYSP and Hyde Park PD	**Jamie Feith**	34	White	Female	No	Shooting	Yes	Open	Pending investigation
156	4/29/2022	Clinton	NYSP	**Jason Barnaby**	47	White	Male	No	Suicide	Yes	Closed	Officer did not cause death
157	4/30/2022	Queens	NYPD	**Hye-Lim Baik**	35	Asian	Female	No	Suicide	Yes	Closed	Officer did not cause death
158	5/1/2022	Otsego	Otsego County CF	**Joseph Walley**	38	White	Male	Yes	Medical	Yes	Open	Pending preliminary assessment
159	5/2/2022	New York	NYPD	**Velantina Shafaizieva**	58	White	Female	No	Suicide	Yes	Closed	Officer did not cause death
160	5/3/2022	Oswego	Oswego County Sheriff	**Adam Cook**	33	White	Male	No	Suicide	No	Closed	Officer did not cause death
161	5/3/2022	Schenectady	NYSP	**Yohannes Bernot**	25	Black	Male	No	Vehicular	Yes	Closed	Officer did not cause death
162	5/3/2022	Washington	DOCCS (Great Meadows)	**Toby Smith**	48	White	Male	Yes	Medical	No	Open	Pending preliminary assessment
163	5/7/2022	Erie	NYSP	**Benjamin Wence**	44	White	Male	No	Vehicular	Yes	Open	Pending preliminary assessment

Table A. Incidents Notified to the Attorney General Under Section 70-b, September 1, 2021 through August 31, 2022												
A	B	C	D	E	F	G	H	I	J	K	L	M
#	Date of Death	County	Agency	Name	Age	Race/Ethnic Group	Gender	Incarcerated	Incident Type	Agency Video	Status	Comments
164	5/7/2022	Bronx	NYC DOC	**Deshawn Carter**	25	Black	Male	Yes	Suicide	Yes	Open	Pending preliminary assessment
165	5/8/2022	Orange	NYPD	**Edward Wilkins**	20	White	Male	No	Murder-suicide	No	Open	Pending investigation
166	5/9/2022	Kings	NYPD	**Myasia Arnette**	20	Black	Female	No	Vehicular	Yes	Closed	Officer did not cause death
167	5/10/2022	Bronx	NYPD	**Rameek Smith**	26	Black	Male	No	Shooting	Yes	Open	Pending investigation
168	5/11/2022	Chemung	DOCCS (Elmira)	**Sheldon Midlarsky**	86	White	Male	Yes	Overdose	No	Open	Pending preliminary assessment
169	5/11/2022	St. Lawrence	DOCCS (Riverview)	**Lacey Williams**	54	Black	Male	Yes	Medical	Yes	Open	Pending preliminary assessment
170	5/13/2022	Bronx	NYPD	**Billy Lee**	51	White	Male	No	Shooting	No	Open	Pending investigation
171	5/17/2022	Bronx	NYC DOC	**Mary Yehudah**	31	Black	Female	Yes	Medical	Yes	Open	Pending preliminary assessment
172	5/19/2022	St. Lawrence	DOCCS (Gouverneur)	**Hipolito Nunez**	33	Hispanic	Male	Yes	Other	Yes	Closed	Officer did not cause death
173	5/22/2022	Chemung	DOCCS (Elmira)	**Nathaniel Sergio**	40	White	Male	Yes	Suicide	No	Closed	Officer did not cause death
174	5/25/2022	Monroe	Rochester PD	**Joshua Goebel, MacArthur Chisolm**	Unknown	Unknown	Male Male	No	Shooting	N/A	Closed	No death
175	5/28/2022	Bronx	NYC DOC	**Emmanuel Sullivan**	21	Black	Male	Yes	Overdose	Yes	Open	Pending preliminary assessment
176	5/29/2022	Washington	Hudson Falls PD	**David Barr Greenwood**	59	White	Male	No	Suicide	Yes	Closed	Officer did not cause death

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#	Date of Death	County	Agency	Name	Age	Race/Ethnic Group	Gender	Incarcerated	Incident Type	Agency Video	Status	Comments
177	5/30/2022	Erie	DOCCS (Wende)	**Adam Berwid**	86	White	Male	Yes	Medical	No	Closed	Officer did not cause death
178	5/30/2022	Cayuga	DOCCS (Auburn)	**Edward Plummer**	61	Hispanic	Male	Yes	Medical	No	Open	Pending preliminary assessment
179	6/1/2022	Rockland	Ramapo PD	**Carrie Deas**	86	Unknown	Female	No	Medical	No	Closed	Officer did not cause death
180	6/1/2022	Dutchess	DOCCS (Greenhaven)	**Mark Thomas**	41	White	Male	Yes	Suicide	Yes	Open	Pending preliminary assessment
181	6/3/2022	Niagara	Niagara Falls PD	**Reginald Barnes**	29	Black	Male	No	Shooting	No	Closed	No death
182	6/4/2022	New York	NYPD	**Anthony Troy James**	27	Black	Male	No	Medical	Yes	Open	Pending investigation
183	6/4/2022	Onondaga	Solvay PD	**Christopher Lannie**	40	White	Male	No	Suicide	No	Closed	Officer did not cause death
184	6/6/2022	Erie	DOCCS (Wende)	**Alvin Hall**	57	Black	Male	Yes	Medical	No	Open	Pending preliminary assessment
185	6/7/2022	Oneida	DOCCS (Mohawk)	**Daniel Martin**	71	Black	Male	Yes	Medical	Yes	Closed	Officer did not cause death
186	6/14/2022	Erie	Erie County Holding Center	**Sean Riordan**	30	White	Male	Yes	Medical	No	Open	Pending preliminary assessment
187	6/17/2022	Wyoming	DOCCS (Attica)	**Dean Klejment**	55	White	Male	Yes	Medical	Yes	Open	Pending preliminary assessment
188	6/17/2022	Ulster	DOCCS (Ulster)	**Matthew Lowery**	52	Black	Male	Yes	Overdose	No	Open	Pending preliminary assessment
189	6/18/2022	Bronx	NYC DOC	**Antonio Bradley**	28	Black	Male	Yes	Suicide	Yes	Closed	Officer did not cause death

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190	6/19/2022	Westchester	DOC (Westchester County)	**Steven Cohen**	69	White	Male	Yes	Medical	No	Open	Pending preliminary assessment
191	6/20/2022	Bronx	NYC DOC	**Anibal Carrasquillo**	39	Hispanic	Male	Yes	Overdose	Yes	Open	Pending preliminary assessment
192	6/20/2022	Albany	Albany PD	**Eric Frazier**	55	Black	Male	No	Shooting	Yes	Closed	No death
193	6/21/2022	Bronx	NYC DOC	**Albert Drye**	52	Black	Male	Yes	Medical	Yes	Open	Pending preliminary assessment
194	6/24/2022	Chemung	DOCCS (Elmira)	**Ronny Torres**	28	Hispanic	Male	Yes	Suicide	No	Closed	Officer did not cause death
195	6/25/2022	Albany	Albany County Sheriff	**Ahliek Leonard**	20	Black	Male	Yes	Overdose	No	Open	Pending preliminary assessment
196	6/25/2022	Kings	NYPD	**Lynn Christopher**	67	Black	Female	No	Vehicular	Yes	Closed	Officer did not cause death
197	6/28/2022	Kings	NYPD	**Luke Ganster**	26	White	Male	No	Suicide	Yes	Closed	Officer did not cause death
198	6/28/2022	Dutchess	DOCCS (Green Haven)	**Jarrett Frost**	30	Black	Male	Yes	Incarcerated person violence (stabbing)	Yes	Open	Pending preliminary assessment
199	6/29/2022	Onondaga	Syracuse City PD	**Michael Brantley**	43	Black	Male	No	Suicide	No	Open	Pending preliminary assessment
200	6/29/2022	Franklin	NYSP	**Joshua Kavota**	33	Black	Male	No	Shooting	Yes	Open	Pending investigation
201	7/2/2022	Oneida	DOCCS (Mohawk)	**David Connolly**	70	White	Male	Yes	Medical	No	Open	Pending preliminary assessment
202	7/3/2022	Ulster	New Paltz PD	**Andrew Kanninen**	44	White	Male	No	Overdose	Yes	Open	Pending preliminary assessment

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203	7/6/2022	Genesee	Genesee County Sheriff	**Nicholas Keiffer**	26	White	Male	No	Vehicular	Yes	Closed	Officer did not cause death
204	7/9/2022	Queens	NYPD	**Raul Hardy**	60	Black	Male	No	Shooting	Yes	Open	Pending investigation
205	7/9/2022	Kings	NYPD	**Malik Williams**	19	Black	Male	No	Shooting	Yes	Open	Pending investigation
206	7/10/2022	Bronx	NYC DOC	**Elijah Mohammed**	31	Black	Male	Yes	Overdose	Yes	Open	Pending preliminary assessment
207	7/10/2022	Bronx	NYC DOC	**Shaquille Wilson**	28	Black	Male	Yes	Medical	N/A	Closed	No death
208	7/15/2022	Bronx	NYC DOC	**Michael Lopez**	34	Hispanic	Male	Yes	Overdose	Yes	Open	Pending preliminary assessment
209	7/16/2022	Chemung	DOCCS (Elmira)	**Roger Ested**	63	Black	Male	Yes	Medical	No	Open	Pending preliminary assessment
210	7/18/2022	Chemung	DOCCS (Elmira)	**Tyler Rodkey**	35	White	Male	Yes	Overdose	No	Open	Pending preliminary assessment
211	7/21/2022	Bronx	NYC DOC	**Raymond Chaluisant**	18	Hispanic	Male	No	Shooting	Yes	Closed	Indictment issued
212	7/24/2022	Ulster	DOCCS (Eastern)	**Roger Pragle**	71	White	Male	Yes	Medical	No	Open	Pending preliminary assessment
213	7/25/2022	Kings	NYPD	**Jamaine Smith**	50	Black	Male	No	Medical	Yes	Open	Pending preliminary assessment
214	7/30/2022	Dutchess	DOCCS (Fishkill)	**Gregory Birch**	66	Black	Male	Yes	Medical	No	Open	Pending preliminary assessment
215	7/31/2022	Franklin	DOCCS (Upstate)	**Ladale Kennedy**	41	Black	Male	Yes	Medical	Yes	Open	Pending preliminary assessment

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216	7/31/2022	Erie	DOCCS (Wende)	**Juan Maldonado**	62	Hispanic	Male	Yes	Medical	No	Open	Pending preliminary assessment
217	8/2/2022	Washington	DOCCS (Great Meadows)	**Christian Rodriguez**	34	Hispanic	Male	Yes	Overdose	No	Open	Pending preliminary assessment
218	8/2/2022	Onondaga	Onondaga County Sheriff	**Ayanna Byrd**	Infant	Black	Female	Yes	Medical	No	Open	Pending preliminary assessment
219	8/5/2022	Queens	NYPD	**Joshua Wilkinson**	18	Black	Male	No	Shooting	N/A	Closed	No death
220	8/8/2022	Suffolk	Suffolk County PD	**Bobby Morant**	56	Black	Male	No	Medical	No	Open	Pending preliminary assessment
221	8/8/2022	Greene	NYSP	**Christopher Stanton**	40	White	Male	No	Vehicular	Yes	Closed	Officer did not cause death
222	8/13/2022	Oneida	DOCCS (Mohawk)	**Jeremy Eaton**	45	White	Male	Yes	Suicide	No	Open	Pending preliminary assessment
223	8/14/2022	Westchester	DOC (Westchester County)	**Patrick Reddon**	37	Black	Male	Yes	Medical	Yes	Open	Pending preliminary assessment
224	8/15/2022	Bronx	NYC DOC	**Ricardo Cruciani**	68	Hispanic	Male	Yes	Suicide	Yes	Open	Pending preliminary assessment
225	8/18/2022	Monroe	NYSP	**Kron Hathaway**	21	Black	Male	No	Vehicular	N/A	Closed	No death
226	8/19/2022	Queens	NYPD	**Angel Lopez** **Jeremy Rosario**	22 18	Hispanic Hispanic	Male Male	No No	Vehicular	No	Open	Pending preliminary assessment
227	8/19/2022	Wyoming	DOCCS (Attica)	**Jose Cruz**	55	Hispanic	Male	Yes	Medical	No	Open	Pending preliminary assessment

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228	8/20/2022	Delaware	NYSP	**Devin J. Freudenmann**	42	White	Male	No	Suicide	Yes	Open	Pending preliminary assessment
229	8/25/2022	Bronx	NYC DOC	**Michael Nieves**	40	Hispanic	Male	Yes	Suicide	Yes	Open	Pending preliminary assessment
230	8/28/2022	Westchester	NYSP	**Kahseen T. Trotter**	22	Black	Male	No	Vehicular	Yes	Open	Pending preliminary assessment
231	8/28/2022	Cattaraugus	Cattaraugus County Jail	**David Foster**	30	Black	Male	Yes	Overdose	Yes	Open	Pending preliminary assessment
232	8/31/2022	Bronx	NYPD	**Cathy Garcia**	69	Black	Female	No	Vehicular	Yes	Open	Pending preliminary assessment. Death was 8/25/22. OSI notified 8/31/22.

Table B. Incidents Notified to the Attorney General Under Section 70-b, April 1 through August 31, 2021												
A	B	C	D	E	F	G	H	I	J	K	L	M
#	Date of Death	County	Agency	Name	Age	Race/Ethnic Group	Gender	Incarcerated	Incident Type	Agency Video	Status	Comments
1	4/1/2021	Bronx	MTA PD	**Dylon McCluskey**	33	Unknown	Male	No	Medical	No	Closed	Officer did not cause death
2	4/3/2021	Bronx	NYPD	**Abadual Gallo**	Unknown	Unknown	Male	No	Shooting	Yes	Closed	No death
3	4/5/2021	Seneca	DOCCS (Five Points)	**Todd Branham**	64	White	Male	Yes	Medical	No	Closed	Officer did not cause death
4	4/6/2021	Otsego	Oneonta PD	**Tyler Green**	23	White	Male	No	Shooting	Yes	Closed	Report issued
5	4/7/2021	Greene	DOCCS (Coxsackie)	**Jeremy Joseph**	40	White	Male	Yes	Suicide	No	Closed	Officer did not cause death
6	4/8/2021	New York	NYPD	**Derek Graves**	52	Black	Male	No	Medical	No	Closed	Officer did not cause death
7	4/9/2021	Nassau	Nassau County PD	**Hubert Lewis**	61	Black	Male	No	Following Restraint	No	Closed	Officer did not cause death
8	4/14/2021	Brooklyn	NYPD	**Irena Pekarska**	52	White	Female	No	Suicide	Yes	Closed	Officer did not cause death
9	4/15/2021	Dutchess	DOCCS (Fishkill)	**Andrew Moore**	36	White	Male	Yes	Medical	No	Closed	Officer did not cause death
10	4/19/2021	Bronx	NYC DOC (Rikers)	**Thomas Braunson**	35	Black	Male	Yes	Medical	No	Closed	Officer did not cause death
11	4/20/2021	Manhattan	NYPD	**Jose Muniz**	31	Hispanic	Male	No	Shooting	No	Closed	No death
12	4/26/2021	Sullivan	DOCCS (Sullivan)	**Joshua Hunter**	31	White	Male	Yes	Suicide	No	Closed	Officer did not cause death
13	4/26/2021	Seneca	DOCCS (Five Points)	**Andrew Jackling**	43	White	Male	Yes	Suicide	No	Closed	Officer did not cause death
14	4/28/2021	Franklin	NYSP	**Barry Stewart**	55	White	Male	No	Suicide	No	Closed	Officer did not cause death
15	4/28/2021	Saratoga	NYSP/ Saratoga County Sheriff	**Robert Sanders**	49	White	Male	No	Suicide	Yes	Closed	Officer did not cause death
16	4/29/2021	Dutchess	Redhook PD	**Nick Annas**	77	White	Male	No	Suicide	No	Closed	Officer did not cause death

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17	4/30/2021	Rockland	Village of Spring Valley PD	**Robert Berenter**	67	White	Male	No	Medical	No	Closed	Officer did not cause death
18	5/1/2021	Bronx	NYC DOC (Rikers)	**Richard Blake**	45	Black	Male	Yes	Medical	Yes	Closed	Officer did not cause death
19	5/2/2021	Cattaraugus	Cattaraugus County Jail	**Franklin Chase**	35	White	Male	Yes	Medical	No	Closed	Officer did not cause death
20	5/6/2021	Dutchess	DOCCS (Green Haven)	**Malik Abdullah**	66	Black	Male	Yes	Medical	Yes	Closed	Officer did not cause death
21	5/6/2021	Cayuga	DOCCS (Cayuga)	**Domenick Krango**	64	White	Male	Yes	Medical	No	Closed	Officer did not cause death
22	5/6/2021	Manhattan	NYPD	**Johnny Diaz**	44	Hispanic	Male	No	Shooting	No	Closed	No death
23	5/7/2021	Ontario	Ontario County Sheriff	**Matthew Chwiecko**	37	White	Male	No	Medical	Yes	Closed	Officer did not cause death
24	5/10/2021	Rockland	Town of Clarkstown PD	**Michael Torossain**	67	White	Male	No	Medical	No	Closed	Officer did not cause death
25	5/11/2021	Washington	DOCCS (Washington)	**Michael Schermerhorn**	31	White	Male	Yes	Medical	No	Closed	Officer did not cause death
26	5/11/2021	Oswego	NYSP	**Philip Watros**	32	White	Male	No	Suicide	Yes	Closed	Officer did not cause death
27	5/12/2021	Kings	NYPD	**Boyce Hayward**	26	Hispanic	Male	No	Shooting	Unknown	Closed	No death
28	5/14/2021	Monroe	Rochester PD	**Mark Gaskill**	28	White	Male	No	Shooting	Yes	Closed	Report issued
29	5/18/2021	Columbia	Columbia County Jail	**William Greco**	37	White	Male	Yes	Suicide	Unknown	Closed	No death
30	5/20/2021	Suffolk	Suffolk County PD	**Jesse Bonsignore**	44	White	Male	No	Shooting	No	Closed	Report issued
31	5/21/2021	Kings	NYPD	**Angelo DeGracia**	42	Hispanic	Male	No	Medical	Yes	Closed	Officer did not cause death
32	5/22/2021	Cayuga	DOCCS (Cayuga)	**Darrell Swartwood**	45	White	Male	Yes	Medical	No	Closed	Officer did not cause death

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33	5/23/2021	Queens	NYPD	**Lopamudra Desai**	82	Hispanic	Female	No	Vehicular	No	Open	Pending investigation
34	5/24/2021	Queens	NYPD	**Marcelo Palaez & Leonardo Rodriguez**	46	Hispanic	Male	No	Vehicular	No	Open	Pending investigation
35	5/29/2021	Orange	Town of Goshen PD	**Jason Smykla**	37	White	Male	No	Medical	No	Closed	Officer did not cause death
36	6/1/2021	Greene	DOCCS (Greene)	**James LaRoche**	40	Black	Male	Yes	Medical	Yes	Closed	Officer did not cause death
37	6/4/2021	Kings	NYPD	**John Greico**	67	White	Male	Yes	Medical	Yes	Closed	Officer did not cause death
38	6/4/2021	Monroe	Rochester PD	**Timothy Flowers**	29	Black	Male	No	Shooting	Yes	Closed	Report issued
39	6/10/2021	Bronx	NYC DOC (Rikers)	**Jose Mejia**	34	Hispanic	Male	Yes	Medical	Yes	Open	Pending investigation
40	6/12/2021	Clinton	DOCCS (Clinton)	**Edgardo Devictor-Lopez**	36	Hispanic	Male	Yes	Medical	No	Closed	Officer did not cause death
41	6/12/2021	Orange	Town of Wallkill PD	**Christopher VanKleeck**	31	White	Male	No	Shooting	Yes	Closed	Report issued
42	6/14/2021	Greene	DOCCS (Coxsackie)	**Andrew Gibson**	62	Black	Male	Yes	Medical	No	Closed	Officer did not cause death
43	6/17/2021	Rockland	Village of Spring Valley PD	**Victor Martinez**	46	Hispanic	Male	No	Medical	No	Closed	Officer did not cause death
44	6/19/2021	Otsego	DOCCS (Otsego)	**Steven Pawlowski**	45	White	Male	Yes	Suicide	Yes	Closed	Officer did not cause death
45	6/23/2021	Manhattan	NYPD	**Gary Bryant**	22	Black	Male	No	Suicide	Yes	Closed	Officer did not cause death
46	6/23/2021	Schenectady	Schenectady PD	**Leon Martin**	15	Black	Male	No	Vehicular	Yes	Closed	No death

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47	6/25/2021	Westchester	City of Peekskill PD	**Unknown**	27	Unknown	Male	No	Medical	No	Closed	No death
48	6/25/2021	Erie	DOCCS (Wende)	**Edwin Ortiz**	56	Hispanic	Male	Yes	Medical	No	Closed	Officer did not cause death
49	6/26/2021	Onondaga	DOCCS (Five Points)	**Lyle Davoy**	64	White	Male	Yes	Medical	No	Closed	Officer did not cause death
50	6/28/2021	Dutchess	DOCCS (Green Haven)	**John Malaussen**	55	White	Male	Yes	Medical	Yes	Closed	Officer did not cause death
51	6/29/2021	Brooklyn	NYPD	**Maria Loaiza**	77	Hispanic	Female	No	Vehicular	No	Closed	Officer did not cause death
52	6/29/2021	Delaware	Delaware County Sheriff	**Philip Treadwell**	53	White	Male	No	Suicide	Yes	Closed	Officer did not cause death
53	6/30/2021	Clinton	DOCCS (Clinton)	**William Shafer**	34	White	Male	Yes	Medical	Yes	Closed	Officer did not cause death
54	6/30/2021	Bronx	NYC DOC (Rikers)	**Robert Jackson**	42	Black	Male	Yes	Medical	Yes	Open	Pending preliminary assessment
55	6/30/2021	Queens	NYPD	**Margarito Perez**	21	Hispanic	Male	No	Vehicular	No	Closed	No death
56	7/4/2021	Staten Island	NYPD	**Miguel Avila**	51	Hispanic	Male	No	Suicide	Yes	Closed	Officer did not cause death
57	7/6/2021	Wyoming	DOCCS (Attica)	**Louis Stoller**	54	White	Male	Yes	Medical	No	Closed	Officer did not cause death
58	7/6/2021	Clinton	DOCCS (Clinton)	**Rodney Horn**	55	Black	Male	Yes	Medical	Yes	Closed	Officer did not cause death
59	7/6/2021	Wyoming	DOCCS (Attica)	**Keith Goodman**	61	White	Male	Yes	Medical	Yes	Closed	Officer did not cause death
60	7/8/2021	Brooklyn	NYPD	**Steven Leconte**	53	Black	Male	No	Shooting	Yes	Closed	Report issued
61	7/8/2021	Manhattan	NYPD	**Borkot Ullah**	24	Asian	Male	No	Vehicular	Yes	Closed	Officer did not cause death

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62	7/8/2021	Nassau	Rockville Centre PD	**Unknown**	Unknown	Unknown	Unknown	No	Unknown	No	Closed	No death
63	7/10/2021	Franklin	DOCCS (Franklin)	**Charles McGill**	57	Black	Male	Yes	Medical	No	Closed	Officer did not cause death
64	7/11/2021	Wyoming	DOCCS (Attica)	**Nicholas Perham**	36	White	Male	Yes	Medical	No	Closed	Officer did not cause death
65	7/14/2021	Dutchess	DOCCS (Green Haven)	**Hale Adler**	37	White	Trans Female	Yes	Medical	No	Closed	Officer did not cause death
66	7/15/2021	Columbia	NYSP	**Sarah Craddock**	40	White	Female	No	Shooting	Yes	Closed	No death
67	7/16/2021	Nassau	Nassau County PD	**Daniyal Shaukat**	24	Asian	Male	No	Vehicular	No	Closed	Officer did not cause death
68	7/19/2021	Onondaga	NYSP	**Charles Fadale**	66	White	Male	No	Vehicular	No	Closed	Officer did not cause death
69	7/24/2021	Suffolk	Quogue Village PD	**Justin Mendez**	22	Hispanic	Male	No	Vehicular	Yes	Closed	Officer did not cause death
70	7/25/2021	Cortland	Cortland County Sheriff	**Casey Stockton**	26	White	Male	No	Vehicular	Yes	Closed	Officer did not cause death
71	7/26/2021	Chautauqua	Chautauqua County Jail	**Louis Rivera**	65	Hispanic	Male	Yes	Medical	Yes	Closed	Officer did not cause death
72	7/26/2021	Westchester	DOCCS (Sing Sing)	**Eriberto Bisono**	27	Hispanic	Male	Yes	Suicide	No	Closed	Officer did not cause death
73	7/29/2021	Clinton	DOCCS (Clinton)	**George Grant**	60	Black	Male	Yes	Medical	Yes	Closed	Officer did not cause death
74	7/30/2021	Staten Island	NYPD	**Daniel Milton**	22	White	Male	No	Following Restraint	Yes	Closed	Officer did not cause death
75	8/4/2021	Westchester	Yonkers PD	**Jojuan Alston**	42	Black	Male	No	Medical	Yes	Closed	Officer did not cause death
76	8/6/2021	Delaware	NYSP	**Roger Lynch**	59	White	Male	No	Shooting	Yes	Open	Pending investigation
77	8/8/2021	Oneida	CNYPC	**Jack Wright**	Unknown	Unknown	Unknown	Yes	Medical	No	Closed	No defined officer

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78	8/9/2021	Oneida	Oneida County Sheriff	**Ronald Pierce**	56	Black	Male	Yes	Medical	Yes	Closed	Officer did not cause death
79	8/10/2021	Bronx	NYC DOC (Rikers)	**Brandon Rodriguez**	25	Hispanic	Male	Yes	Suicide	Yes	Closed	Officer did not cause death
80	8/11/2021	Chemung	DOCCS (Elmira)	**David Kingsley**	33	White	Male	Yes	Suicide	No	Closed	Officer did not cause death
81	8/15/2021	Onondaga	Syracuse PD	**Joseph Evans**	67	Black	Male	No	Shooting	Yes	Closed	No death
82	8/18/2021	Manhattan	NYPD	**Unknown**	Unk.	Black	Female	No	Suicide	Yes	Closed	Officer did not cause death
83	8/19/2021	Dutchess	NYSP	**Allan Forbes**	Unknown	Unknown	Male	No	Vehicular	Unknown	Closed	No death
84	8/21/2021	Dutchess	DOCCS (Fishkill)	**Mark Garrett**	57	Unknown	Male	Yes	Medical	No	Closed	Officer did not cause death
85	8/21/2021	Herkimer	Mohawk Village PD	**James Jewett Jr.**	29	White	Male	No	Vehicular	No	Closed	No death
86	8/23/2021	Brooklyn	NYPD	**Peter Barenboim**	72	White	Male	No	Suicide	Yes	Closed	Officer did not cause death
87	8/24/2021	Erie	Buffalo PD	**Sequoyah Woodberry**	21	Black	Female	No	Vehicular	No	Closed	Officer did not cause death
88	8/24/2021	Oneida	DOCCS (Mid-State)	**Su Kim**	64	Asian	Male	Yes	Suicide	No	Closed	Officer did not cause death
89	8/24/2021	Greene	NYSP	**Tyler Lane**	33	White	Male	No	Vehicular	No	Closed	Officer did not cause death
90	8/25/2021	Putnam	Putnam County Sheriff	**George Taranto**	77	White	Male	No	Medical	Yes	Closed	Officer did not cause death. OSI notified 10/1/2021.
91	8/25/2021	Bronx	NYPD	**Malik Rahman**	52	Black	Male	Yes	Medical	Yes	Closed	Officer did not cause death
92	8/27/2021	Chemung	NYSP	**David Wandell**	53	White	Male	No	Shooting	Yes	Closed	Report issued
93	8/28/2021	Dutchess	DOCCS (Green Haven)	**Abel Rosas**	55	Hispanic	Male	Yes	Medical	No	Closed	Officer did not cause death

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94	8/29/2021	Bronx	NYPD	**Michael Rosado**	24	Hispanic	Male	No	Shooting	Yes	Open	Pending investigation
95	8/30/2021	Bronx	NYC DOC (Rikers)	**Segundo Guallpa**	58	Hispanic	Male	Yes	Suicide	Yes	Closed	Officer did not cause death
96	8/30/2021	Rockland	Village of Spring Valley PD	**Davidson Stinfill**	19	Unknown	Male	No	Medical	No	Closed	Officer did not cause death

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1	4/19/2021	Bronx	NYC DOC	**Thomas Braunson**	35	Black	Male	Yes	Medical	No	Closed	Officer did not cause death
2	5/1/2021	Bronx	NYC DOC	**Richard Blake**	45	Black	Male	Yes	Medical	Yes	Closed	Officer did not cause death
3	6/10/2021	Bronx	NYC DOC	**Jose Mejia**	34	Hispanic	Male	Yes	Medical	Yes	Open	Pending investigation
4	6/30/2021	Bronx	NYC DOC	**Robert Jackson**	42	Black	Male	Yes	Medical	Yes	Open	Pending preliminary assessment
5	8/10/2021	Bronx	NYC DOC	**Brandon Rodriguez**	25	Hispanic	Male	Yes	Suicide	Yes	Closed	Officer did not cause death
6	8/30/2021	Bronx	NYC DOC	**Segundo Guallpa**	58	Hispanic	Male	Yes	Suicide	Yes	Closed	Officer did not cause death
7	9/7/2021	Bronx	NYC DOC	**Esias Johnson**	24	Black	Male	Yes	Overdose	Yes	Closed	Officer did not cause death
8	9/19/2021	Bronx	NYC DOC	**Karim Isaabdul**	41	Black	Male	Yes	Medical	Yes	Closed	Officer did not cause death
9	9/22/2021	Bronx	NYC DOC	**Stephen Khadu**	24	Black	Male	Yes	Medical	Yes	Closed	Officer did not cause death
10	10/15/2021	Bronx	NYC DOC	**Victor Mercado**	64	Hispanic	Male	Yes	Medical	Yes	Closed	Officer did not cause death
11	10/19/2021	New York	NYC DOC	**Anthony Scott**	58	Black	Male	Yes	Suicide	Yes	Open	Pending preliminary assessment
12	12/7/2021	Bronx	NYC DOC	**Thamar Francois**	Unknown	Unknown	Unknown	No	Medical	N/A	Closed	Not an inmate
13	12/10/2021	Bronx	NYC DOC	**Malcolm Boatwright**	28	Black	Male	Yes	Medical	Yes	Closed	Officer did not cause death

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14	12/14/2021	Bronx	NYC DOC	**William Brown**	37	Black	Male	Yes	Overdose	Yes	Open	Pending preliminary assessment
15	1/7/2022	Queens	NYC DOC	**Sean Sarker**	Unknown	Unknown	Male	Yes	Stabbing	No	Closed	No defined officer
16	2/16/2022	Bronx	NYC DOC	**Ullah Rahm**	Unknown	Unknown	Male	No	Suicide	N/A	Closed	No death
17	2/27/2022	Bronx	NYC DOC	**Tarz Youngblood**	38	Black	Male	Yes	Overdose	Yes	Open	Pending preliminary assessment
18	3/17/2022	Bronx	NYC DOC	**George Pagan**	48	Black	Male	Yes	Medical	No	Open	Pending preliminary assessment
19	3/18/2022	Bronx	NYC DOC	**Herman Diaz**	52	Hispanic	Male	Yes	Medical	No	Open	Pending preliminary assessment
22	5/7/2022	Bronx	NYC DOC	**Deshawn Carter**	25	Black	Male	Yes	Suicide	Yes	Open	Pending preliminary assessment
23	5/17/2022	Bronx	NYC DOC	**Mary Yehudah**	31	Black	Female	Yes	Medical	Yes	Open	Pending preliminary assessment
24	5/28/2022	Bronx	NYC DOC	**Emmanuel Sullivan**	21	Black	Male	Yes	Overdose	Yes	Open	Pending preliminary assessment
25	6/18/2022	Bronx	NYC DOC	**Antonio Bradley**	28	Black	Male	Yes	Suicide	Yes	Closed	Officer did not cause death
26	6/20/2022	Bronx	NYC DOC	**Anibal Carrasquillo**	39	Hispanic	Male	Yes	Overdose	Yes	Open	Pending preliminary assessment

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27	6/21/2022	Bronx	NYC DOC	**Albert Drye**	52	Black	Male	Yes	Medical	Yes	Open	Pending preliminary assessment
28	7/10/2022	Bronx	NYC DOC	**Elijah Mohammed**	31	Black	Male	Yes	Overdose	Yes	Open	Pending preliminary assessment
29	7/10/2022	Bronx	NYC DOC	**Shaquille Wilson**	28	Black	Male	Yes	Medical	N/A	Closed	No death
30	7/15/2022	Bronx	NYC DOC	**Michael Lopez**	34	Hispanic	Male	Yes	Overdose	Yes	Open	Pending preliminary assessment
32	8/15/2022	Bronx	NYC DOC	**Ricardo Cruciani**	68	Hispanic	Male	Yes	Suicide	Yes	Open	Pending preliminary assessment
33	8/25/2022	Bronx	NYC DOC	**Michael Nieves**	40	Hispanic	Male	Yes	Suicide	Yes	Open	Pending preliminary assessment