Special Investigations and Prosecutions Unit

Report on the Investigation into The Death of Susan Harrington
EXECUTIVE SUMMARY

On July 8, 2015, Governor Andrew Cuomo signed Executive Order No. 147 (the “Executive Order”), appointing the Attorney General as special prosecutor “to investigate, and if warranted, prosecute certain matters involving the death of an unarmed civilian . . . caused by a law enforcement officer.” On August 19, 2019, Washington County Sheriff’s Deputy Cori J. Winch was operating a police vehicle on State Route 40 in the Town of Argyle, Washington County, when his vehicle crossed a double yellow line and struck a vehicle in the oncoming lane killing the operator of that vehicle, Susan J. Harrington. Governor Cuomo subsequently issued Executive Order No. 147.27, expressly conferring jurisdiction on the Attorney General to investigate any potential unlawful acts or omissions related to Ms. Harrington’s death.1

At approximately 6:00 a.m. on August 19, 2019, Deputy Winch of the Washington County Sheriff’s Office (WCSO) was finishing a 12:00 a.m. to 7:00 a.m. patrol shift and responded to a call in the Village of Fort Edward, N.Y. for an automobile/deer collision. After completing paperwork, Deputy Winch left the Village of Fort Edward driving his patrol vehicle, a 2017 Ford Explorer AWD Police Interceptor en route to the Salem, N.Y. station to conclude his shift. At approximately 6:36 a.m., as Deputy Winch was driving southbound on State Route 40 just south of the Village of Argyle, he approached a slight right curve in the road that also happened to be on the crest of a small hill. As Deputy Winch approached the curve from the north, Susan Harrington, travelling in a 2014 Honda CRV was approaching the same curve from the south. Both vehicles were traveling at approximately the posted speed limit of 55 mph. As Deputy Winch entered the curve, he continued traveling in a straight-line, crossing over the double yellow center lines and into the northbound lane. Ms. Harrington apparently attempted to avoid a collision by steering her vehicle to the right. Deputy Winch’s vehicle struck Ms. Harrington’s vehicle head on, the collision causing his vehicle to spin 180 degrees before coming to rest in the northbound lane facing north. Ms. Harrington’s vehicle was also spun 180 degrees and came to rest in a field east of the roadway facing south. The collision was particularly violent, and Ms. Harrington was killed on impact. Deputy Winch suffered a fractured ankle and was taken from the scene to Glens Falls Hospital for treatment. Deputy Winch told a Washington County Sheriff’s deputy at the scene that he did not remember what happened.

The Office of the Attorney General’s investigation and review of this matter included the following, among other materials:

- Review of all records relating to the incident generated by the WCSO and the New York State Police;
- Review of Collision Reconstruction Report prepared by the New York State Police Collision Reconstruction Unit;
- Review of text messages and internet usage on Deputy Winch’s cell phone for a period of approximately 36 hours before the collision;
- Interviews of Deputy Winch; Deputy/Investigator Jason Diamond (“Deputy Diamond”), who rode with Deputy Winch on patrol until shortly before the collision;

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1 Executive Order 147.27 is attached as Exhibit 1.
and “R.D.”, Deputy Winch’s former girlfriend, who was with Deputy Winch throughout the day and evening of August 18, 2019 beginning at 2:00 a.m.;

- Review of surveillance camera video footage from a self-storage facility on State Route 40 in Argyle, N.Y. that captured the collision;
- Review of 911 calls and radio transmissions related to the incident;
- Review of toxicology reports on Deputy Winch’s blood;
- Review of records from the responding ambulance company;
- Review of statements from first responders;
- Review of the report of the autopsy performed on Ms. Harrington’s body prepared by Dr. Michael Sikirica;

Review of the foregoing materials suggests that at the end of his overnight shift, Deputy Winch was fatigued when he began the drive from Fort Edward to the Salem station. Deputy Winch may arguably be faulted for failing to perceive that he was at risk for falling asleep while driving a vehicle while fatigued. Under New York law, however, failure to perceive a risk in itself does not give rise to criminal liability. Rather, the law requires that in order for criminal liability to attach to a person’s conduct, there must be some showing that the person engaged in some additional blameworthy or risk-creating conduct in addition to the failure to perceive a particular risk. Deputy Winch was not impaired by drugs or alcohol, distracted by a cell phone or on-board computer, and did not engage in otherwise blameworthy or risk-creating conduct. Accordingly, Deputy Winch’s conduct did not rise to the level of criminal culpability.

**STATEMENT OF FACTS**

Shortly before midnight on the evening of August 18, 2019, Deputy Cori J. Winch (“Deputy Winch”) of the Washington County Sheriff’s Office (“WCSO”) reported to the Sheriff’s patrol station located in Salem, New York to begin a seven-hour patrol shift which commenced at 12:00 a.m., on the morning of August 19, 2019. Deputy Winch began his shift by driving his patrol vehicle from the Salem station to the Washington County Law Enforcement Center (LEC) located in the Village of Fort Edward, N.Y. to meet Deputy/Investigator Jason Diamond, Deputy Winch’s patrol partner for the shift. The two deputies patrolled throughout Washington County during the shift, responding to a handful of calls. At approximately 6:00 a.m., the deputies returned to the LEC where Deputy Winch was to retrieve a different patrol vehicle from the one he had started his shift with and drive that different patrol vehicle to the Salem station. After retrieving WCSO Patrol Unit 330, a 2017 Ford Explorer AWD Police Interceptor, Deputy Winch responded to a deer/automobile collision in the Village of Fort Edward. After processing the report, Deputy Winch drove toward the Salem station to conclude his shift.

At approximately 6:36 a.m., Deputy Winch was driving southbound on State Route 40 in the Town of Argyle. Just south of the Village of Argyle, Deputy Winch’s vehicle approached a slight right curve in the road that also happened to be on the crest of a small hill. As Deputy Winch’s vehicle was approaching the curve from the north, Susan Harrington, travelling in a 2014 Honda CRV, was approaching the same curve from the south. Both vehicles were traveling at approximately the posted speed limit of 55 mph. As Deputy Winch entered the curve, his vehicle...
continued traveling in a straight-line crossing over the double yellow center lines and traveling into the north bound lane. As Ms. Harrington entered the curve she appears to have negotiated the curve until realizing that she was about to be struck by Deputy Winch’s vehicle, at which point she applied the brakes and steered her vehicle to the right. Deputy Winch’s vehicle struck Ms. Harrington’s vehicle head on, the collision causing his vehicle to spin 180 degrees before coming to rest in the northbound lane facing North. Ms. Harrington’s vehicle was also spun 180 degrees and ultimately came to rest in a field east of the roadway facing South. The below photograph is an aerial view depicting both vehicles; the top of the picture is north, Ms. Harrington’s vehicle is on the right, and Deputy Winch’s patrol vehicle is on the left.

The collision occurred in front of a self-storage facility that had security surveillance cameras mounted on the outside of the building facing the road; it was therefore captured on video and recorded. The collision was particularly violent, and Ms. Harrington was killed on impact. Deputy Winch suffered a fractured ankle and was taken from the scene to Glens Falls Hospital for treatment. Deputy Winch provided a consent to search a sample of his blood which tested negative for alcohol. The blood sample tested positive for morphine, which had been administered at the scene of the collision by medical personnel, and negative for any other drugs.

Collision Reconstruction

Investigator Jeremy Shultis and other members of the New York State Police (“NYSP”) Troop G Collision Reconstruction Unit (CRU) responded to and processed the scene. Both vehicles were removed to NYSP Troop G Headquarters for processing. At the request of Washington County Sheriff Jeffrey Murphy, the NYSP conducted the criminal investigation of the incident and NYSP Investigator David Mosher (“Investigator Mosher”) was the lead investigator. Deputy Winch gave
the NYSP a written consent to search his cellular telephone and provided the phone to investigators.

Investigator Mosher obtained a consent to search WCSO Unit 330 from Sheriff Murphy. Investigators accessed the Event Data Recorder from Unit 330 and Ms. Harrington’s vehicle and obtained 5 seconds of pre-crash data from both vehicles. The Event Data Recorder system records data at half-second intervals and upon a triggering event, saves the data from five seconds before the event. The data collected from WCSO Unit 330 consisted of vehicle speed, accelerator pedal % full, service brake on/off, and engine rpm. The system also recorded data at .1 second intervals for steering wheel angle. A steering wheel angle of 0.0 degrees indicates that the vehicle is traveling straight ahead. A positive degree angle indicates a steering wheel turned to the left and a negative degree angle indicates a steering wheel turned to the right. The chart below contains values from the data collected from Deputy Winch’s patrol vehicle for 5 seconds prior to the crash at half-second intervals.

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<th>Time</th>
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<th>Engine RPM</th>
<th>Steering Wheel Angle (deg)</th>
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* All other intervals in the 5 second record showed a steering wheel angle of 0.0.

The above chart shows that Deputy Winch took no action with respect to his vehicle for a full five seconds prior to the collision. The accelerator remained in the same position, there was no appreciable turning of the steering wheel to negotiate the curve, and there was no braking whatsoever. As detailed below (Legal Analysis), if there was evidence that Deputy Winch had been distracted from operating his vehicle safely because he was using his cell phone or the on-board computer in the patrol vehicle, an argument could be made that such conduct might rise to the level of criminal negligence; however, there was no such evidence.

As a further part of the collision reconstruction, Deputy Winch’s cell phone was forensically examined by the New York State Police and data extracted. Examination of Deputy Winch’s iPhone showed no voice calls, text messages or internet usage after 6:17 a.m. Similarly, review
of the computer log for Unit 330 shows no computer usage after 6:21 a.m. There was nothing
developed during the course of the investigation that would indicate that the collision was the result
of distracted driving.

The Ford Explorer police vehicle model involved in this case had been the subject of an
investigation by the National Highway Traffic Safety Administration (NHTSA) involving
complaints of exhaust fumes, although no instances of carbon monoxide poisoning or associated
collisions have, to date, been documented by NHTSA. Nevertheless, as a precautionary measure,
WCSO installed carbon monoxide detectors in their Ford Explorers, but no such detector was
found in Deputy Winch’s vehicle. Investigators from CRU interviewed WCSO Captain Anthony
LeClaire who advised that he was not aware of any complaints of exhaust odors or any symptoms
of carbon monoxide poisoning reported by any WCSO personnel operating any of the Ford
Explorers in the fleet, including the vehicle operated by Deputy Winch’s during this incident.
According to Jamie Mattison, Head Mechanic at the Washington County Carpool, the only
instances of carbon monoxide detectors producing audible alarms were due to low batteries. In
any event, a sample of Deputy Winch’s blood was tested by NMS Labs for the presence of carbon
monoxide and the result was negative.

On October 1, 2019, Deputy Winch was interviewed by NYSP Investigator Mosher. According
to Deputy Winch, he reported to the Salem station before midnight and changed clothes.
Deputy Winch then drove a marked patrol unit to the Law Enforcement Center (LEC) in Fort
Edward and met up with his shift partner, Deputy Jason Diamond (“Deputy Diamond”). The two
deputies rode together in Deputy Diamond’s patrol vehicle with Deputy Diamond driving.
According to Deputy Winch, the deputies responded to a few calls during the shift and at
approximately 6:00 a.m., they returned to the Fort Edward station. Deputy Winch was then
dispached to a call for a motor vehicle/deer accident involving a Department of Public Works
vehicle. According to Deputy Winch, he responded to the Washington County Car Pool and
processed a report and then left for the Salem station in Unit 330. According to Deputy Winch,
he left the Village of Fort Edward traveling on State Route 197 towards the Village of Argyle. En
route he passed a marked Washington County Sheriff’s unit going in the opposite direction. (The
separately obtained statements of Deputy Matthew Jackson and Deputy Michael Weber
corroborate Deputy Winch’s account; both recalled Deputy Winch waving to them as he passed in
his vehicle.) Deputy Winch said he did not recall passing any landmarks that he would normally
look at in the Village of Argyle.

Deputy Winch stated that he had been off from work for seven days prior to reporting for work
at midnight on August 19, 2019. He said he did not recall feeling fatigued during his shift and that
he had slept approximately 10-12 hours during the day, before reporting for his shift. According
to Deputy Winch, his normal shift hours were from 5:00 p.m. until 3:00 a.m., and that working
midnight to 7:00 a.m. was unusual for him.

In terms of the actual collision, Deputy Winch said that at some point he realized that he had
been in an accident but did not know what he had hit. Deputy Winch stated that he could feel pain
in no specific area and then realized that his right leg was injured. Deputy Winch denied
consuming drugs or alcohol before his shift.
In addition to the foregoing information, Investigator Shultis also reviewed the surveillance video of the collision from the self-storage facility which confirmed that Deputy Winch took no evasive action and failed to negotiate the curve as he entered it. Based on the foregoing information, the Collision Reconstruction Unit concluded that the collision was caused by Deputy Winch falling asleep at the wheel immediately before the collision.²

Text Messages and Internet Usage

As previously noted, CRU forensically examined Deputy Winch’s cell phone and generated a report. According to a timeline set forth in the extraction report, on August 19, 2019 at 06:07:31 a.m., Deputy Winch’s then-girlfriend, R.D., sent Deputy Winch a text message asking him how work was. Deputy Winch responded by saying that it wasn’t over yet, but that it was “okay”. Then, at 06:08:03 a.m., Deputy Winch sent a text to R.D. stating, “I’m exhausted”. R.D. responded by texting that she’s sleepy because she had trouble falling asleep, and stated, “I can only imagine how sleepy you are”. At 06:09:18 a.m., Deputy Winch replied, “I can’t wait to sleep.” The collision occurred approximately 27 minutes later.

The forensic examination of Deputy Winch’s cell phone also revealed numerous text messages to several friends on the evening of August 17, 2019 regarding a get together at “J.Z.’s” house. The text messaging continued intermittently until approximately 2:00 a.m. on the morning of August 18, 2019, when R.D. appears to have picked up Deputy Winch and brought him home from the gathering. Cell phone activity, both internet usage and text messaging resumed at 08:53:15 a.m., nearly seven hours later, and continued intermittently until 11:27:29 a.m., at which time Deputy Winch replied to WCSO Sgt. Sullivan about picking up a WCSO Unit 330 in Fort Edward and returning it to the Salem station at the end of his upcoming shift. Text and internet activity resume at 03:11:21 p.m. and continue intermittently until Deputy Winch reported for work at 12:00 midnight on August 19, 2019. At 03:11:30 p.m. during the time of intermittent cell phone usage, Deputy Winch sent a text message to J.Z. stating, “I’m still in bed.”

On August 3, 2020, SIPU staff interviewed WCSO Deputy/Investigator Jason Diamond, in the presence of his attorney, John Aspland, Esq. Deputy Diamond advised that he began a double shift on August 18, 2020 at 2:00 p.m. and finished his shift at 7:00 a.m. on August 19, 2020. Shortly after 12:00:00 a.m., near the middle of his double shift, Deputy Diamond was joined by Deputy Winch and the two patrolled in Deputy Diamond’s car, which Deputy Diamond drove. According to Deputy Diamond, he and Deputy Winch had a “good shift” where they only answered a few calls, and talked quite a bit, particularly about Deputy Winch processing for a job with the New York State Police. Deputy Diamond said that Deputy Winch never discussed being tired or being at a party the evening before; neither did Deputy Winch fall asleep during the shift. Sometime around 6:00 a.m., Deputy Diamond drove back to the LEC in Fort Edward. Deputy Winch retrieved his patrol vehicle to return to the Salem station and then responded a deer/automobile collision call.

On September 4, 2020, SIPU staff interviewed Deputy Cori Winch at the Washington County Law Enforcement Center in Fort Edward, N.Y., in the presence of his attorney, John Aspland, Esq.

² The complete Collision Reconstruction Report prepared by the Troop G Collision Reconstruction Unit is attached as Exhibit 2.
Deputy Winch stated that on August 19, 2019 he was scheduled to work a voluntary overtime shift that started at 12:00 a.m. and ended at 7:00 a.m. Deputy Winch stated that at the beginning of his shift he answered a call at the Salem, N.Y. sub-station which lasted approximately fifteen minutes. According to Deputy Winch, he then drove to the Fort Edward station to meet Deputy Jason Diamond, his partner for the shift. During their shift the two answered approximately three or four calls throughout the county. At around 6:00 a.m., the two returned to the Fort Edward station where Deputy Winch picked up his patrol vehicle to drive back to Salem station. Deputy Winch then received a report of a car/deer accident involving a County Highway vehicle. Deputy Winch responded to the Washington County car pool, located next to the Fort Edward station.

After completing the call, and Deputy Winch started driving back to Salem. Deputy Winch stated he took State Route 197 to State Route 40 in the Village of Argyle, where he continued south through the village and kept driving on State Route 40 until the collision. Deputy Winch stated he was not physically tired at the end of the shift, just mentally tired. Although Deputy Winch admitted to being mentally tired at the end of his shift, he said that he did not fall asleep during his shift with Deputy Diamond.

When asked about the party on the evening of August 17, 2019, at J.Z.’s place, Deputy Winch stated that he had been at the party with his girlfriend R.D., but she left early while he stayed. Deputy Winch said that at some point during the night, he sent a text to R.D. asking her to pick him up because he was consuming alcohol and would not drive. He denied being intoxicated. He said he sent that text shortly before 2:00 a.m. on August 18, 2019. Deputy Winch stated he then went home and went to bed. According to Deputy Winch, he spent most of the day of August 18, 2019, in bed before reporting for his shift. Deputy Winch acknowledged sending and receiving text messages starting at approximately 9:00 a.m. on the morning of the August 18, 2019. However, Deputy Winch maintained that he spent most of the day in bed and slept off and on all day. Deputy Winch said that he got between ten and twelve total hours of sleep between leaving the party at approximately 2:00 a.m. on August 18, 2019 and starting his shift at midnight on August 19, 2019. Deputy Winch attributed his falling asleep to not being acclimated to the 12:00 a.m. to 7:00 a.m. shift.

On September 11, 2020, SIPU staff interviewed R.D., former girlfriend of Deputy Winch, via telephone. R.D. stated that she and Deputy Winch dated for approximately two years before breaking up several months earlier. According to R.D., on August 17, 2019, she and Deputy Winch lived together in his apartment and, that evening, attended a party at J.Z.’s house. According to R.D., she left the party at around midnight and told Deputy Winch to call her if he needed a ride home. At approximately 1:45 a.m. she said she received a message from Deputy Winch asking her to pick him up. R.D. said that when she picked up Deputy Winch, he had been drinking but was not heavily intoxicated; she also noted that Deputy Winch does not drink to excess. According to R.D., she and Deputy Winch went home and went to bed, sleeping until around 9:00 a.m. R.D. stated that she and Deputy Winch stayed in bed most of the day and slept intermittently for several hours.
LEGAL ANALYSIS

Under Penal Law Section 125.10, “a person is guilty of criminally negligent homicide when, with criminal negligence, he causes the death of another person.” Pursuant to Penal Law Section 15.05(4), “a person acts with criminal negligence with respect to a result or to a circumstance described by a statute defining an offense when he fails to perceive a substantial and unjustifiable risk that such result will occur or that such circumstance exists. The risk must be of such a 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.”

In People v. Boutin, 75 N.Y.2d 692, 696 (1990), the Court of Appeals made clear that the mere “failure to perceive a substantial and unjustifiable risk” is in fact insufficient to establish culpability. Rather, “criminally negligent homicide requires not only a failure to perceive a risk of death, but also some serious blameworthiness in the conduct that caused it.” Therefore, unless a defendant has engaged in blameworthy conduct creating or contributing to the substantial and unjustifiable risk of death, there will be no criminal culpability. Id. Simply stated, “‘non-perception’ of a risk, even if death results, is not enough.” Id. 3

Neither Boutin nor any subsequent case has provided much clarity as to what makes risk-creating conduct “blameworthy” or “culpable.” The assessments of blameworthiness remain very fact-specific, with little in the way of rules to guide future determinations. It appears, though, that in order for Deputy Winch to be guilty of criminally negligent homicide for the death of Miss Harrington, his decision to drive that morning (the risk-creating conduct) would have to be “blameworthy” – presumably on the grounds that he was in some way “on notice” of the risk that he could fall asleep at the wheel.

Further, even if Deputy Winch were, to some degree, on notice that he might fall asleep at while driving his failure to perceive the risk of driving would still have to satisfy the “gross deviation” standard. In People v. Haney, 30 N.Y.2d 328, 335 (1972), the Court of Appeal established that the failure to perceive a risk is culpable only if the risk in question “would be apparent to one who shares the community’s general sense of right and wrong.” See also People v. Ricardo B., 73 N.Y.2d 228 at 236 (”[L]iability for criminal negligence should not be imposed unless the inadvertent risk created by the conduct would be apparent to anyone who shares the community’s general sense of right and wrong”); People v. Henson, 33 N.Y.2d 63 (1973) (court noting that criminally negligent homicide only applies to conduct that is “obviously socially undesirable”).

There is essentially no case law in New York involving a driver charged with criminally negligent homicide (or any other crime) for a blameworthy failure to perceive the risk of falling asleep at the wheel. To the contrary, a lack of sleep, combined with alcohol consumption that results in alcohol impairment at the time the driver chooses to get behind the wheel, has been

3 Boutin also emphasized just how negligent a defendant’s conduct must be to fall within the ambit of the statute. “[C]riminal liability cannot be predicated on every act of carelessness resulting in death…. [T]he carelessness required for criminal negligence is appreciably more serious than that for ordinary civil negligence.” Boutin, 75 N.Y.2d at 695.
deemed the type of blameworthy risk creating conduct necessary to sustain criminally negligent homicide. In People v. Heidorf, 186 A.D.2d 915, 916 (App. Div. 3d Dept. 1992), the court upheld a conviction for criminally negligent homicide against a driver who after a night of drinking alcohol, slept for only two hours and then attempted to drive home. At an intersection the defendant failed to stop at a stop sign and collided with another vehicle killing the driver of that vehicle. A breathalyzer test administered two hours later showed the defendant to have a BAC of .06. The court in Heidorf noted that the evidence established that defendant had consumed a substantial quantity of beer on the night before the accident, slept only two hours and failed to yield the right of way at an intersection resulting in a broadside collision with the decedent's vehicle. “Under the circumstances, the jury was justified in concluding that this evidence showed defendant as having engaged in some ‘criminally culpable risk-creating conduct’ that ‘created or contributed to a ‘substantial and unjustifiable’ risk of death’ and that defendant's failure to perceive this risk was serious enough to require criminal sanction” (citations redacted). Id at 916. Insofar as Heidorf can be read as an assessment of the defendant’s “blameworthiness,” that blameworthiness would appear to have arisen from his decision to drive despite being in a compromised state due to lack of sleep and earlier alcohol consumption – a condition of which he would naturally have been “on notice.”

Although not interpreting New York’s criminally negligent homicide statute, courts in a number of other states have considered the issue of when falling asleep at the wheel can give rise to criminal liability. In State v. Valyou, 180 Vt. 627 (2006), the Supreme Court of Vermont affirmed that a jury could find a driver to be to be grossly negligent in violation of Vt. Stat. Ann. tit. 23, § 1091 (West) because the defendant admitted to feeling drowsy during his commute and that he had, “nodded off a few times” before the collision. “[F]alling asleep at the wheel does not, in and of itself, constitute gross negligence. On the other hand, when a driver is on sufficient notice as to the danger of falling asleep but nevertheless continues to drive, the driver's subsequent failure to stay awake may be grossly negligent. To continue to drive in these circumstances marks a disregard for the risk of injury to such a degree so as to constitute ‘a gross deviation from the standard of care that a reasonable person would have exercised in [defendant’s] situation.’” Similarly, in Conrad v. Commonwealth, 31 Va. App. 113 (1999), a Virginia appellate court upheld a conviction for involuntary manslaughter where the defendant fell asleep while driving and then struck and killed a pedestrian. Because the defendant had been up for twenty-two hours without sleep, chose to drive his vehicle “a fairly long distance” to his home in the early morning and dozed off several times but continued to drive, the evidence was sufficient to demonstrate the necessary mens rea of criminal negligence. Id. at 124.

Deputy Winch’s decision to drive on the morning of August 19, 2019, does not rise to the level of blameworthiness reflected either in Heidorf or the out-of-state cases. To be sure, Deputy Winch had been aware that he was tired, as evidenced by his text exchange with R.D. There is little reason to conclude, however, that he was effectively “on notice” that he was at risk of falling asleep at the wheel. Although Deputy Winch acknowledged having consumed alcohol the night of August 17, 2019, there was no alcohol is his system at the time of the collision (unlike in Heidorf). Both Deputy Winch and R.D. indicated that he had slept many hours over the course of August 18, 2019, even if that sleep was occasionally interrupted by text activity. In any event, there is no evidence from which to conclude that Deputy Winch slept for as little as two hours before driving (as in Heidorf) or had been awake for a full 22 hours straight (as in Conrad). During his shift at
work, both Deputy Winch and his partner denied that Deputy Winch fell asleep or nodded off at any time prior to operating his patrol vehicle (unlike Valyou and Conrad) – and there is no evidence to indicate otherwise. In fact, when passing another WCSO car minutes before the collision, Deputy Winch acknowledged the other Sheriff’s deputies by waving to them.

To the extent that Deputy Winch was aware that he was “exhausted” and “[couldn’t] wait to sleep,” this condition would hardly be unfamiliar to almost any regular driver. It would therefore be difficult to argue that operating a vehicle in this condition constituted conduct that was so “obviously socially undesirable,” that it created a risk that “would be apparent to anyone who shares the community's general sense of right and wrong;” in other words, Deputy Winch’s conduct, without more, does not constitute a “gross deviation from the standard of care that a reasonable person would observe in the situation.”

Deputy Winch’s decision to drive, standing alone, is not the type of “blameworthy” conduct required to sustain a charge of criminally negligent homicide. And, inasmuch as criminally negligent homicide requires proof of the least culpable category of mens rea, there are no other appropriate charges that could be brought in this case.

Ms. Harrington’s death was a genuine tragedy. The OAG finds that Deputy Winch’s actions were the cause of Ms. Harrington’s tragic death; the OAG does not find, however, that Deputy Winch’s actions can properly form the basis for a finding of criminal culpability.
RECOMMENDATION

LAW ENFORCEMENT AGENCIES SHOULD EXPLORE THE AVAILABILITY OF ADVANCED SAFETY FEATURES FOR THEIR FLEET VEHICLES

According to the National Highway Traffic Safety Administration, there are three distinguishing characteristics common to most sleep-related crashes:

a. The incidents generally take place between midnight and 6:00 am,
b. They often involve a single driver with no passenger, and
c. They frequently occur on rural roads and highways.⁴

Although this incident took place slightly after the peak hours of midnight to 6:00 am (6:36 am specifically), it otherwise fit the classic profile - Dep. Winch was alone, driving on a rural highway, at a time when he would usually have been sleeping (as noted above, Dep. Winch normally finished his shift at 3:00 am.)

Advanced safety features are evolving in the areas of drowsy and distracted driving. This technology operates to avoid or mitigate crashes before impact occurs. For instance, Lane Departure Warning systems are now optional features on some automobiles;⁵ these systems send a signal, such as an audio alert, to the driver when the vehicle is veering from its lane. Alternatively, Lane Keeping Assistance technology applies pressure to a vehicle’s brakes and/or torque to the steering wheel when the system senses that the vehicle is about to depart from its lane.⁶

We recommend that police agencies, particularly those in rural jurisdictions where officers are often driving alone on rural roads and highways, explore adding some form of advanced safety feature to their fleet vehicles to lessen the chance of this type of incident taking place in the future.

⁵ https://www.safercar.gov/Vehicle+Shoppers/Safety+Technology/ldw/
EXECUTIVE ORDER

In view of the request of Attorney General Letitia James, my order and requirement, embodied in Executive Order Number one hundred and forty-seven, dated July 8, 2015, is hereby amended to include an additional paragraph to the penultimate paragraph as amended by Executive Order Numbers 147.1 - 147.26 to read as follows:

FURTHER, the requirement imposed on the Special Prosecutor by this Executive Order shall include the investigation, and if warranted, prosecution:

(aa) of any and all unlawful acts or omissions or alleged unlawful acts or omissions by any law enforcement officer, as listed in subdivision 34 of section 1.20 of the Criminal Procedure Law, arising out of, relating to or in any way connected with the death of Susan Harrington on August 19, 2019, in Washington County.

GIVEN under my hand and the Privy Seal of the State in the City of Albany this fourth day of October in the year two thousand nineteen.

BY THE GOVERNOR

[Signature]

Secretary to the Governor
EXHIBIT 2
Two-Vehicle Fatal Collision
Police Involved

State Route 40
Town of Argyle
Washington County

August 19, 2019 6:37 a.m.

Troop G
Collision Reconstruction Unit

760 Troy-Schenectady Road
Latham, New York 12110
(518) 250-7470

Prepared by
Investigator Jeremy Shultis
Collision Reconstruction Findings Report

NYSP Station / Outside Agency
SP Greenwich

Collision Date
08/19/2019

Time of Collision
6:37 a.m.

C/T/V of Collision
Town of Argyle

County
Washington

Location
State Route 40

Report Type:
☑ Summary Report
☐ Full Report
☐ Supplemental Report
☐ Amended Report
☐ EDR Image Only
☐ No Report / Consultation (Explain)

Comments: Two-vehicle, police vehicle involved fatal collision.

Vehicle 1
☑ Female
Winch, Corl, J.
DOB: [redacted]
☒ Deceased
☒ Injured

Vehicle 2
☒ Female
Harrington, Susan, J.
DOB: [redacted]
☒ Deceased

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<th>Full Report</th>
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Number of Diagrams: 1

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<tr>
<td>COLLISION SCENE EVIDENCE</td>
<td>DIAGRAM(S)</td>
</tr>
</tbody>
</table>

Number of Diagrams: 9

Submitted By (Rank & Name)
Investigator Jeremy B. Shultis

Troop CRU / Station
GCRU / Latham

Peer Review By
Investigator Robert L. Mower

Supervisory Review By
Senior Investigator Travis A. Webster

Shield: 3928
Date Submitted: 05/28/2020
FIU Senior Investigator
Brian Kenney

CRU Case Number
G2019-0819
Date: 6/17/2020

Shield: 102
Date Reviewed: 6/01/2020

Shield: 5071
Date Reviewed: 6/10/2020
Date Published: 6/22/2020
INTRODUCTION

On Monday, August 19, 2019, at approximately 7:15 a.m., I, Investigator Jeremy Shultis of the New York State Police Troop G Collision Reconstruction Unit (GCRU), received notification to respond to the scene of a two-vehicle fatal motor vehicle collision which occurred on State Route 40 in the Town of Argyle, Washington County, New York.

I arrived at the scene at approximately 8:45 a.m. Troopers Travis Kline (GCRU) and Neil Blakely (GCRU) also responded to the scene to assist with the investigation. Numerous other members of the New York State Police and Argyle Fire Department were on scene and assisted with scene management.

A preliminary assessment of the scene information indicated that the collision occurred on August 19, 2019, at approximately 6:37 a.m., when a marked patrol vehicle from the Washington County Sheriff’s Office (WCSO), a 2017 Ford Explorer all-wheel-drive PoliceInterceptor designated as WCSO Unit 330 (Vehicle #1), driven by Cori J. Winch, was southbound on State Route 40. Vehicle #1 crossed over the center lane markings into the path of a 2014 Honda CRV (Vehicle #2) bearing New York Registration BDC1949, driven by Susan J. Harrington, who was traveling northbound. The operator of Vehicle #2 took evasive action by steering to the right; however, she was unable to avoid the collision. The collision caused Vehicle #1 to rotate counter-clockwise and come to an uncontrolled final rest in the northbound lane of travel facing northwest. Vehicle #2 was redirected southeast and came to an uncontrolled final rest in the grass field adjacent to the roadway. It was upright and facing south.

Upon my arrival, the operator of Vehicle #1 had been transported by ambulance to Glens Falls Hospital in Glens Falls, New York, for treatment of injuries incurred in the collision. Both vehicles remained at their uncontrolled final rest position. The restrained operator of Vehicle #2 died due to injuries sustained in the collision and her body remained in the vehicle.

I photographed the scene, documenting its condition at that time. The scene was marked in preparation for mapping. It was checked for roadway defects or other items, which may have contributed to causing the collision. No such defects or items were found. Trooper Kline and I forensically mapped the scene evidence using a DT Research Global Positioning System data collector and an Unmanned Aircraft System (UAS), designated as CRU UAS-7.

At the time of my arrival the weather was clear, and the road was dry. The temperature was approximately 70 degrees Fahrenheit at the time of the investigation. Investigator David Mosher indicated that the conditions were consistent with those he encountered at the time he arrived on the scene shortly after the collision was reported.
At the scene of the collision, State Route 40 was a two lane, asphalt-surfaced roadway oriented in a general north-south direction with asphalt-surfaced shoulders adjacent to both travel lanes. Northbound traffic traversed a slight left curve while southbound traffic traversed a slight right curve. The lanes were demarcated from each other by a solid double yellow line, indicative of a no passing zone. The roadway width was approximately 28.8 feet wide as measured from the edge of pavements, with the southbound lane being approximately 11.3 feet wide and the northbound lane being approximately 11.4 feet wide as measured from their respective edge of pavements to the center of the double yellow lane marking. The northbound and southbound shoulders were approximately 2.7 feet wide and 3.4 feet wide respectively, as measured from the edge of pavement to the approximate center of their respective solid white lane marking. The posted speed limit in this area of State Route 40 was 55 mph.

The evidence at the scene included tire marks, pavement scars, furrows, vehicle debris, both vehicles and the deceased operator of Vehicle #2. The first evidence observed was a tire mark that was oriented to the north and originated approximately 0.08-foot from the center of the northbound fog line. The tire mark was approximately 15.1 feet in length and was consistent with being made from the left side tires of Vehicle #2 as it was braking prior to impact. Approximately 28.5 feet north of the north end of this tire mark was a series of gouges on the asphalt on the east shoulder in proximity to the fog line. These gouges are consistent with being the area of impact between the vehicles. These gouges were made by the undercarriage components of the vehicle front ends as they were forced
downward during maximum engagement. Approximately 6.2 feet north of these gouges, originating on the fog line was a tire mark that curved to the southeast, it started wide and narrowed as it progressed. The tire mark just described was consistent with being made by the front left tire of Vehicle #2 as it moved and rotated post-impact. From the area of impact, a generally southeast oriented path of vehicle debris, vehicle fluids and furrows in the grass field adjacent to the roadway led to the uncontrolled final rest location of Vehicle #2. Vehicle #2 came to rest upright, facing south, approximately 35.2 feet from the area of impact as measured to the approximate center of Vehicle #2. The restrained and deceased operator remained in the vehicle.

A second path of vehicle debris, vehicle fluids and roadway scars extended in a generally south direction from the area of impact. They led to the uncontrolled final rest location of Vehicle #1 which was upright facing northwest. Its front end was in the northbound lane and its rear end extended to the edge of pavement of the east shoulder. The evidence was consistent with Vehicle #1 travelling southbound, crossing over the center lane markings and striking Vehicle #2 in the northbound lane.

On August 20, 2019 at the SP Latham impound lot in Latham, New York, Trooper Travis Kline and I inspected Vehicle #1. Vehicle #1 exhibited severe damage consistent with a frontal collision with deeper intrusion on the front left. Vehicle #1 was equipped with three-point lap belt/shoulder harnesses for all seating positions with supplemental front and side curtain airbags. Upon inspection, the driver’s seatbelt was found to be retracted and free spooling. There was stretching and melting of the webbing due to load stressing. This evidence was consistent with the driver of Vehicle #1 wearing his seatbelt at the time of the collision. The driver’s front airbag and both side curtain airbags had deployed. No evidence of pre-collision tire defects or failures were observed on any of the tires, nor was there any evidence of pre-impact steering deficiencies or failures.

A search of investigations pertaining to the involved Ford Explorer Police Interceptor was performed and revealed NHTSA Action Number EA17002, which pertained to Ford Explorer exhaust odor. According to NHTSA, the Office of Defects Investigation (ODI) opened preliminary evaluation (PE16-008) in July of 2016. This evaluation revealed 791 reports pertaining to Model Year 2011-2017 Ford Explorers, 11 of which involved Police Interceptors. Per ODI, there was no substantive data or actual evidence to support carbon monoxide(CO) poisoning; however, data did suggest that CO levels may be elevated in certain driving scenarios. This investigation remains open and had been upgraded on 7/27/2017 to an Engineering Analysis, EA 17-002. Washington County repair order R112-0001244, dated 08/11/2017, listed a carbon monoxide detector being installed in the vehicle; however, the detector was not observed at the scene of the collision nor was one found to be in the vehicle at the time of the vehicle inspection.

I spoke with Captain Anthony LeClaire of the WCSO who advised me that the installation of carbon monoxide detectors in their vehicles was done so as a preventative measure, and that he was not aware of any complaints from his officers regarding exhaust odors or symptoms related to carbon monoxide poisoning prior to or subsequent to the
detector installation. In speaking with Washington County Carpool, Head Mechanic, Jamie Mattison, he advised me that any audible alarm from the carbon monoxide detectors of the WCSO vehicles that had been investigated by them, was attributed to a low battery in the detector. He advised that he had no evidence or data of any exhaust odor or carbon monoxide issues with the WCSO fleet.

![Vehicle #1 at SP Latham](image)

During the inspection, I imaged the Event Data Recorder (EDR) of Vehicle #1 using the Bosch Crash Data Retrieval (CDR) System, under authority of a signed consent by Washington County Sheriff, Jeffrey Murphy. The Airbag Control Module (ACM) contained a completely recorded and locked deployment event. The data contained five seconds of pre-crash data, recorded in one-half second increments, including but not limited to Speed, Vehicle Indicated (MPH [km/h]); Accelerator Pedal, % Full; Service Brake On/Off and Engine RPM. Approximately 5.0 seconds prior to the impact the recorded Speed, Vehicle Indicated and Accelerator Pedal, % Full were listed as 52.5 mph and 28.8%, respectively. The Accelerator Pedal remained the same for the entirety of the data while the speed increased to 56.3 mph. This was consistent with the slight downhill grade present in the area of the collision for Vehicle #1. The Service Brake On/Off was Off for the entirety of the 5.0 seconds of pre-crash data. The ACM also recorded 5.0 seconds of pre-crash data in 0.1 second intervals for multiple parameters, including Steering Wheel Angle (deg). The listed samples of steering wheel angle were 0.0 degrees for all but two samples that were listed as 0.1 degrees. This data was consistent with the operator of Vehicle #1 not taking any evasive action to avoid the collision.
According to the report, Vehicle #1 experienced a maximum longitudinal Delta-V of -38 mph and the safety belt status of the driver was, “Buckled”.

The chart below is from the Bosch Crash Data Retrieval Report of Vehicle #1 showing the Pre-Crash Data, -5.0 to -0.5 sec (Event Record 1).

<table>
<thead>
<tr>
<th>Time (sec)</th>
<th>Speed, Vehicle Indicated (MPH [km/h])</th>
<th>Accelerator Pedal, % Full</th>
<th>Service Brake On/Off</th>
<th>Engine RPM</th>
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<td>-4.0</td>
<td>53.2 [86]</td>
<td>28.8</td>
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<tr>
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<td>53.5 [86]</td>
<td>28.8</td>
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<tr>
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<td>53.9 [87]</td>
<td>28.8</td>
<td>Off</td>
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<tr>
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<td>54.2 [87]</td>
<td>28.8</td>
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A search of the National Highway Traffic Safety Administration (NHTSA) Recall Database for information pertaining to Vehicle #1 was conducted on May 26, 2020. That VIN-specific search revealed that there were no unrepaired recalls associated with Vehicle #1.

On August 21, 2019 at the SP Latham impound lot in Latham, New York, Troopers Kline, Blakely and I inspected Vehicle #2. Vehicle #2 exhibited severe damage consistent with a frontal collision with deeper intrusion on the front left. Vehicle #2 was equipped with three-point lap belt/shoulder harnesses for all seating positions with supplemental front, seat side and side curtain airbags. Upon inspection, the driver’s seatbelt was found to be extended and locked. The webbing had been cut by responding medical personnel. There was stretching and melting of the webbing due to load stressing. This evidence was consistent with the driver of Vehicle #2 wearing her seatbelt at the time of the collision. The driver’s side front airbag, driver’s side seat airbag and both side curtain airbags had deployed. No evidence of pre-collision
tire defects or failures were observed on any of the tires, nor was there any evidence of pre-impact steering deficiencies or failures.

During the inspection, I imaged the Event Data Recorder (EDR) of Vehicle #2 using the Bosch Crash Data Retrieval (CDR) System, under authority of implied consent. The Supplemental Restraint System (SRS) contained a completely recorded and locked deployment event. The data contained five seconds of pre-crash data, recorded in one-half second increments, including but not limited to Speed, Vehicle Indicated (MPH [km/h]): Accelerator Pedal Position, % Full; Service Brake On/Off; ABS Activity (On,Off) and Steering Input (deg). Approximately 5.0 seconds prior to the impact the recorded Speed, Vehicle Indicated and Accelerator Pedal, % Full were listed as 53 mph and 23%, respectively. At approximately 1.0 second prior to impact the accelerator pedal position was reported as 0% and the steering input went from 10 degrees left to -15 degrees right. This was consistent with the curvature of the roadway and the beginning of evasive action. At 0.0 second, or the approximate time of the impact, Vehicle #2 Speed, Vehicle Indicated was 46 mph, ABS Activity switched to “ON” and the Steering Input increased to -40 degrees to the right. This data was consistent with the operator of Vehicle #2 observing Vehicle #1 encroaching into her lane and attempting to avoid a collision by decreasing her speed and steering to the right.

According to the report, Vehicle #2 experienced a maximum longitudinal Delta-V of -38 mph and the safety belt status of the driver was Buckled.

The chart below is from the Bosch Crash Data Retrieval Report of Vehicle #2 showing the Pre-Crash Data, -5.0 to -0.0 sec (Event Record 1).

<table>
<thead>
<tr>
<th>Time Stamp (sec)</th>
<th>Speed, Vehicle Indicated (MPH [km/h])</th>
<th>Service Brake (On,Off)</th>
<th>ABS Activity (On,Off)</th>
<th>Steering Input (deg)</th>
<th>Accelerator Pedal Position, % Full</th>
</tr>
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<tbody>
<tr>
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<td>Off</td>
<td>0</td>
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<td>Off</td>
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<td>23</td>
</tr>
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<td>22</td>
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<tr>
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<tr>
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<tr>
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<td>Off</td>
<td>10</td>
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<tr>
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<tr>
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<tr>
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</tr>
<tr>
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</tr>
<tr>
<td>0.0</td>
<td>46</td>
<td>On</td>
<td>On</td>
<td>-40</td>
<td>0</td>
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</tbody>
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A search of the NHTSA Recall Database for information pertaining to Vehicle #2 was conducted on May 26, 2020. That VIN-specific search revealed that there were no unrepaired recalls associated with Vehicle #2.

The operator of Vehicle #2, Susan J. Harrington, died as a result of injuries sustained in the collision and her body was transported to the Glens Falls Hospital morgue.
On August 20, 2019, Forensic Pathologist Michael Sikirica, M.D., performed an autopsy on the body of Susan J. Harrington with Trooper Kline and myself present. Doctor Sikirica ruled the cause of death as multiple severe traumatic blunt force injuries from a motor vehicle collision.

On August 29, 2019 Investigator Kevin Reppenagen secured a signed voluntary consent from Cori J. Winch to search his cellphone. According to the SJS narrative of Investigator David Mosher, the search of the cellphone of Cori J. Winch resulted in no indication of usage at the time of the collision. Investigator Mosher also confirmed that there was no indication of activity on the computer of Vehicle #1 at the time of the collision.

Subsequent to a signed consent from Cori J. Winch, a blood sample was secured and submitted for analysis to the New York State Police Forensic Investigation Center in Albany, New York. This sample was tested for alcohol and drug(s) and generated results for both which were annotated on separate reports. The Toxicology Report, which tested for alcohol, yielded a result of “None Detected.” The Toxicology Report-Supplemental, which tested for drug(s), reported a result of “Present” for morphine. According to Investigator Mosher, Winch had been administered pain medications which included morphine by responding medical personnel. Additionally, a blood sample from Cori J. Winch was sent to NMS Labs located in Horsham, Pennsylvania to be tested for opiates and carbon monoxide exposure. That report generated a result of positive findings for only morphine.

A signed Supporting Deposition was obtained from Cori J. Winch. In sum and substance, he stated that he had been off for seven days prior to reporting for his shift from midnight to 7:00 a.m. and had slept well prior to reporting for work. He had been the passenger in the vehicle with his night shift partner until around 6:00 a.m. when he had gone back to the Fort Edward Station and was assigned to a collision. After handling that collision, he was heading toward Argyle and recalled waving to a marked Washington County Sheriff’s vehicle passing in the opposite direction. Winch stated that he did not remember passing any landmarks he normally would see when passing through the Village of Argyle and at some point, realized he had been in a crash. Winch further stated that he did not recall feeling fatigued during his shift.

Video footage of the collision was secured from the adjacent Argyle Self-Storage building. In the video, Vehicle #1 could be seen southbound on State Route 40 when it crossed the center lane markings into the path of Vehicle #2 which was northbound. Just prior to the collision, the operator of Vehicle #2 braked and steered to the right. At no time in the video did Vehicle #1 appear to take evasive action.

---

2 Toxicology Report for Cori J. Winch, dated 9/16/2019, by Tiffany M. Moreno, Forensic Scientist III, Toxicology.
3 Toxicology Report-Supplemental for Cori J. Winch, dated 9/16/2019, by Laura L. Mangione, Forensic Scientist III, Toxicology.
4 Toxicology Report for Cori J. Winch, dated 9/16/2019, by Daniel S. Isenschmids, Forensic Toxicologist, NMS Labs.
Roadway defects and vehicular defects have all been considered and ruled out as contributing to the cause of this collision.

The primary cause of this collision was failure to maintain his lane, on the part of Vehicle #1 operator, Cori J. Winch. The lack of driver input on his part was consistent with fatigue and/or falling asleep while operating the vehicle.
NEW YORK STATE POLICE
COLLISION RECONSTRUCTION UNIT

Two-Vehicle Fatal Collision
Police Involved
State Route 40
Town of Argyle, Washington County
August 19, 2019 at 6:37 a.m.

Measurements Taken By:
Investigator Jeremy Shultis

Drawn By:
Investigator Jeremy Shultis

0  
50  
125  

Scale (In Feet)