



Office of the New York State Attorney General Letitia James

Office of Special Investigation

Office of Special Investigation
Sixth Annual Report
October 1, 2026

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1. INTRODUCTION

This is the Sixth Annual Report of the New York Attorney General's Office of Special Investigation (OSI), issued October 1, 2026, pursuant to Paragraph 7 of New York Executive Law Section 70-b (Section 70-b). Prior OSI Annual Reports, including two biennial reports from OSI's predecessor unit, can be found on the [OSI Annual Reports page](#).

OSI

Section 70-b

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

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

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

OSI's investigations are criminal investigations. When OSI determines that criminal charges are not warranted, it is not a determination that no wrongdoing has occurred; it is a determination that a prosecutor would not be able to prove beyond a reasonable doubt at trial that an officer committed a crime. There may still be civil remedies available in connection with the death of the person. In addition, there is now a New York law, passed by the Legislature in May of this year, establishing a person's right to bring a civil action if a government official has deprived the person of their constitutional rights, Civil Rights Law Section 85. CVR 85 can be read here: [Civil Rights Law 85](#).

The full text of Section 70-b as amended can be read here: [Section 70-b](#). Prior to April 1, 2021, Governor's Executive Order 147, issued in 2015 and in effect through March 31, 2021 (EO 147), gave the Attorney General a narrower form of authority, to investigate and, when warranted, to 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) person. EO 147 can be read here: [Executive Order 147](#).

OSI's Personnel

OSI is authorized for 24 assistant attorneys general (AAGs) and 12 legal support analysts, assigned to 10 offices around the state (Albany, Binghamton, Buffalo, Manhattan, Mineola, Poughkeepsie, Rochester, Suffolk County, Syracuse, and White Plains). One of the AAGs and three of the analysts work primarily on responding to the increasing volume of Freedom of Information Law (FOIL) requests OSI handles. The Attorney General has recently increased the number of detectives in her Investigation Division to be assigned to OSI from 20 to 25 (including supervisors). The detectives, like the AAGs, are distributed around the state. In addition, OSI is authorized for two senior criminal justice coordinators and two criminal justice liaisons who, together with attorneys and detectives, attend meetings with family members of persons who have died in law enforcement encounters and provide continuing support to those family members, as described in more detail in the subsection on Family Meetings, below. Finally, OSI has two bureau administrators who perform essential roles in OSI's record-keeping and case-tracking, correspondence with District Attorneys, data, and metrics.

OSI's Process: Assessments and Investigations

As mentioned, 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. When OSI is initially notified of an incident it is not always clear whether these three elements – a death, a defined officer, and causation – are present.

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

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

However, the vast majority of notifications received by OSI clearly involve a death and a defined officer. When the third element – causation – is not initially clear, OSI calls its investigations "preliminary assessments," though they are often very detailed and may take months to complete. For example, if a person dies from illness in a prison, OSI, in the course of its preliminary assessment, gathers evidence to determine whether the death was caused by the neglect of a correction officer. This may require the review of many hours of video; review of handwritten logbooks and electronic logs, incident reports, medical records, and

autopsy and toxicology reports; and interviews of correction 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 correction officer caused the death and will close the matter.

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

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

In cases where the investigation is complete, and it is clear that prosecution is not warranted, then, prior to beginning the drafting and approval process for a full Investigation Report, the Attorney General may make a public announcement that OSI has completed the investigation and will not be presenting evidence to a grand jury. A public announcement of this kind is called a Notification of Investigative Findings (Notification). The objective of these Notifications is to advance the time when OSI announces the conclusion of an investigation in an effort to be more responsive to the police departments involved and to the families of the people who have died. When the Attorney General releases a Notification, OSI follows up with a full, published Investigation Report, as required by Section 70-b.

Family Meetings and Video Releases

When OSI begins a full investigation, we reach out to the family members of the person who has died and ask to meet with them in person. In these family meetings the AAG and the detective assigned to the investigation, as well as a senior criminal justice coordinator or a criminal justice liaison (Coordinator or Liaison) introduce themselves, provide their contact information, explain OSI's independent investigative role under the law, and describe OSI's investigative process. (In cases where a family member may also be a witness in the investigation, OSI will have a separate meeting to interview the family member according to our regular witness interview practice.)

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

If there is video that captured the incident in which the person died, OSI will offer the family members an opportunity to view relevant segments at the initial family meeting or soon thereafter. In such cases, the Attorney General will publicly release relevant video segments, in accordance with her published video release policy. (The video release policy is here: [Release Policy](#).) OSI will always provide the family an opportunity to view video before the Attorney General releases it. (A recent amendment to Section 70-b is the addition of paragraph 3-a, relating to OSI's handling and disclosure of video and audio recordings.)

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

If OSI is going to issue an Investigation Report/Notification, the OSI team explains the steps OSI took in the investigation and OSI's investigative findings and legal analysis. (In addition, in many investigations, OSI staff and members of the Attorney General's office of Intergovernmental Affairs will communicate with elected officials and community leaders.) In cases where OSI obtains an indictment, followed by pretrial hearings and a trial, the Coordinator or Liaison keeps family members informed of the progress of the proceedings and accompanies the family members in the courtroom.

Sections in This Report

Criminal Charges and Resolutions

Since the last Annual Report, OSI took two cases to trial, obtaining guilty verdicts in both, and brought criminal charges in five new cases, all of which are pending as of the publication of this report; in one of the five new cases the defendant has pleaded guilty and awaits sentencing. See Section 2 of this Report for summaries of these seven cases.

Recusals

OSI has not asked a court to recuse it from an investigation or to appoint a special prosecutor since the last Annual Report. In that Report, we described the potential conflicts of interest that led us to ask to be recused from two investigations of possible homicides by correction

officers in the state prison system in connection with the deaths of Roberts Brooks and Messiah Nantwi. Since the last Annual Report, the Legislature passed, and the Governor signed, new legislation designed to reduce the occasions on which OSI would need to seek recusal in similar situations. See Section 3 of this Report for an explanation of the way certain potential conflicts of interest may lead OSI to seek recusal, for an explanation of the new law, and for summaries of the results of the prosecutions in the Brooks and Nantwi cases.

Investigation Reports and Notifications

OSI has closed 41 investigations since the last Annual Report by issuing an Investigation Report or a Notification describing incidents in which an officer caused a death and OSI concluded that criminal charges were not warranted. (One of the Investigation Reports was the follow-up to a Notification issued in the prior reporting period.) See Section 4, below, for summaries of the Investigation Reports and Notifications OSI has published since the last Annual Report.

New York City Department of Correction

OSI investigates (or assesses to determine causation) the deaths of people in the custody of correction departments around the state, including persons in the custody of the New York City Department of Correction (NYC DOC), which includes the facilities on Rikers Island. Since the last Annual Report OSI has completed 11 assessments of NYC DOC cases. See Section 5, below, for summaries of those assessments.

Recommendations

Paragraph 7 of Section 70-b directs OSI to include in the Annual Report “recommendations for any systemic or other reforms recommended as a result of [OSI’s] investigations.” See Section 6, below, for OSI’s recommendations.

Data

Because Section 70-b requires that OSI’s Annual Report be published every year on October 1, OSI uses a data year ending August 31 to allow for 30 days to collate and analyze OSI’s annual data. See Section 7, below, for a discussion of selected data. See these [tables](#) for OSI’s complete data from April 1, 2021 (the effective date of Section 70-b) through August 31, 2026.

2. CRIMINAL CHARGES AND DISPOSITIONS

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

Since the last Annual Report, OSI went to trial in two cases, obtaining guilty verdicts in both, and brought criminal charges in five new cases; the defendant has pleaded guilty in one of the five new cases and awaits sentencing. These seven cases are summarized below, in order of the date of the incident.

Completed Trial: People v Christopher Baldner, Ulster County (Date of Incident: December 22, 2020)

On March 13, 2026, an Ulster County Court jury found former New York State Police (NYSP) Trooper Christopher Baldner guilty after trial of Manslaughter in the Second Degree. On June 2, 2026, the Judge of the Ulster County Court sentenced Mr. Baldner to two and a half to seven and a half years in prison and remanded him into custody. A Justice of the Appellate Division denied his application for bail pending appeal.

The evidence at trial established that on December 22, 2020, at 11:40 pm, Tristin Goods was driving on the New York State Thruway with his wife and two daughters, aged 11 and 12, on the way to visit family for Christmas. The defendant was on patrol in his marked NYSP car and stopped the Goods family car for speeding. During the stop the defendant pepper sprayed the car's occupants, and Mr. Goods sped away. During the pursuit, when both cars were traveling over 100 miles per hour, the defendant rammed his police vehicle into the rear of the Goods family car, twice. The first strike destabilized the Goods family car, and the second strike caused it to skid out of control into the center median, crash into the guide rail, and flip over. The impact ejected Monica Goods from the car, killing her.

Monica Goods was Black; she was 11 years old when she died. (Paragraph 7(b) of Section 70-b requires the Annual Report to provide the "racial, ethnic, age, gender and other demographic information concerning the persons involved" in an incident.) The defendant retired from NYSP after the incident. The indictment is here: [Christopher Baldner Indictment](#). (A prior trial, in October-November 2025, ended in a mistrial.)

Pending Indictment: People v Kevin Richmond, Orange County (Date of Incident: July 27, 2023)

The indictment charges that off-duty New York City Police Department (NYPD) Officer Kevin Richmond, who was driving his personal car, committed Vehicular Manslaughter in the Second Degree and Driving While Intoxicated when, being intoxicated, he drove into a motorcycle

ridden by Nidia Nieves on I-87, causing Ms. Nieves to be thrown to the pavement. Ms. Nieves suffered traumatic injuries and was pronounced dead at the scene.

Nidia Nieves was Hispanic; she was 54 years old when she died. The indictment ([Kevin Richmond Indictment](#)) is pending in Orange County Court; no trial date has been set. NYPD terminated Mr. Richmond after the incident.

Completed Trial: People v Erik Duran, Bronx County (Date of Incident: August 23, 2023)

On February 6, 2026, a Bronx County Supreme Court Justice found NYPD Sergeant Erik Duran guilty after trial of Manslaughter in the Second Degree (the defendant had waived a jury). On April 9, 2026, the Justice sentenced Mr. Duran to three to nine years in prison and remanded him into custody. A Justice of the Appellate Division granted him bail pending appeal.

Mr. Duran was working in plain clothes, supervising a narcotics “buy and bust” operation. Eric Duprey, who was unarmed, had just sold drugs to an undercover officer on Mr. Duran’s team. As Mr. Duran and his team moved in to arrest Mr. Duprey, Mr. Duprey tried to evade them on a motorized scooter. As he rode past the defendant at 25 to 30 miles per hour, the defendant, attempting to prevent Mr. Duprey’s escape, picked up a heavy picnic cooler filled with ice and drinks and threw it at Mr. Duprey’s head with such force that, video showed, the cooler and its contents exploded and caused Mr. Duprey and the scooter to crash to the ground. Mr. Duprey was killed instantly when his head hit the pavement.

Eric Duprey was Hispanic; he was 30 years old when he died. NYPD terminated Mr. Duran after the conviction. The indictment is here: [Erik Duran Indictment](#).

Pending Indictment: People v Stanley Cadet and Kayla Lopez, Suffolk County (Date of Incident: May 11, 2024)

The indictment charges that off-duty NYPD officer Stanley Cadet and civilian Kayla Lopez, who were driving their personal cars, committed Manslaughter in the Second Degree, Assault in the Second and Third Degrees, Reckless Endangerment in the Second Degree, and other crimes when they drove recklessly and their cars collided, ejecting and killing Ms. Lopez’s passenger Anna Wilson and causing injury to other passengers in Ms. Lopez’s car and the passenger in Mr. Cadet’s car.

(OSI is prosecuting Ms. Lopez pursuant to a Governor’s executive order, [here](#), dated August 8, 2025, because Ms. Lopez is not a police or peace officer.)

Ms. Wilson was White; she was 22 years old when she died. The indictment ([Stanley Cadet, Kayla Lopez Indictment](#)) is pending in Suffolk County Court; no trial date has been set. NYPD terminated Mr. Cadet after the incident.

Guilty Plea: People v Tiffany Howell, Westchester County (Date of Incident: January 22, 2026)

The indictment charges that off-duty NYPD Sergeant Tiffany Howell, who was driving her personal car, committed Aggravated Vehicular Homicide, Manslaughter in the Second Degree, and other crimes when, being intoxicated, she drove the wrong way on the Taconic State Parkway and collided head-on into a car driven by Manuel Boitel, killing him.

On August 19, 2026, Ms. Howell pleaded guilty to Aggravated Vehicular Homicide and Manslaughter in the Second Degree before a Judge of the Westchester County Court. The Judge adjourned the case and said she would sentence Ms. Howell to four to 12 years in prison at the next court appearance.

Mr. Boitel was Hispanic; he was 61 years old when he died. The indictment is here: [Tiffany Howell Indictment](#). Ms. Howell resigned from NYPD after the incident.

Pending Charges: People v Ryan Bordeau, Franklin County (Date of Incident: January 28, 2026)

A criminal court complaint charges that off-duty New York State Department of Corrections and Community Supervision (DOCCS) Correction Officer (CO) Ryan Bordeau, who was driving his personal pickup truck, committed Vehicular Manslaughter in the Second Degree and Driving While Intoxicated when, being intoxicated, he drove off a road and crashed into a ditch, killing his front-seat passenger, Jennifer Hathorn.

Ms. Hathorn was White; she was 49 years old when she died. The complaint ([Ryan Bordeau Complaint](#)) is pending in Franklin County Court; no trial date has been set. DOCCS suspended Mr. Bordeau after the incident.

Pending Indictment: People v Lance Woods, Niagara County (Date of Incident: February 14, 2026)

The indictment charges that off-duty Buffalo Police Department (BPD) Officer Lance Woods committed Murder in the Second Degree when he shot his wife, Alexis Skoczylas, in their house, causing her death.

Ms. Skoczylas was White; she was 35 years old when she died. The indictment ([Lance Woods Indictment](#)) is pending in Niagara County Court; no trial date has been set. BPD suspended Mr. Woods for 30 days without pay after the incident; after that period BPD suspended him with pay.

3. RECUSALS

Background

The laws of New York vest the Office of the Attorney General (OAG) with statutory duties (a) under Section 17 of the Public Officers Law, to provide for the defense of state employees in civil actions arising from their public employment, and (b) under Section 70-b of the Executive Law, to investigate and, where appropriate, prosecute offenses in connection with deaths caused by police officers or peace officers. There are circumstances where there is a risk that the Attorney General's duties under these two laws could be perceived as in conflict.

For example, OSI under Section 70-b could begin an investigation of a correction officer employed by DOCCS for possible crimes committed in connection with the death of a person incarcerated in one of the state's prisons. At the same time, that officer, being a state employee, may already be a client of the State Counsel division of OAG, under Section 17 of the Public Officers Law, in a lawsuit brought against the officer for conduct committed in connection with a prior, unrelated incident in a DOCCS facility.

The Robert Brooks and Messiah Nantwi Cases

In fact, this situation arose twice, as described in OSI's last Annual Report, in connection with the death of Robert Brooks on December 10, 2024, in DOCCS's Marcy Correctional Facility, and in connection with the death of Messiah Nantwi on March 1, 2025, in DOCCS's Midstate Correctional Facility. After OSI began its investigations, OAG's conflict checking process showed that certain DOCCS officers in both investigations were already represented by OAG in prior lawsuits about unrelated events, pursuant to OAG's duty to defend state employees, as explained above. Because of the risk that this could be a conflict of interest, OSI brought motions in both cases for the Attorney General to be recused as the prosecutor and for the court to appoint a special prosecutor to continue the investigations and, if warranted, to seek charges against the correction officers involved.

As a result of OSI's motions, the District Attorney of Onondaga County was appointed by the court to be the special prosecutor in both cases, and he obtained indictments and convictions in the two cases as follows:

Robert Brooks:

Correction Officer David Kingsley: found guilty at trial of Murder in the Second Degree and Manslaughter in the First Degree, sentenced to 25 years to life

Correction Officer Nicholas Anzalone: pleaded guilty to Manslaughter in the First Degree, sentenced to 22 years

Correction Officer Anthony Farina: pleaded guilty to Manslaughter in the First Degree, sentenced to 22 years

Correction Officer Christopher Walrath: pleaded guilty to Manslaughter in the First Degree, sentenced to 15 years

Sergeant Michael Mashaw: pleaded guilty to Manslaughter in the Second Degree, sentenced to three to nine years

Correction Officer Robert Kessler: pleaded guilty to Assault in the Second Degree, sentenced to four years

Correction Officer David Walters: pleaded guilty to Manslaughter in the Second Degree, sentenced to two and one third to seven years

Sergeant Glenn Trombly: pleaded guilty to Offering a False Instrument for Filing in the First Degree and Reckless Endangerment in the Second Degree, sentenced to two years

Correction Officer Michael Fisher: pleaded guilty to Reckless Endangerment in the Second Degree, sentenced to six months

Correction Officer Nicholas Gentile: pleaded guilty to Attempted Tampering with Evidence, sentenced to a conditional discharge

Correction Officer Shea Schoff: pleaded guilty to Official Misconduct, sentenced to a conditional discharge

Sealed: two defendants were charged with crimes and acquitted of all charges at trial.

Messiah Nantwi:

Correction Officer Jonah Levi: found guilty at trial of Manslaughter in the First Degree, sentenced to 25 years

Correction Officer Caleb Blair: pleaded guilty to Manslaughter in the First Degree, sentenced to 11 years

Sergeant Francis Chandler: pleaded guilty to Gang Assault in the Second Degree, sentenced to 4 years

Correction Officer Daniel Burger: pleaded guilty to Offering a False Instrument for Filing in the First Degree, sentenced to one and a third to four years.

Correction Officer Joshua Bartlett: pleaded guilty to Hindering Prosecution in the First Degree and Falsifying Business Records in the First Degree, sentenced to one year

Correction Officer Thomas Eck: pleaded guilty to Offering a False Instrument for Filing in the First Degree, sentenced to nine months

Correction Officer Craig Klemick: pleaded guilty to Offering a False Instrument for Filing in the First Degree, sentenced to nine months

Correction Officer Nicholas Vitale: pleaded guilty to Offering a False Instrument for Filing in the First Degree, sentenced to a conditional discharge

Correction Officer Nathan Palmer: pleaded guilty to Hindering Prosecution in the First Degree and Falsifying Business Records in the First Degree, sentenced a conditional discharge

Correction Officer Frank Jacobs: pleaded guilty to Official Misconduct, sentenced to a conditional discharge

Sergeant David Ferrone: pleaded guilty to Tampering with Evidence, sentenced to a conditional discharge

Sergeant Donald Slawson: pleaded guilty to Attempted Tampering with Evidence, sentenced to a conditional discharge

Sergeant Michael Iffert: pleaded guilty to Offering a False Instrument for Filing in the First Degree, sentenced to a conditional discharge

Correction Officer Adam Joseph: pleaded guilty to Official Misconduct, sentenced to a conditional discharge.

The violent actions of the correction officers in these two cases came to light because of OSI's work. Section 70-b directs OSI to investigate, among other things, any incident in which there is a question whether the death was caused by a peace officer (which includes a correction officer), and OSI therefore investigates (or assesses) every death in every DOCCS facility. Under OSI's protocols, as soon as OSI is notified of a death in a DOCCS facility (other than a death from a long-term illness), OSI personnel immediately respond in person to the facility and begin their investigative work. In the Brooks and Nantwi cases, OSI, working with DOCCS's investigations group and NYSP, was able to identify, lock down, and download video from body-worn cameras, which showed the conduct of officers who later became defendants in the District Attorney's cases. In particular, in the Brooks case, OSI personnel discovered that the body-worn cameras of certain correction officers were recording in standby mode (without audio), even though the officers had not activated those cameras, and facilitated the

preservation and downloading of those videos within the first few days after the incident. In the Nantwi case, OSI, working with the DOCCS investigations group and NYSP, identified and downloaded video from body-worn cameras, interviewed material witnesses, and obtained search warrants to secure items for forensic testing and analysis.

New Legislation

To address the risks presented by these kinds of potential conflicts of interest, the Legislature passed, and the Governor signed, an omnibus corrections bill, which, among other things, added Paragraph 8 to Section 70-b (New Paragraph 8). The preamble to the conflicts of interest section of the bill states that it is the Legislature's objective to enable the Attorney General to carry out the requirements of both Executive Law Section 70-b (OSI's enabling statute) and Public Officers Law Section 17 (the statute requiring the Attorney General to represent state employees when they are sued in connection with their employment) in a manner that is consistent with the rules of professional conduct. New Paragraph 8 requires that OAG establish an information barrier between OSI and State Counsel (the division within OAG that represents state employees) and authorizes the Attorney General to designate an acting attorney general, walled off from State Counsel, to supervise OSI's investigations and prosecutions of state employees. OAG has implemented the legislation with an Executive Order and related actions. The Executive Order will be superseded by published regulations in the near future.

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

OSI's Process: Published Investigation Reports and Notifications

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

In determining whether criminal charges are warranted, OSI's attorneys, like all prosecutors, are ethically bound to evaluate whether the admissible evidence obtained in the investigation would carry the People's burden to prove the criminal charges beyond a reasonable doubt at trial and, where relevant, the burden to disprove the defense of justification beyond a reasonable doubt at trial. See American Bar Association Standards for the Prosecution Function, Standard 3-4.3, Minimum Requirements for Filing and Maintaining Criminal

Charges, and New York Rules of Professional Conduct, Rule 3.8, Special Responsibilities of Prosecutors and Other Government Lawyers. See below, in this Section, for an explanation of the defense of justification under New York law and the prosecutor's burden to disprove the defense of justification beyond a reasonable doubt.

In certain cases, when the investigation is complete and OSI has determined not to prosecute, OSI will issue a public Notification of Investigative Findings prior to issuing an Investigation Report. As mentioned above in the Introduction, these Notifications are intended to accelerate the announcement of the closing of an investigation prior to the drafting and approval process involved in issuing the full Investigation Report. When OSI issues a Notification, an Investigation Report will follow, as required by Section 70-b. See OSI's [Policy on Notifications of Investigative Findings](#).

OSI's Investigations

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

- interviews of

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

- and reviews of

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

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

Officer Interviews

OSI's practice is to ask the officers involved in a case for a formal investigative interview. However, officers often refuse those requests. As in any criminal investigation, the subjects and witnesses in OSI's investigations, including officers, have the right not to talk to law enforcement, pursuant to the Fifth Amendment to the United States Constitution. OSI has civil subpoena authority, and uses it, but even when a person is civilly subpoenaed and appears for testimony, he or she has a right to refuse to answer questions. In New York criminal investigations, a prosecutor can only require a person to speak by subpoenaing the person to a grand jury and taking the person's testimony under oath, because a witness in the grand jury is granted full immunity from prosecution by operation of law, Criminal Procedure Law Article 50 and Section 190.40. Immunity is considered a complete substitute for the person's Fifth Amendment privilege. In this context, the immunity granted by New York law means that the grand jury witness cannot be prosecuted for any crime arising from the events about which they testify in the grand jury. (However, the person could be prosecuted for perjury if they lie in the grand jury.)

Police departments can and do compel statements from officers when conducting internal investigations of possible misconduct. Unlike grand jury testimony, providing these kinds of compelled statements does not immunize an officer from prosecution. However, the statements themselves, pursuant to the officer's Fifth Amendment rights, cannot be used directly or indirectly in the criminal investigation of the officer or in any subsequent prosecution. *Garrity v New Jersey*, 385 US 493 (1967). As a result, any OSI investigator or AAG who came to have knowledge of a compelled statement would be considered "tainted" and would have to leave the investigation, and OSI would be required to bring in a new team of investigators and AAGs who had no knowledge of the statements.

New York's Law of Justification

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

Two provisions in Article 35 are often relevant to OSI's investigations. One is the general provision justifying all persons' (civilians' or officers') use of deadly physical force to defend themselves or others from another person's wrongful use of deadly physical force (Penal Law

Section 35.15, Subdivision 2). The other is a provision specifically justifying police officers' or peace officers' use of deadly physical force to defend themselves or others from another person's wrongful use of deadly physical force when the officer is making an arrest for a criminal offense or preventing an escape from custody for a criminal offense (Penal Law Section 35.30, Subdivisions 1 and 2).

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

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

Investigation Reports and Notifications OSI Published in the Last 12 Months

The 41 Investigation Reports and Notifications OSI published since the last Annual Report are summarized below in order of date of death. The full version of every published OSI Investigation Report and Notification is on the Attorney General's public website, here: [OSI Investigations](#).

Daniel McAlpin, September 9, 2022, Ulster County

On the evening of September 9, 2022, officers with the New York State Police (NYSP) and Ulster County Sheriff's Office (UCSO) went to Daniel McAlpin's house in Ulster County to execute an order for his hospitalization pursuant to New York Mental Hygiene Law Section 9.45. Mr. McAlpin was alone in the house, on the second floor. There was a stairway to the second floor off the kitchen, and officers spoke to Mr. McAlpin through the closed door at the base of the stairway. Mr. McAlpin said he was safe, did not intend to harm himself, and repeatedly told the officers to leave. At the direction of an NYSP sergeant, officers opened the stairway door. Mr. McAlpin was standing near the top of the stairs, holding a large knife and an Airsoft pellet gun. Officers ordered him to drop the weapons, and an officer deployed a Taser. Mr. McAlpin descended the stairs while swinging the knife. When he neared the bottom of the stairs, he turned toward an NYSP trooper, who fired two shots at him. Mr. McAlpin fell to the floor, still holding the knife. Mr. McAlpin swung the knife and moved in a way that could

have been seen as an attempt to get up from the floor, and the trooper fired three more shots at him. Mr. McAlpin died of his wounds at the scene.

This incident was captured on body worn camera (BWC): [here](#), [here](#), [here](#), [here](#), [here](#), and [here](#). A knife, an Airsoft gun, as well as numerous plastic BBs were recovered from the scene.

OSI determined that a prosecutor would not be able to disprove beyond a reasonable doubt at trial that the firing trooper's actions were justified and closed the case by publishing an Investigation Report. The Report included several recommendations that NYSP implement protocols for involving mental health professionals when responding to mental health calls.

Mr. McAlpin was White; he was 41 years old when he died.

Milagros Bonet, May 4, 2023, Bronx County

Milagros Bonet was struck by a car driven by an on-duty NYPD officer on October 6, 2022, and died on May 4, 2023, from complications resulting from that collision. The death was never notified to OSI by NYPD; OSI learned of the death from newspaper articles almost a year after Ms. Bonet died.

On October 6, 2022, at 3:00 p.m., Ms. Bonet and several other people were standing on the corner of Westchester Avenue and Hoe Avenue in Bronx County when the officer, driving a marked police car with lights and sirens activated, and responding to a report of a stolen vehicle, struck the group with his car. The collision occurred when the officer attempted to pass a civilian car, which was stopped at an intersection, by driving into the opposing lane of traffic. The civilian driver started to make a left turn as the police car was passing it and, when the two cars collided, the police driver lost control, and his car hit a group of people standing on the sidewalk. Several people in the group were injured, including Ms. Bonet, who died seven months later from complications of remote blunt impact injuries sustained during the collision.

OSI concluded that a prosecutor would not be able to prove beyond a reasonable doubt at trial that the officer-driver committed a crime and closed the matter with an Investigation Report.

Ms. Bonet was Hispanic; she was 65 years old when she died.

Anthony Zaremski, May 23, 2023, Saratoga County

In the morning of May 23, 2023, members of the Saratoga County Sheriff's Office (SCSO) executed a federal search warrant at Mr. Zaremski's apartment in Clifton Park as part of a Drug Enforcement Agency (DEA) investigation. The deputies were not equipped with body worn cameras (BWCs). An SCSO deputy led the team into the apartment, turned down a hallway, and saw Mr. Zaremski raise a handgun and open fire. The deputy returned fire and shot Mr. Zaremski in the leg and in the head. The deputy was shot in the leg, another bullet grazed a deputy's helmet, and another bullet hit a deputy's ballistic vest. EMS, who were staged nearby,

transported the deputy and Mr. Zaremski to Albany Medical Center, where Mr. Zaremski was pronounced dead. The deputy underwent surgery and was later released from the hospital. A Smith & Wesson M&P 9mm handgun and 12 expended 9mm shell casings were recovered at the scene.

OSI concluded that a prosecutor would not be able to disprove beyond a reasonable doubt at trial that the firing deputy's actions were justified and closed the case by publishing an Investigation Report.

SCSO's special operations team (SOT) did not use BWCs when executing search warrants. Therefore, OSI recommended that SCSO require SOT members to be equipped with and to activate BWCs during every encounter with members of the public, with certain limited exceptions.

Mr. Zaremski was White; he was 23 years old when he died.

Samuel Williams, May 29, 2023, Bronx/New York County

On the evening of May 28, 2023, twelve NYPD officers in four cars assigned to the Manhattan North Community Response Team (CRT) drove over the University Heights Bridge from the Bronx to Manhattan. Mr. Williams drove a blue dirt bike over the bridge in the opposite direction; he was the lead bike in a group of dirt bikes and all-terrain vehicles. The first police car went by the group. The officer in the second police car turned left, angling his car into the opposing lanes of traffic in an attempt to stop the dirt bikes. The officer driving the third police car likewise turned his car into the opposing lanes of traffic. Mr. Williams went around the second car and collided with the third car. The collision launched Mr. Williams over the hood of the third car to the ground. Mr. Williams got up and hobbled toward the hood of the fourth police car where he was placed in handcuffs and arrested. Mr. Williams was taken to a hospital and had surgery for his broken leg. He died the next day, May 29, 2023, from complications of the surgery.

This incident was captured on BWC: [here](#) and [here](#).

OSI concluded that a prosecutor would not be able to prove beyond a reasonable doubt at trial that the driving officers had committed a crime and closed the matter with the issuance of an Investigation Report.

Mr. Williams was Black; he was 36 years old when he died.

Shaun Humphrey, August 15, 2023, Erie County

On August 8, 2023, Mr. Humphrey had been arrested, but not yet arraigned, and was detained at Erie County Holding Center (EHC) in a pre-classification cell. At 12:28 p.m. a deputy saw Mr. Humphrey display seizure-like behavior and roll off his bunk onto the floor. The deputy called for a medical emergency, and other ECSO deputies and facility medical staff members responded. ECSO deputies provided security while medical staff assessed Mr. Humphrey.

Medical staff requested that Mr. Humphrey be taken to a hospital, and, while waiting for the ambulance, administered two doses of Narcan to him. After the second dose Mr. Humphrey became responsive and combative. For a little under three minutes, deputies struggled to handcuff Mr. Humphrey and, when they succeeded, rolled him on his side. During at least some of the struggle, at least one deputy, an ECSO sergeant, put his body weight on Mr. Humphrey while Mr. Humphrey was in a face-down position. After the deputies rolled Mr. Humphrey on his side, he seemed to be calm and breathing normally for a little over a minute. However, Mr. Humphrey began to struggle again, for about one and a half minutes, and during that time deputies put shackles on his legs. Mr. Humphrey seemed to stop struggling, and one deputy said to the others that they needed to be careful to avoid positional asphyxiation. A few moments later, deputies realized Mr. Humphrey had become unresponsive. Deputies removed Mr. Humphrey from the cell and, along with medical and ambulance personnel, attempted to aid him. An ambulance took Mr. Humphrey to Buffalo General Hospital, where he remained until August 15, 2023, when he died. The medical examiner deemed the cause of death to be asphyxia due to prone position with compression of torso, with acute cocaine intoxication as a contributory factor, and deemed the manner of death to be homicide.

This incident was captured on BWC: [here](#), [here](#), [here](#), [here](#), and [here](#).

OSI concluded that a prosecutor would not be able to prove beyond a reasonable doubt at trial that the deputies had committed a crime and closed the matter with the issuance of an Investigation Report.

Mr. Humphrey was Native American; he was 52 years old when he died.

Margaret Lucey, January 8, 2024, Suffolk County

On January 8, 2024, in Suffolk County, an off-duty Quogue Village Police Officer was driving his personal car when he struck Ms. Lucey as she was crossing Ponquogue Avenue at the intersection with Good Ground Road. Ms. Lucey was transported to Stony Brook Southampton Hospital and died of her injuries the same day. Ms. Lucey was 89 years old when she died.

OSI determined that a prosecutor would not be able to prove beyond a reasonable doubt at trial that the off-duty officer had committed a crime and closed the matter with the issuance of an Investigation Report.

Ms. Lucey was White; she was 89 years old when she died.

King Crittenden, January 14, 2024, Wyoming County Correctional Facility

At 11:00 a.m. on January 14, 2024, King Crittenden suffered a seizure in his dormitory unit at Wyoming County Correctional Facility (WCF), a DOCCS prison, and became unresponsive. Medical staff and correction officers responded and gave aid, including Narcan, and Mr. Crittenden became responsive and combative. Nine officers used body holds, handcuffs, and a spit hood to gain control of Mr. Crittenden. After 10 minutes, during which Mr. Crittenden

continued to struggle and the officers continued to restrain him, Mr. Crittenden became unresponsive and pulseless. Despite additional attempts at aid, a Wyoming County Community Hospital physician pronounced Mr. Crittenden dead. The medical examiner deemed the cause of death to be physical restraint in the setting of seizure disorder, hypertensive and atherosclerotic cardiovascular disease, and morbid obesity, and deemed the manner of death to be homicide.

At the time of Mr. Crittenden's death, WCF did not have fixed video surveillance cameras, and WCF's officers were not equipped with BWC; officers at WCF are now equipped with BWC.

OSI concluded that a prosecutor would not be able to prove beyond a reasonable doubt at trial that any of the correction officers had committed a crime and closed the matter with the issuance of an Investigation Report.

Mr. Crittenden was Black; he was 34 years old when he died.

Lisa Haight, February 2, 2024, Erie County

On February 2, 2024, Ms. Haight was a passenger in a van taking her and others from Jamestown to Buffalo for health care appointments. When the van neared the exit from I-90 to Milestrip Road, Ms. Haight stabbed another passenger several times with a knife. The driver stopped the van on the side of the highway, told Ms. Haight to get out, and, when she did get out, drove to a hospital to get care for the stabbed passenger. Shortly after, the owner of a house in Hamburg, about a mile away from where Ms. Haight got out of the van, called 911 and reported that a woman was "trying to break into my house." He said he pushed her out, but she was trying to get back in; he said she was barefoot in the snow. Three Town of Hamburg Police Department (THPD) officers responded to the house, unaware of the nearby incident on I-90, and tracked footprints in the snow to the partially open back door of another house, nearby. When no one answered their knock, they entered.

The officers found Ms. Haight naked in a bathtub, cutting herself with a steak knife. An officer told Ms. Haight to put the knife down and step forward, but she did not seem to understand and did not respond coherently. After several minutes of attempted conversation, Ms. Haight dropped the knife and walked toward the officers. The officers told OSI they grabbed her wrists to take her into custody, but that Ms. Haight resisted. According to the officers, Ms. Haight lunged forward, grabbed what they thought was a red and black knife from the floor, and swung it at an officer's face, who jumped back and screamed. Another officer drew his pistol and fired three shots, striking Ms. Haight. The officers radioed "shots fired" and began aid. Emergency medical personnel arrived and took over care. Ms. Haight was pronounced dead.

When this incident occurred THPD did not equip its officers with BWC; THPD officers are now equipped with BWC. The knife Ms. Haight used in the bathtub was recovered; the red and black metallic object she swung at one officer, which was actually a flashlight, was recovered.

OSI concluded that a prosecutor would not be able to disprove beyond a reasonable doubt at trial that the firing officers' actions were justified and closed the case by publishing an Investigation Report.

Ms. Haight was Black; she was 36 years old when she died.

Djamshed Nematov, March 8, 2024, Queens County

On March 8, 2024, at 6:57 p.m., three NYPD officers were dispatched to an apartment building in Queens following 911 calls reporting that a man had stabbed his wife with a knife. When they arrived, the officers went up a set of stairs and encountered Mr. Nematov in the second-floor hallway holding a large knife. Mr. Nematov ran toward the officers with the knife raised and pointed at them. Two officers fired their service weapons, striking Mr. Nematov, who died of his wounds. Two knives were recovered.

BWC captured the incident [here](#), [here](#), and [here](#), and security footage [here](#).

Mr. Nematov was White; he was 46 years old when he died.

Win Rozario, March 27, 2024, Queens County

In the afternoon of March 27, 2024, a 911 caller said, "I think my son is on drugs and is acting mad erratic." The caller gave an address in Queens County. (Investigation later determined that Mr. Rozario was the caller.) Two NYPD officers responded to the address, which was a frame house on a residential block. They activated their body worn cameras, approached the house on foot, and knocked at the door. After a few minutes, Mr. Rozario's younger brother answered the door and told the officers his brother was having an "episode." The brother and the officers went up a set of stairs to the second-floor apartment. Mr. Rozario and his mother were in the apartment. As shown on BWC, moments after the officers entered Mr. Rozario went to a drawer in the kitchen, took out a pair of scissors, and turned toward the officers. One officer deployed a Taser, striking Mr. Rozario; his mother took the scissors from him and put them on a chair in the kitchen. An officer deployed a Taser a second time, but Mr. Rozario pulled out the Taser prong, picked up the scissors, and walked toward the officers, who were in the living room.

When Mr. Rozario got close to one of the officers, the other officer, who was to Mr. Rozario's left, fired one shot. The bullet struck Mr. Rozario in the left arm and traveled through his upper body from left to right, injuring his heart. Mr. Rozario's mother and brother then wrestled with Mr. Rozario, pushing him back into the kitchen, and the scissors fell to the floor. Mr. Rozario got free of his mother and brother and picked up the scissors. The officers yelled, "No, no," and "Put it down." Mr. Rozario took one step forward, and an officer fired a second gunshot. Mr. Rozario stopped moving forward but remained standing, holding the scissors. After a brief pause, one officer shouted, "Put it down," and the other officer fired a third shot. Mr. Rozario was still standing, with the scissors in his hand and, after another brief pause, one officer fired a fourth shot, and after a final brief pause, the other officer fired a fifth shot. Mr. Rozario fell

to the floor as the fifth shot was fired. He was taken to Jamaica Hospital Medical Center where he was pronounced dead a short time later.

The incident was captured on BWC [here](#), and [here](#).

OSI concluded that a prosecutor would not be able to disprove beyond a reasonable doubt at trial that the firing officers were justified and closed the case by issuing an Investigation Report.

OSI made a series of recommendations regarding New York City's emergency responses to persons in mental health crises. Please see the Recommendations section of this Report, below, for additional details about these recommendations.

Mr. Rozario was South Asian; he was 19 years old when he died.

Jesus Alberto Nunez Reyes, April 20, 2024, Queens County

In the early morning hours of April 20, 2024, two NYPD officers, who were on foot at the corner of Roosevelt Avenue and 103rd Street in Queens, heard people shouting for help. The officers walked toward the commotion and saw Mr. Nunez Reyes holding a knife to a woman who was trying to push him away. One officer yelled to Mr. Nunez Reyes to drop the knife, but Mr. Nunez Reyes continued to hold the knife. The officer fired a Taser at Mr. Nunez-Reyes, with no effect. As Mr. Nunez-Reyes, still holding the knife, walked toward the other officer and a group of people standing on the sidewalk, the officer shot Mr. Nunez Reyes three times. Mr. Nunez Reyes died of his injuries.

The incident was captured on BWC [here](#), and [here](#). A knife was recovered on the ground next to Mr. Nunez Reyes.

OSI concluded that a prosecutor would not be able to disprove beyond a reasonable doubt at trial that the firing officer's actions were justified and closed the case by publishing an Investigation Report.

Mr. Nunez Reyes was Hispanic; he was 65 years old when he died.

Devon Allen, April 30, 2024, New York County

On the afternoon of April 30, 2024, a Homeland Security Investigations (HSI) task force team drove to the area around West 25th Street in Manhattan, to find and detain Mr. Allen, who was suspected of committing an assault in December 2023 and was wanted for questioning in connection with a federal drug and gang investigation. The HSI task force team consisted of an HSI lieutenant, an HSI agent, and an NYPD detective. They found Mr. Allen near an optical shop at 200 West 24th Street. Apparently seeing the officers, Mr. Allen started to run, but the detective grabbed him. Mr. Allen tried to pull away, but the detective and agent wrestled with him, and the three fell into the optical shop, where the struggle continued on the floor. As the detective and agent tried to handcuff him, the detective saw Mr. Allen going to the pouch he

was wearing across his chest. When the detective put his hand on the pouch, he felt a gun inside and yelled, “Gun.” The agent and lieutenant fired at Mr. Allen, who died of his wounds. A gun was recovered from the pouch.

OSI concluded that a prosecutor would not be able to disprove beyond a reasonable doubt at trial that the firing officers’ actions were justified and closed the case by publishing an Investigation Report.

The federal lieutenant and federal agent were not equipped with BWC because the federal agency does not use BWC. The NYPD officer was not equipped with BWC because he was working on a federal task force. OSI recommended that federal agents and NYPD members working with federal agents wear and activate BWC for all policing activities.

Mr. Allen was Black; he was 25 years old when he died.

Christin Emile, May 12, 2024, Kings County

On May 12, 2024, three NYPD officers on routine patrol in Brooklyn stopped for a red light at Church Avenue and East 53rd Street. While waiting at the light, they heard men arguing on Church Avenue. The officers made a left turn onto Church Avenue, pulled up and stopped alongside the parked cars on Church, and, when they left their car to investigate the dispute, they saw Mr. Emile holding a gun. Mr. Emile ran from the officers and disregarded commands to drop the gun. During the chase, officers fired a Taser at Mr. Emile with no effect, and he continued to run with the gun. Two officers shot Mr. Emile, striking him, and he died of his wounds.

The incident was captured on BWC [here](#), and [here](#), and security footage [here](#). A loaded gun was recovered from the ground where Mr. Emile fell.

OSI concluded that a prosecutor would not be able to disprove beyond a reasonable doubt at trial that the firing officers’ actions were justified and closed the case by publishing an Investigation Report.

Mr. Emile was Black; he was 34 years old when he died.

Andre Mayfield, May 26, 2024, Kings County

On May 26, 2024, two NYPD officers had just finished responding to a domestic dispute and were parked on Eldert Street, in Brooklyn, completing reports. Mr. Mayfield walked up to the passenger side of the police car and threw a glass bottle at the side window. Both officers got out of the car. Mr. Mayfield walked toward the officers holding a knife. Both officers discharged Tasers at Mr. Mayfield, who was temporarily stunned and fell to the ground; a second knife fell from Mr. Mayfield as he hit the ground. Mr. Mayfield stood back up and again moved toward the officers, holding a knife. The officers told Mr. Mayfield to “back up,” but he continued to advance, and the officers fired their guns, striking Mr. Mayfield, who died of his wounds.

The incident was captured on BWC [here](#), and [here](#), and security footage, [here](#). Two knives were recovered at the scene.

OSI concluded that a prosecutor would not be able to disprove beyond a reasonable doubt at trial that the firing officers' actions were justified and closed the case by publishing an Investigation Report.

Mr. Mayfield was Black; he was 26 years old when he died.

Albert Melendez, Jr., July 16, 2024, Sullivan County

On July 16, 2024, an Ulster County Sheriff's Office (UCSO) deputy reported that a black Mazda going south on Route 209 had failed to pull over for a traffic stop. Two NYSP troopers in one car took over the pursuit in Sullivan County; when they tried to pull Mr. Melendez over he drove away at a high rate of speed. The troopers followed Mr. Melendez for several miles until he attempted to turn around at the intersection of Rock Hill Drive and Emerald Place. The passenger trooper got out of the NYSP car and stood in front of Mr. Melendez's car in an attempt to block his path. Mr. Melendez drove directly at the trooper, striking him in the legs, and hitting the rear of the trooper car. The trooper jumped to the passenger side of Mr. Melendez's car and shot Mr. Melendez, striking him. Mr. Melendez died of his wounds.

The incident was captured on BWC [here](#) and [here](#).

OSI concluded that a prosecutor would not be able to disprove beyond a reasonable doubt at trial that the firing trooper's actions were justified and closed the case by publishing an Investigation Report.

Mr. Melendez was Hispanic; he was 32 years old when he died.

James Cushman, August 30, 2024, Erie County

On August 30, 2024, Mr. Cushman called 911 to report a disturbance at his house: he said his mother had a gun, and that he had a knife to defend himself. As soon as an Orchard Park Police Department (OPPD) officer arrived at the house and got out of his patrol car, Mr. Cushman came at him on foot with a knife. The officer yelled, "Drop the knife," and backed up. Mr. Cushman stopped, walked back toward his house, and said, "You should have shot me." The officer again told Mr. Cushman to drop the knife, and Mr. Cushman eventually put it down. Another OPPD officer arrived and told Mr. Cushman's mother, who was standing nearby, to go into the house. Mr. Cushman grabbed the knife and came at the officers again. Both officers backed up and told Mr. Cushman to drop the knife. Mr. Cushman again stopped, walked back toward his house, and said, "Why didn't you do it?" As a third OPPD patrol car turned onto the street, Mr. Cushman came at the officers a third time, the officers again yelled, "Drop the knife," and, when Mr. Cushman was less than 10 feet away and not appearing to slow down or stop, two officers fired at and struck him. Mr. Cushman died of his wounds.

Mr. Cushman's interactions with the OPPD officers were recorded by a neighbor's doorbell camera, [here](#), and the 911 call line, which remained open during the incident. When this incident occurred, OPPD did not equip its officers with BWC; OPPD's officers are now equipped with BWC. Investigators recovered a knife from the scene.

OSI concluded that a prosecutor would not be able to disprove beyond a reasonable doubt at trial that the firing officers' actions were justified and closed the case by publishing an Investigation Report.

Mr. Cushman was White; he was 31 years old when he died.

Vilmond Jean-Baptiste, September 13, 2024, Kings County

On September 13, 2024, Mr. Jean-Baptiste was a suspect in three homicides and the subject of an open warrant for a New York City Administrative Code violation. Six NYPD Warrant Squad officers went to an apartment where they believed Mr. Jean-Baptiste to be and knocked on the door; a man in the apartment allowed them in. The officers found Mr. Jean-Baptiste hiding in a shower in a bathroom, fully clothed and holding a knife. The officers told Mr. Jean-Baptiste to drop the knife, but he did not. One officer fired a Taser at him, without effect, and Mr. Jean-Baptiste threw a bottle at the officers. Mr. Jean-Baptiste stepped out of the shower and moved toward the officers holding the knife. Three officers fired, striking Mr. Jean-Baptiste, who died of his wounds. A knife was recovered.

The incident was captured on BWC [here](#), [here](#), [here](#), [here](#), [here](#), and [here](#).

OSI concluded that a prosecutor would not be able to disprove beyond a reasonable doubt at trial that the firing officers' actions were justified and closed the case by publishing an Investigation Report.

Mr. Jean-Baptiste was Black; he was 38 years old when he died.

Emil Williams, February 18, 2025, Queens County

On February 18, 2025, an NYPD officer at a security post outside the 111th Precinct stationhouse saw a man, later identified as Mr. Williams, walk toward him holding a gun, which he raised and pointed at the officer. The officer radioed for assistance, took cover behind a parked police car, and told Mr. Williams to put the gun down. Three other officers ran outside from the stationhouse, and officers repeatedly told Mr. Williams to put the gun down. When Mr. Williams kept his gun pointed at them, four officers fired, striking Mr. Williams, who died of his wounds.

This incident was captured on BWC [here](#), [here](#), and [here](#) and security footage, [here](#). A loaded gun was recovered from the ground near Mr. Williams.

OSI concluded that a prosecutor would not be able to disprove beyond a reasonable doubt at trial that the firing officers' actions were justified and closed the case by publishing an Investigation Report.

Mr. Williams was Black; he was 79 years old when he died.

Winston Johnson, March 6, 2025, Richmond County

On March 6, 2025, a person called 911 to report that a man was firing shots in a parking lot on Staten Island. (Investigation later determined that Mr. Johnson was the 911 caller.) Officers who responded to the parking lot saw Mr. Johnson, who was holding a gun. Mr. Johnson fired a shot in the air and then pointed his gun at the officers. Officers took cover behind their cars and told Mr. Johnson to drop the gun. Mr. Johnson did not comply, and officers fired, striking Mr. Johnson, who died of his wounds.

The incident was captured on BWC [here](#). Officers recovered a gun at the scene.

OSI concluded that a prosecutor would not be able to disprove beyond a reasonable doubt at trial that the firing officers' actions were justified and closed the matter by publishing a Notification of Investigative Findings (an Investigation Report will follow).

Mr. Johnson was Black; he was 55 years old when he died.

Jose Franciso Escobar Vasquez, March 15, 2025, Suffolk County

On March 15, 2025, an off-duty Metropolitan Transportation Authority police officer was driving south on Route 110 (Broadway) in Suffolk County, in his personal car. After the officer drove past the partial intersection at Francine Avenue, Mr. Escobar Vasquez walked into the left southbound lane of Route 110 and was struck by the officer's car. Mr. Escobar Vasquez was pronounced dead at the scene. The officer was driving 43 to 47 mph in a 40-mph zone when he struck Mr. Escobar Vasquez and was not intoxicated, impaired, or distracted.

OSI concluded a prosecutor would not be able to prove beyond a reasonable doubt at trial that the officer had committed a crime and closed the matter by publishing an Investigation Report.

Mr. Escobar Vazquez was Hispanic; he was 57 years old when he died.

Miles Digneau, March 21, 2025, Oswego County

On March 21, 2025, an Oswego County Sheriff's Office (OCSO) deputy and an NYSP trooper went to Mr. Digneau's house to conduct a wellness check after a family member called a suicide hotline expressing concern. At the same time, another OCSO deputy went to Mr. Digneau's house to serve him with an order of protection, directing Mr. Digneau to stay away from his three-year-old son, who was, at that time, with Mr. Digneau at the house. Shortly after the officers arrived, while in Mr. Digneau's garage, an OCSO deputy told Mr. Digneau that a family member would be coming to pick up his son due to the order of protection, and Mr.

Digneau attempted to leave the garage, holding his son. The trooper took Mr. Digneau's son from him, and a struggle ensued during which Mr. Digneau swung a large metal C-clamp, which struck the trooper's head. An OCSO deputy fired, striking Mr. Digneau, who died of his wounds.

The incident was captured by BWC [here](#) and [here](#).

OSI concluded that a prosecutor would not be able to disprove beyond a reasonable doubt at trial that the deputy's actions were justified and closed the case by publishing an Investigation Report.

Members of OCSO's Civil Division had "discretion" when to use BWC during service of an order of protection; OSI recommended that OCSO require officers to use BWC during all interactions with the public. OSI also recommended that OCSO develop and implement written policies and better training for dealing with people in crisis.

Mr. Digneau was White; he was 32 years old when he died.

Matthew Brown, March 25, 2025, Oneida County

On March 24, 2025, a family member of Mr. Brown's called 911 and said Mr. Brown was having a "psychotic attack." Two NYSP troopers went to the house at the address given in the call and knocked on the front door. Matthew Brown opened the door, and the troopers entered the house. As the troopers attempted to speak with him, Mr. Brown said, "The bullet," and moved toward one of the troopers, who grabbed Mr. Brown's arms and pushed him away. Mr. Brown again moved toward the trooper and moved his hand toward the trooper's gun. At that point, both troopers took Mr. Brown to the floor and handcuffed him behind his back. The troopers radioed for an ambulance. An Oneida County Sheriff's Office (OCSO) deputy arrived at the house and helped the troopers keep Mr. Brown restrained while they waited for the ambulance. After being held prone on the floor and handcuffed for 21 minutes, Mr. Brown became unresponsive, and, despite treatment by ambulance crews and hospital staff, was pronounced dead. The medical examiner deemed the cause of death to be "bupropion toxicity," with prone restraint a contributory factor, and deemed the manner of death to be "homicide"; in an interview, the medical examiner said the restraint did not cause asphyxiation but did contribute to the stressful nature of the incident.

The incident was captured by BWC [here](#), [here](#), and [here](#).

OSI concluded that a prosecutor would not be able to disprove beyond a reasonable doubt at trial that the officers' actions were justified and closed the case by publishing an Investigation Report.

OSI recommended that NYSP train its members on the risks of prone restraint, and that the agencies involved improve their policies and resources for responding to mental health crises.

Mr. Brown was White; he was 30 years old when he died.

Bruce Boyd, April 4, 2025, Suffolk County

On April 4, 2025, Suffolk County Police Department (SCPD) officers went to a house in Brentwood in response to a request for a wellness check. When officers arrived, they knocked on the door but got no answer. A neighbor approached from across the street and put Mr. Boyd's wife, who was at work, on the phone with an officer who told her the police were at her house to check on her husband. The officers waited for Mr. Boyd's wife to come to the house. When she arrived she opened the front door of the house and walked in and ran out moments later. Officers backed across the front lawn as Mr. Boyd emerged from an interior hallway covered in blood and holding a knife in each hand. Mr. Boyd ran across the front lawn toward one officer with one knife raised as officers repeatedly shouted at him to drop the knife. When Mr. Boyd was within a few feet of the officer other officers fired, striking Mr. Boyd, who died of his wounds.

The incident was captured on BWC [here](#) and [here](#). Officers recovered two knives at the scene.

OSI concluded that a prosecutor would not be able to disprove beyond a reasonable doubt at trial that the officers' actions were justified and closed the matter by publishing a Notification of Investigative Findings (an Investigation Report will follow).

Mr. Boyd was Black; he was 54 years old when he died.

David Levine, April 9, 2025, Saratoga County

On April 9, 2025, Mr. Levine drove to the parking lot of the NYSP barracks in Ballston Spa, Saratoga County, got out of his car with a long gun, and shot at the building. Troopers came out of the building, took cover, and told Mr. Levine to drop the gun. Mr. Levine said, "No, shoot me," and raised the gun toward a trooper. Several troopers fired, striking Mr. Levine, who died of his wounds.

This incident was captured by BWC [here](#), [here](#), [here](#) and [here](#). Troopers recovered a rifle at the scene.

OSI concluded that a prosecutor would not be able to disprove beyond a reasonable doubt at trial that the troopers' actions were justified and closed the matter by publishing a Notification of Investigative Findings (an Investigation Report will follow).

Mr. Levine was White; he was 69 years old when he died.

Nancy Loftus, April 12, 2025, Orange County

On April 12, 2025, two NYSP troopers went to a mobile home in the Town of Deerpark after a 911 caller said Ms. Loftus had stabbed him with a knife. When the troopers arrived, the 911 caller met them in the driveway and said Ms. Loftus had a gun and was waving it around. The troopers told the 911 caller to get behind a car and took cover behind their NYSP car and drew their service weapons. Ms. Loftus came out of the front door of the home onto its porch

with what appeared to be a gun in her hand, and the troopers shouted, “Drop the gun!” and “Put your hands in the air!” The troopers fired their guns, but after the initial shots one of the troopers said, “Hands are up, hands are up. Get down!” The troopers fired additional shots and struck Ms. Loftus, who died of her wounds.

The incident was captured by BWC [here](#), and [here](#). A pellet gun was recovered from the porch of the home near Ms. Loftus.

OSI concluded that a prosecutor would not be able to disprove beyond a reasonable doubt at trial that the troopers’ actions were justified and closed the matter by publishing an Investigation Report.

Ms. Loftus was White; she was 69 years old when she died.

King Wong, April 14, 2025, Queens County

On April 14, 2025, four NYPD officers, responding to multiple 911 calls of a man with a knife, saw Mr. Wong as he walked across 31st Street in Astoria, Queens, holding a kitchen knife in his right hand. The officers repeatedly told Mr. Wong to drop the knife. Two officers fired Tasers at Mr. Wong, without effect. Mr. Wong walked quickly toward the officers, still holding the knife. Three officers fired, striking Mr. Wong, who died of his wounds.

The incident was captured on BWC [here](#), [here](#), [here](#), and [here](#). A knife was recovered from the scene.

OSI concluded that a prosecutor would not be able to disprove beyond a reasonable doubt at trial that the officers’ actions were justified and closed the matter by publishing an Investigation Report.

Mr. Wong was Asian; he was 61 years old when he died.

Damon Louther, May 13, 2025, Kings County

On May 13, 2025, NYPD officers, responding to a 911 call reporting a domestic dispute at an apartment in Brooklyn, saw Mr. Louther in the apartment hallway, holding a knife. Mr. Louther moved toward the officers and said, “You’re gonna have to put a bullet in me.” One officer fired his Taser, striking Mr. Louther, but Mr. Louther pulled the Taser prongs from his body and continued moving toward the officers. A second officer fired his gun, striking Mr. Louther, who died of his wounds.

The incident was captured on BWC [here](#) and [here](#). Officers recovered a knife at the scene.

OSI concluded that a prosecutor would not be able to disprove beyond a reasonable doubt at trial that the officers’ actions were justified and closed the matter by publishing a Notification of Investigative Findings (an Investigation Report will follow).

Mr. Louther was Black; he was 25 years old when he died.

Donnell Hogan, May 13, 2025, Onondaga County

OSI issued a Notification of Investigative Findings regarding Mr. Hogan, which was summarized in the 2025 Annual Report. OSI released the Investigation Report after the last Annual Report was issued.

Mr. Hogan was Black; he was 42 years old when he died.

John Bonds, May 27, 2025, Albany County

On May 27, 2025, an off-duty Colonie Police Department (CPD) Officer was driving his personal car, at night, south on Old Loudon Road, in the hamlet of Latham, when he struck Mr. Bonds, who was walking and pushing a cart in the southbound lane of the road. Mr. Bonds died of his injuries on June 2, 2025, at Albany Medical Center.

After initially refusing three times, the off-duty officer agreed to submit to a breath test and a blood sample, more than three hours after the collision. The breath test result and the toxicology report indicated that the officer's blood alcohol content (BAC) was .02%, but, because the number was below .03%, retrograde extrapolation could not be used to estimate his BAC range at the time of the collision.

Security video of the incident is [here](#).

OSI concluded that a prosecutor would not be able to prove beyond a reasonable doubt at trial that the officer had committed a crime and closed the matter by publishing an Investigation Report.

Mr. Bonds was Black; he was 65 years old when he died.

Mark Bemis, June 18, 2025, Chautauqua County

On June 18, 2025, two Chautauqua County Sheriff's Office (CCSO) deputies went to Mr. Bemis's house in response to a 911 call reporting a domestic dispute. The first deputy to arrive saw Mr. Bemis in the open garage, holding a shotgun, and told him to drop it. Mr. Bemis fired a shot. The deputy took cover behind a tree and continued to tell Mr. Bemis to put the gun down. A second deputy arrived and took cover behind another tree. The first deputy fired at Mr. Bemis, without apparently striking him, and Mr. Bemis fired at the deputy, striking him in the hand. Both deputies fired again, striking Mr. Bemis, who died of his wounds.

The incident was captured on BWC [here](#), and [here](#). Investigators recovered a shotgun at the scene.

OSI concluded that a prosecutor would not be able to disprove beyond a reasonable doubt at trial that the deputies' actions were justified and closed the matter by publishing a Notification of Investigative Findings (an Investigation Report will follow).

Mr. Bemis was White; he was 66 years old when he died.

Shelton Ennis, June 26, 2025, New York County

On June 26, 2025, two NYPD officers on patrol saw Mr. Ennis, in Riverside Park, toss away a can of beer. The officers got out of their car and asked Mr. Ennis for his identification so they could issue him a summons. Mr. Ennis said he had no identification on him and gave a false name and date of birth. The officers said they could not find the name in the NYPD database and would have to take him to the precinct to identify him. At that point Mr. Ennis ran from the officers. One officer ran after him and tackled him, and they both fell to the ground. Mr. Ennis became unresponsive upon striking the ground and died soon after. The medical examiner deemed the cause of death to be “hemopericardium [blood in the pericardial sac of the heart] with cardiac tamponade due to laceration of right ventricular wall due to blunt impact to chest,” and deemed the manner of death to be “homicide (the decedent was tackled from behind by police officer during police pursuit).”

OSI concluded that a prosecutor would not be able to disprove beyond a reasonable doubt at trial that the officer’s use of force against Mr. Ennis was justified, nor prove beyond a reasonable doubt at trial that the officer had committed a crime, and closed the matter by publishing an Investigation Report.

Mr. Ennis was Black; he was 54 years old when he died.

Emilson Joan Ordoñez-Banegas, July 13, 2025, Suffolk County

On July 13, 2025, Suffolk County Police Department (SCPD) officers responded to a 911 call reporting an assault with a knife behind a row of stores in Centereach. When the officers arrived they saw a man with lacerations to his neck and hand. The man told them another man had stabbed him with a knife and fled into the wooded area behind the stores. While EMTs rendered aid to the injured man and the officers stood by, Mr. Ordoñez-Banegas suddenly ran from the wooded area toward the group, holding a knife. One officer fired, striking Mr. Ordoñez-Banegas, who died of his wounds.

The incident was captured by BWC [here](#) and [here](#). Officers recovered a knife at the scene.

OSI concluded that a prosecutor would not be able to disprove beyond a reasonable doubt at trial that the officer’s actions were justified and closed the matter by publishing a Notification of Investigative Findings (an Investigation Report will follow).

Mr. Ordoñez-Banegas was Hispanic; he was 28 years old when he died.

Akintunde Campbell, July 31, 2025, Monroe County

On July 31, 2025, two Rochester Police Department officers went to Ernestine Street following 911 calls reporting a man looking into and entering cars. When they arrived they saw Mr. Campbell, who matched the description from the 911 calls, standing in a driveway. The officers asked Mr. Campbell what he was doing, and he said he was waiting for a friend, and started to walk away. The officers saw a bulge in the front pocket of Mr. Campbell’s hoodie,

which they believed to be a gun, and attempted to detain Mr. Campbell. A struggle ensued, and Mr. Campbell broke away, keeping his hand in the pocket of the hoodie. The officers pointed their guns at Mr. Campbell and repeatedly asked what was in the pocket. Mr. Campbell pulled a gun from the pocket and held it with both hands toward the officers. The officers told Mr. Campbell to drop the gun, but he did not. Both officers fired, striking Mr. Campbell, who died of his wounds.

This incident was captured on BWC [here](#). Officers recovered a loaded gun on the sidewalk.

OSI concluded that a prosecutor would not be able to disprove beyond a reasonable doubt at trial that the officers' actions were justified and closed the matter by publishing a Notification of Investigative Findings, followed by an Investigation Report.

Mr. Campbell was Black; he was 38 years old when he died.

Hugh Davis, August 9, 2025, Erie County

On August 13, 2025, four Cheektowaga Police Department officers went to an apartment building in the City of Buffalo to arrest Mr. Davis for Assault in the Second Degree and other charges. Three officers went up a flight of stairs to a second-floor apartment, and one of the officers knocked on the door and announced that police were there. After several minutes of knocking with no response, the center panel of the door fell into the apartment, and Mr. Davis was visible, holding a large kitchen knife. An officer shouted, "He's got a knife!" as Mr. Davis came through the doorway, swinging the knife toward the officers. Mr. Davis stumbled, fell, and swung the knife again. The officers told Mr. Davis to drop the knife, and one officer fired, striking Mr. Davis, who died of his wounds.

The incident was captured on BWC [here](#), [here](#) and [here](#). A knife was recovered at the scene.

OSI concluded that a prosecutor would not be able to disprove beyond a reasonable doubt at trial that the officers' actions were justified and closed the matter by publishing a Notification of Investigative Findings, followed by an Investigation Report.

Mr. Davis was Black; he was 60 years old when he died.

Lahionel Soto, August 17, 2025, New York County

On August 17, 2025, an off-duty NYPD Officer was speaking with friends next to a double-parked car on West 173rd Street, when two mopeds drove past them, made a U-turn, and stopped next to them. As one of the moped drivers, Mr. Soto, got off his moped, he spoke to the officer, took a firearm from his waistband, and approached the officer. The officer took his off-duty firearm from his waistband and fired, striking Mr. Soto, who died of his wounds.

The incident was captured on security video, which can be viewed [here](#), and [here](#). A loaded gun was recovered from the scene.

OSI concluded that a prosecutor would not be able to disprove beyond a reasonable doubt at trial that the off-duty officer's actions were justified and closed the matter by publishing an Investigation Report.

Mr. Soto was Hispanic; he was 30 years old when he died.

Erasmo Huerta Gonzalez, August 23, 2025, Queens County

In the afternoon of August 23, 2025, an NYPD officer, on patrol and driving about seven miles per hour, ran over Mr. Huerta Gonzalez as he lay on a roadway in Flushing Meadows Corona Park. Mr. Huerta Gonzalez died of his injuries. The investigation did not find evidence that the officer was distracted, impaired by drugs or alcohol, or otherwise driving in a dangerous manner.

NYPD officers' body-worn cameras (BWC) were activated at the time of the incident and can be viewed [here](#) and [here](#).

OSI concluded that a prosecutor would not be able to prove beyond a reasonable doubt at trial that the officer had committed a crime and closed the matter by publishing an Investigation Report.

Mr. Huerta Gonzalez was Hispanic; he was 38 years old when he died.

Nathan Novakowski, September 28, 2025, Chemung County

On September 28, 2025, an NYSP trooper went to a house in response to a 911 call reporting a domestic dispute. Upon arrival, the trooper saw Mr. Novakowski holding a pair of scissors and standing over his mother, who was on a couch and screaming, "Get away from me." The trooper told Mr. Novakowski to drop the scissors, but Mr. Novakowski did not and yelled at the trooper, "Shoot me." A Chemung County Sheriff's Office deputy arrived. The trooper fired, striking Mr. Novakowski, who died of his wounds.

This incident was captured on BWC [here](#). Officers recovered scissors at the scene.

OSI concluded that a prosecutor would not be able to disprove beyond a reasonable doubt at trial that the trooper's actions were justified and closed the matter by publishing a Notification of Investigative Findings (an Investigation Report will follow).

Mr. Novakowski was White; he was 18 years old when he died.

Royston Bacchus, October 5, 2025, Kings County

On October 5, 2025, NYPD officers went to an apartment building on East 86th Street in response to a 911 call reporting that a man was violating an order of protection requiring him to stay away from a woman who lived in the building. Upon arrival, officers saw Mr. Bacchus leaving the building and pursued him on foot to Coventry Road. Mr. Bacchus stood in the street, holding a gun. Officers told Mr. Bacchus to drop the gun, and Mr. Bacchus said, "Shoot

me.” When Mr. Bacchus raised the gun toward the officers, one officer fired, striking Mr. Bacchus, who died of his wounds.

The incident was captured on BWC [here](#). Officers recovered a loaded gun at the scene.

OSI concluded that a prosecutor would not be able to disprove beyond a reasonable doubt at trial that the officer’s actions were justified and closed the matter by publishing a Notification of Investigative Findings, followed by an Investigation Report.

Mr. Bacchus was Black; he was 28 years old when he died.

Paul Alvarez, December 18, 2025, Erie County

At about 9:25 p.m. on December 18, 2025, an off-duty Town of Cheektowaga Police Department officer was driving his personal pickup truck west in the westbound lane of Clinton Street in the Town of West Seneca, when he struck and killed Paul Alvarez, who was walking east in the westbound lane. It was dark and raining, and the officer said he had been momentarily distracted by his dog, which was in the back seat of the truck. There was no evidence that the officer was intoxicated, using a cell phone, or driving recklessly at the time of the collision.

OSI concluded that a prosecutor would not be able to prove beyond a reasonable doubt at trial that the officer had committed a crime and closed the matter by publishing an Investigation Report.

Mr. Alvarez was Hispanic; he was 16 years old when he died.

Carl Slone, January 10, 2026, Erie County

On January 9, 2026, an off-duty Erie County Sheriff’s Office deputy was driving his personal truck when he slowly made left turn from a parking lot onto Elmwood Avenue in the City of Buffalo and struck Mr. Slone, who was crossing Elmwood Avenue mid-block. Mr. Slone died of his injuries. The investigation did not find evidence that the off-duty deputy was intoxicated, impaired, or distracted.

This incident was captured on security video, which can be viewed [here](#), and [here](#).

OSI concluded that a prosecutor would not be able to prove beyond a reasonable doubt at trial that the deputy had committed a crime and closed the matter by publishing an Investigation Report.

Mr. Slone was White; he was 82 years old when he died.

Maria and Magdalena Garcia, January 22 and February 16, 2026, Bronx County

On January 22, 2026, off-duty Port Authority Police Department Officer Mario Garcia Jr. shot his sister, Maria Garcia, who died soon after, and his mother, Magdalena Garcia, who died on February 16, 2026, and then took his own life. OSI did not find evidence that anyone other

than Officer Garcia had caused the two deaths and closed the matter by publishing an Investigation Report.

Maria and Magdalena were Hispanic; Maria was 59 years old when she died, and Magdalena was 86 years old when she died.

5. NEW YORK CITY DEPARTMENT OF CORRECTION

Background

NYC DOC operates jails on Rikers Island, which is in Bronx County. People in the custody of NYC DOC include detainees awaiting trial, detainees awaiting sentencing, and prisoners sentenced to one year or less of jail time. NYC DOC also has custody of detainees and prisoners in transit, at courthouses, and in hospitals. According to the Fact Sheet published by DCJS, [here](#), the NYC DOC population in August 2026 was 6,339, a 13% decrease from August 2025.

NYC DOC's operation of the jails at Rikers Island is the subject of ongoing federal litigation, begun in 2011. On January 27, 2026, the federal court appointed a "remediation manager" for the Rikers Island complex, to manage the jails together with NYC DOC. (Decision: [here](#). News item: [here](#).) On July 21, 2026, the remediation manager submitted a 33-page plan, [here](#), to the judge for improving the jails. (News item: [here](#).)

Based on reports and proposals by the Independent Commission on New York City Criminal Justice and Incarceration Reform, the city passed ordinances requiring that the jails on Rikers Island be closed and replaced by borough-based jails by 2027. However, the 2027 deadline will not be met; *City & State* estimates that the Brooklyn jail will open first, in 2029, and that the Manhattan jail will open last, in 2032. (News item: [here](#).)

Cause of Death under Criminal Law Principles

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

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

their conduct set in motion or continued in motion the events which resulted in death, *People v Matos*, 83 NY2d 509, 511 (1994).

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

Under Section 70-b, OSI’s authority to prosecute and to issue Investigation Reports is limited to incidents in which a police officer or a peace officer, as defined, including a correction officer, has caused a death. If no defined officer has caused a death, OSI does not have legal authority to prosecute a crime or to issue an Investigation Report. The medical personnel in the jails and prisons are not defined officers under Section 70-b. When OSI conducts a preliminary assessment of a death in a jail or prison and finds insufficient evidence to conclude that the death was caused by a correction officer, that finding is not necessarily a conclusion that the conduct of the involved officer was proper or that the conditions in the jail or prison were in compliance with legal standards.

NYC DOC Assessments Completed by OSI in the Last 12 Months

Summarized below are the 11 assessments, in order of date of death, OSI completed since the last Annual Report concerning deaths of people in NYC DOC custody. See OSI’s [data tables](#) for the status, as of August 31, 2026, of all NYC DOC notifications OSI has received since April 1, 2021, the effective date of Section 70-b. (In the summaries below, references to a “person” or “people” means people in custody unless otherwise indicated. All of the correction facilities mentioned below are on Rikers Island, unless otherwise indicated.)

Charizma Jones, July 14, 2024

Notification

On July 23, 2024, OSI learned of the death of Charizma Jones from an article in the New York Daily News. She had died on July 14, 2024, at New York Presbyterian Weill Cornell Medical Center (NYP). She was incarcerated in the Rose M. Singer Center (RMSC) on Rikers Island before being transferred to a series of hospitals beginning on May 6, 2024.

Summary of Facts

On April 28, 2024, while in custody at RMSC, Ms. Jones developed a sore throat and began to feel ill. She was admitted to an isolation unit of the RMSC infirmary called MEDLOCK. Ms. Jones was prescribed amoxicillin and her condition improved. She was discharged from the infirmary to the general population on May 3, 2024. Ms. Jones’s fever returned on May 4, 2024, and she fainted in the housing area. She was transported to the clinic for evaluation, then readmitted to MEDLOCK. During the night of May 5-6, 2024, Ms. Jones began vomiting

and had a rash and fever. Test results on May 6 showed certain elevated liver enzyme levels, and, as a result, NYC DOC transferred Ms. Jones to Elmhurst Hospital later that day.

While at Elmhurst Hospital Ms. Jones was diagnosed with drug induced liver injury and, on May 21, was transferred to the advanced liver treatment center of Mount Sinai Hospital. She stayed there until June 25, 2024, when her condition deteriorated and she was transferred to NYP. NYC DOC released her from custody on July 11, 2024, pursuant to a court order based on the severity of her condition. Ms. Jones died on July 14, 2024, at NYP from multiple bacterial and fungal infections.

The medical examiner deemed the cause of death to be “complications of medical therapy initiated for the treatment of Streptococcus Pyogenes (‘Scarlet Fever’) infection,” and deemed the manner of death to be “therapeutic complication.”

Allegations of Misconduct

The news article from which OSI learned of Ms. Jones’s death and other media items reported allegations that correction officers prevented medical staff from treating Ms. Jones while she was at the RMSC clinic. OSI’s review found that on May 5, 2024, a Patient Care Associate (PCA), a Registered Nurse (RN), and a Licensed Practical Nurse (LPN) wrote in the medical records that they were unable to obtain vitals from Ms. Jones because officers refused to open Ms. Jones’s cell door, and that they advised the attending physician of this. In addition, the medical records for that day (May 5) showed that nursing staff spoke with Ms. Jones, who denied distress, and provided her with medication and food through the slot in the cell door. OSI’s review of video from that day showed medical staff frequently speaking with Ms. Jones through the cell door and providing medication through the door’s slot, though video did not show medical staff entering the cell or show Ms. Jones coming out of the cell. OSI interviewed the PCA, who did not recall being prevented from accessing Ms. Jones; OSI sought to interview the RN, but she was on extended leave.

OSI interviewed the medical examiner (ME) about the allegations that correction staff prevented medical staff from accessing Ms. Jones. The ME said that failure to obtain vitals from Ms. Jones on May 5 did not alter the course of her care and treatment because the treating physician was aware of the fever level, and Ms. Jones was being treated for it appropriately, initially responding well to the antibiotic treatment. The liver enzyme test and onset of vomiting the following day (May 6) were the clinical factors that required elevated care, and the ME said that once the treating physician became aware of those developments she appropriately had Ms. Jones taken to Elmhurst Hospital.

Conclusion

OSI did not find reason to believe that any action or omission by an officer caused or contributed to the death of Ms. Jones.

Ms. Jones was Black; she was 24 years old when she died.

Anthony Jordan, August 20, 2024

On August 20, 2024, at 4:04 a.m., several people woke up to the sound of Mr. Jordan falling out of his bed and hitting the floor in a housing area in the North Infirmary Command. They helped him back onto his bed and notified a nearby officer, who called in a medical emergency. Medical staff responded, gave Mr. Jordan oxygen, and brought him to the medical clinic in a wheelchair. FDNY EMTs arrived and took over the care of Mr. Jordan, who was alive and breathing but unable to speak. They took him to Mount Sinai Hospital, but during transport he went into cardiac arrest. Mr. Jordan was pronounced dead at the hospital minutes after arrival. The medical examiner deemed the cause of death to be hypertensive and atherosclerotic cardiovascular disease and chronic substance abuse and deemed the manner of death to be natural.

OSI did not find reason to believe that any action or omission by an officer caused or contributed to the death of Mr. Jordan.

Mr. Jordan was Black; he was 63 years old when he died.

Ariel Quidone, March 15, 2025

Ariel Quidone came into the custody of NYC DOC on March 7, 2025, after failing to make bail on a Manhattan robbery charge. He was housed in the Eric M. Taylor Center, and later in the Robert N. Davoren Center. He began to show signs of illness on March 10, when a member of Rikers Island mental health staff saw him vomiting into a garbage can in a day room, and, the same day, when he told a different member of mental health staff that his stomach hurt. No medical assistance was provided to Mr. Quidone on March 10. On March 12 Mr. Quidone was escorted by a correction officer to a medical clinic in the facility, and video showed that he was visibly ill. No medical staff attended to him in the clinic, and Mr. Quidone walked out after about 40 minutes. On March 13 Mr. Quidone's family called the facility to tell medical personnel that Mr. Quidone was suffering from drug withdrawal. Mental health staff saw Mr. Quidone twice that day, and he told them his stomach hurt, but they did not refer him to medical staff. In the afternoon of the same day, March 13, another detainee saw Mr. Quidone vomiting and then, about 10 minutes later, saw that Mr. Quidone was unresponsive and alerted an officer, who in turn activated a medical emergency. A Rikers Island doctor began to treat Mr. Quidone and then had him taken by ambulance to Elmhurst Hospital.

Mr. Quidone arrived at the hospital at 4:58 p.m. on March 13, 2025, in cardiac arrest. Mr. Quidone had a pulse, and medical staff stabilized him. A CT scan showed that Mr. Quidone had a perforated bowel. He was diagnosed with septic shock from acute appendicitis. On March 14, 2025, doctors performed an appendectomy, but Mr. Quidone never recovered and died the next day. The medical examiner determined that the cause of death was "septic complications of perforated appendix due to acute appendicitis" and deemed the manner of death to be "natural."

OSI did not find reason to believe that any action or omission by an officer caused or contributed to the death of Mr. Quidone.

Mr. Quidone was Hispanic; he was 20 years old when he died.

Benjamin Kelly, June 20, 2025

At the time of his death, Mr. Kelly was housed in the Eric M. Taylor Center in a mental observation wing. On June 6, 2025, a NYC Health and Hospitals Correctional Health Services (CHS) clinician wrote that Mr. Kelly had “conducted him/herself in a manner which is likely to result in serious harm to him/herself or to others” and “appears to be mentally ill,” based in part on two self-harm incidents since May 30. Mr. Kelly was placed on suicide watch for five days. CHS Suicide Watch Progress notes from June 11, 2025, said Mr. Kelly denied suicidal ideation, plan, or intent, did not appear to be in acute psychiatric distress, and did not present a risk of harm to others. The clinician and a CHS doctor discontinued suicide watch but kept Mr. Kelly in the mental observation unit. Mr. Kelly’s Suicide Watch History said he had been on suicide watch for five days during a prior incarceration in 2013.

On June 20, 2025, at 3:00 p.m., an officer conducting a tour found Mr. Kelly hanging: a bedsheet was tied around his neck, and the other end of the sheet was tied to a window grate in his cell. A medical emergency was activated, aid was provided, and medical staff arrived and took over. Mr. Kelly was pronounced dead at 3:31 p.m.

The medical examiner deemed the cause of death to be hanging and the manner of death to be suicide.

OSI did not find reason to believe that any action or omission by an officer caused or contributed to the death of Mr. Kelly.

Mr. Kelly was White; he was 37 years old when he died.

James Maldonado, June 20, 2025

On June 18, 2025, at 10:00 a.m., NYPD arrested Mr. Maldonado in Staten Island and took him to the 120th Precinct stationhouse. On June 19, 2025, at 8:06 p.m., Mr. Maldonado reported that he felt lightheaded and weak and was taken to a hospital. On June 20, 2025, at 1:07 a.m., he was discharged from the hospital and taken to Criminal Court and arraigned. At 1:46 p.m. he boarded an NYC DOC bus, which arrived on Rikers Island at 3:15 p.m. and made stops, delivering people to the various facilities on the island. As the bus neared the Eric M. Taylor Center (EMTC), officers on the bus saw that Mr. Maldonado was unresponsive and, at 4:28 p.m., alerted staff at the EMTC sallyport to call medical. At 4:32 p.m. medical staff arrived to render aid and, at 4:49 p.m., a doctor declared Mr. Maldonado dead. The medical examiner deemed the cause of death to be “acute intoxication due to the combined effects of fentanyl, morphine and methadone” and deemed the manner of death to be “accident (substance use).”

OSI did not find reason to believe that any action or omission by an officer caused or contributed to the death of Mr. Maldonado.

Mr. Maldonado was Hispanic; he was 56 years old when he died.

Christian Collado, July 9, 2025

Mr. Collado was arrested by members of NYPD on October 16, 2024, and taken directly to Mount Sinai Hospital, where he was admitted with a diagnosis of stage 4 cancer. Mr. Collado remained in the hospital until he was arraigned and transferred to NYC DOC custody on October 26, 2024. During his nine-month incarceration Mr. Collado was housed in NYC DOC facilities on Rikers Island that provided medical care and was hospitalized 13 times at the Bellevue Hospital Prison Ward (BHPW) in Manhattan. On June 25, 2025, Mr. Collado was transferred to BHPW for a final time and, on July 9, 2025, was pronounced dead. Based on medical history, the medical examiner deemed the cause of death to be “Stage 4 Ampullary Adenocarcinoma with Liver Metastasis” and deemed the manner of death to be “natural.” (OCME did not perform an autopsy.)

OSI did not find reason to believe that any action or omission by an officer caused or contributed to the death of Mr. Collado.

Mr. Collado was Hispanic; he was 51 years old when he died.

Edwin Quispe, July 22, 2025

On the morning of July 22, 2025, in the 10 Upper housing area of EMTC, an officer left his post without authorization (and was later suspended), leaving a single officer in the unit, who took up the control room post. Officers in the control room post do not conduct rounds and are generally not permitted to leave the control room. At 7:06 a.m. Mr. Quispe entered the 10 Upper housing area bathroom. From 7:06 a.m. to 7:49 a.m. several people walked in and out of the bathroom. At 7:49 a.m. a person entered the bathroom and, at 7:50 a.m., ran out of the bathroom and notified the control room officer that Mr. Quispe was hanging in one of the stalls. The officer called a medical emergency. At 7:53 a.m. a captain arrived and, together with the control room officer and other people, entered the bathroom and cut the ligature from Mr. Quispe’s neck. Mr. Quispe was placed on the floor and the officer performed chest compressions. At 7:56 a.m. medical staff arrived and assumed care. At 8:13 a.m. a doctor arrived and, at 8:28 a.m., declared Mr. Quispe dead.

The medical examiner deemed the cause of death to be hanging. Because there were other people (but not any officers) in the bathroom when Mr. Quispe was hanged the medical examiner could not rule out action by another and so deemed the manner of death to be “undetermined.” According to NYC DOC rules, at least one security round should have been conducted by an officer in the period that Mr. Quispe was in the bathroom, but because of the officer having left his post without authorization, that round was not performed. However, as

hanging becomes fatal within minutes, OSI could not conclude that the unperformed round would have prevented the death.

OSI did not find reason to believe that any action or omission by an officer caused or contributed to the death of Mr. Quispe.

Mr. Quispe was Hispanic; he was 33 years old when he died.

Ardit Billa, August 23, 2025

At the time of his death on August 23, 2025, Mr. Billa was housed in a specialized unit, in the George R. Vierno Center, for seriously mentally ill people in custody, where he had been since August 1. As shown on fixed video, on August 23 at 12:04 a.m., Captain Qamar Khan performed a tour of the housing area and briefly shined his flashlight into Mr. Billa's cell; he continued his tour and returned to Mr. Billa's cell 17 minutes later with three other officers. BWC worn by the officers showed that they opened Mr. Billa's cell at 12:25 a.m. and discovered him naked, unresponsive, and covered in feces, with his head inside the toilet bowl. BWC and photographs taken after Mr. Billa's death showed that the cell floor and walls were smeared with feces. Captain Khan called a medical emergency and pulled Mr. Billa's head out of the toilet. As shown on BWC and fixed video, the officers dragged Mr. Billa into the hallway, where they wiped feces away from Mr. Billa's mouth and nose and performed chest compressions until medical staff arrived at 12:33 a.m. According to the medical records and as seen on fixed video, CHS medical staff provided life-saving interventions, but Mr. Billa could not be resuscitated. He was pronounced dead at 12:58 a.m., six minutes after the arrival of FDNY EMS.

The medical examiner determined that Mr. Billa aspirated due to airway obstruction while attempting to ingest fecal material. OSI's review of Mr. Billa's CHS medical records showed that he suffered from schizophrenia and had been in mental observation housing for the duration of his time in DOC custody. The records showed that in the weeks prior to his death he had voluntarily remained in his cell, was noncompliant with his prescribed psychiatric medications, and refused numerous visits from medical and mental health providers. Mental health staff repeatedly reported that they were unable to assess his condition.

OSI did not find reason to believe that any action or omission by an officer caused or contributed to the death of Mr. Billa.

Mr. Billa was White; he was 29 years old when he died.

Jimmy Avila, August 30, 2025

On August 30, 2025, at 3:30 p.m., in the West Facility, an officer found Mr. Avila hanging from the bed in his cell with a bedsheet tied around his neck. The officer went into the cell, cut Mr. Avila down, and activated a medical emergency. Medical staff responded and performed chest compressions and gave Mr. Avila 11 rounds of epinephrine. A doctor on site pronounced Mr. Avila dead. The medical examiner deemed the cause of death to be hanging and the manner of death to be suicide.

On August 29, 2025, Mr. Avila had been arraigned in Bronx Criminal Court and remanded after being charged with one count of Murder in the Second Degree and two counts of Attempted Murder in the Second Degree. Mental health attention was not indicated on the securing order and, in the court's arraignment file, the special classification section of the file was blank, and the box for suicide risk was not checked. NYC DOC's Suicide Prevention Screening Guidelines form indicated Mr. Avila had a history of counseling and mental health treatment but said he was not thinking about killing himself, had never attempted suicide, and that he did not express feelings of hopelessness. The conclusion indicated on the form was that he did not require constant supervision. The CHS Status Notification and Observation Transfer Form said Mr. Avila should be transferred to Mental Observation but did not require suicide watch.

Video showed an officer giving Mr. Avila food and water at 12:25 p.m. and then conducting rounds every 30 minutes until finding Mr. Avila hanging.

OSI did not find reason to believe that any action or omission by an officer caused or contributed to the death of Mr. Avila.

Mr. Avila was Black; he was 34 years old when he died.

Edwin Ramos, November 11, 2025

Mr. Ramos was arrested by members of NYPD on August 14, 2025, and taken into NYC DOC custody the next day. On November 21, 2025, video showed that Mr. Ramos collapsed in the 6 Upper bathroom at the Otis Bantum Correctional Facility; he was sitting in a bathroom stall and fell forward to the floor. Officers came into the bathroom, saw that Mr. Ramos was unresponsive, and administered Narcan, performed chest compressions, and summoned medical staff. Mr. Ramos was taken to Mount Sinai hospital where he was pronounced dead shortly after arrival. The medical examiner deemed the cause of death to be "Atherosclerotic and Hypertensive Cardiovascular Disease" and the manner of death to be "natural."

OSI did not find reason to believe that any action or omission by an officer caused or contributed to the death of Mr. Ramos.

Mr. Ramos was Hispanic; he was 38 years old when he died.

Kyron Randall, December 22, 2025

On December 21, 2025, at 10:11 a.m., a correction officer saw Mr. Randall throwing up and sick in his cell in a housing unit for seriously mentally ill persons in the George R. Vierno Center (GRVC). The officer notified the nurse and another floor officer, and they activated a medical emergency. Medical staff came to Mr. Randall's cell and observed him to have unintelligible speech, altered mental status, shallow breathing, and an extensive rash on his abdomen and extremities. They took him to the jail clinic, and then FDNY EMS took him to Elmhurst Hospital. Mr. Randall arrived in the emergency department at 12:05 p.m. in severe respiratory distress, with a rash over his abdomen and extremities, and suffering from severe dehydration and "profoundly low" blood pressure. Hospital staff intubated and sedated him and, following testing and bloodwork, diagnosed him with septic shock and multi-organ failure. Despite treatment, Mr. Randall became pulseless and was pronounced dead on December 22 at 12:57 a.m.

The medical examiner determined that the cause of death was "complications of acute haemophilus influenzae infection," with a contributing factor of "hypertensive and atherosclerotic cardiovascular disease." A review of Mr. Randall's CHS medical records showed that he had been feeling unwell and complained of stomachache in the four days prior to his hospitalization, but the records also showed that he repeatedly refused medical care and would not go to the jail clinic. CHS records noted that Mr. Randall had a history of "nonspecific abnormal electrocardiogram (EKG)" and "coronary artery disease," and that in the month prior to his death he refused requests by medical staff to perform an EKG on nine separate occasions.

OSI did not find reason to believe that any action or omission by an officer caused or contributed to the death of Mr. Randall.

Mr. Randall was Black; he was 33 years old when he died.

6. RECOMMENDATIONS

Section 70-b directs OSI to include in the Annual Report recommendations for systemic or other reforms indicated by OSI's investigations. OSI has made a series of recommendations in its prior Annual Reports, most of which remain relevant. Set forth below are a summary and an update of OSI's recommendations.

Video

Video in the Jails and Prisons

In a significant development, OSI's longstanding recommendation that the state require comprehensive video surveillance in the jails and prisons has been partially enacted into law.

In the first of two actions, the Legislature passed and the Governor signed a bill that added Section 135 to the Correction Law, which requires officers in the state prison system to wear body-worn cameras and to activate them when interacting with incarcerated people. CL Section 135 can be read [here](#). In the second action, the Legislature passed and the Governor signed a bill that added Section 135-a to the Correction Law, which requires the Commissioner of the state prison system to develop and implement a plan for installing comprehensive fixed video in the prisons. CL Section 135-a can be read [here](#).

To improve further on this important progress, we continue to recommend that the state require local jails and other holding facilities to use BWC and fixed video.

Body-Worn Cameras and Dashboard Cameras for Police Officers

Consistent with previous years' recommendations, OSI encourages the state to require that police departments equip their officers with and require them to use body-worn cameras and dashboard cameras. OSI recommends that the law include funding for any police agency that would not otherwise be able to afford the implementation of a body-worn camera and dashboard camera program. The absence of body-worn cameras in the cases of Anthony Zaremski, Devon Allen, Lisa Haight, Miles Digneau, and James Cushman, summarized above in Section 4 of this Report, show the continuing need for a law requiring their use.

Please see these links for OSI's video recommendations in previous Annual Reports: [2021](#), [2022](#), [2023](#), [2024](#), and [2025](#).

People in Crisis

OSI continues to recommend better training, policies, and resources for addressing people in crisis. Please see OSI's prior Annual Reports for these recommendations, as well as our summaries of related Legislative advances: [2021](#), [2022](#), [2024](#), [2025](#).

With the caution that members of OSI are not mental health clinicians, and emphasizing that better training, policies, and resources would not necessarily have changed the outcome in any particular case, we highlight here, as we have done in prior Annual Reports, the cases that involved confrontations between police or peace officers and people who seemed to be in crisis (all summarized above in Section 4): Daniel McAlpin, Lisa Haight, Djamshed Nematov, Win Rozario, Andre Mayfield, James Cushman, Emil Williams, Winston Johnson, Matthew Brown, Bruce Boyd, David Levine, Nancy Loftus, King Wong, Donnell Hogan, Mark Bemis, Emilson Ordonez-Banegas, Hugh Davis, and Nathan Novakowski.

Our Investigation Report in the Win Rozario case set forth detailed recommendations for better training, policies, and resources. For example, we recommended:

- That the Legislature pass and the Governor sign a bill called Daniel's Law, named after Daniel Prude, who died after a police encounter in 2020, in Rochester, the objectives of which are, "... to promote the public health, safety and welfare of all citizens by broadly ensuring a public health-based response to anyone in New York experiencing a mental health, alcohol use or substance use crisis; to offer and ensure the most appropriate response to, and treatment of, individuals experiencing crisis due to mental health conditions, alcohol use or substance use conditions; and to deescalate crisis situations so that as few New Yorkers as possible experience nonconsensual transport, use of force, or criminal consequences as a result of mental health, alcohol use or substance abuse crises. The necessity to establish a defined response protocol for behavioral health and substance use crises has never been more urgent."
- And, based on the particular circumstances of the Win Rozario case, that the City of New York expand its crisis response program, called B-HEARD, so that it would: cover all precincts at all times of day and night; cover drug- and alcohol-induced crises; allow its personnel to respond with police officers (co-response), and not only "instead of" police officers; and allow police officers who have responded to a call to request a B-HEARD co-response after officers on scene have made sure the situation is safe for mental health professionals. [Win Rozario Report](#).

OSI continues to recommend that the state provide funding for any agency that cannot otherwise pay for the improved level of training now required by Executive Law 840(8) (here: [EL 840\(8\)](#)) and continues to recommend that police departments improve training not only in deescalation, but in basic tactical responses when dealing with people in crisis.

Suicide and Overdose Prevention in Jails and Prisons

OSI continues to recommend that the state's jails and prisons take certain common-sense steps to reduce the number of deaths from suicides and drug overdoses. In brief:

- Initial suicide and drug abuse/withdrawal screenings should be conducted by professionals who are trained to take inmates' histories and make nuanced observations
- Personnel conducting inmates' initial screenings should have access to the complete mental health histories and drug abuse/withdrawal histories of the incarcerated people they are evaluating
- Whether a person is initially deemed a suicide risk or a drug overdose/withdrawal risk, personnel should regularly follow up on the person's mental health and drug use, and
- Correction officers must strictly adhere to, and supervisors must strictly enforce, the simple rules of good order that already exist, such as conducting (and not skipping) frequent security rounds, looking carefully into every cell during every round, and

prohibiting incarcerated people from obstructing the view into their cells with cardboard over door windows or bedsheets over open-bar cell doors.

See our fuller recommendations in the Annual Reports of [2022](#), [2024](#), and [2025](#).

Although the rate of death from suicides in the state's jails and prisons in the 12 months ending August 31, 2026, of just under 34 per 100,000 (17 suicides in a combined jail and prison population of 51,356) is a decline from last year's rate of just under 60 per 100,000, this year's figure remains significantly higher than the last full-year suicide rate reported by the CDC for the male population of the United States, of 22.2 per 100,000 in 2024. (Combined New York jail and prison population as of September 1, 2026, is based on DOCCS Fact Sheet from [this](#), and DCJS Jail Census from [this](#). CDC data are from [this](#). See Section 7 below for additional detail on causes of death in the jails and prisons.)

The rate of death from drug overdoses in the state's jails and prisons in the current year, of just under 56 per 100,000 (28 overdose deaths in a combined jail and prison population of 51,356), is an increase from last year's rate, of 44 per 100,000, and remains higher than the last full-year overdose death rate reported by the CDC for the male population of the United States, of 32.2 per 100,000 in 2024. (CDC data from [this](#). See Section 7 below for additional detail on causes of death in the jails and prisons.)

The drug that primarily caused overdose deaths in New York's jails and prisons in the 2022 data was fentanyl; now the primary drugs are synthetic cannabinoids. In the 2022 data year fentanyl was involved (alone or in combination with other drugs) in 24 overdose deaths, and synthetic cannabinoids were involved in four. In the current year, to the extent that we have final autopsy reports, fentanyl was involved in three overdose deaths and synthetic cannabinoids were involved in 18.

Pursuits

OSI investigates and assesses many cases involving police vehicle pursuits: please see our detailed data on attempted car stops in Section 7, below. The Attorney General issued a report on June 24, 2025, concerning police pursuits in which she recommended:

- That the state enact a law to increase transparency:
 - o New York law enforcement agencies should be required to track and publish a standardized set of data about traffic pursuits and high-speed chases. This should be facilitated by a centralized agency such as the Division of Criminal Justice Services (DCJS).
- That police departments ban high-speed police pursuits, with very narrow exceptions:
 - o High-speed chases can be deadly. Chases may be necessary when a serious or violent felony has been or will be committed, and when the driver's conduct

poses an imminent threat of death. But, in large part, ordinary speeding or a minor traffic infraction should not lead to a high-speed, dangerous chase.

See the Attorney General's report, [here](#).

In a number of Investigation Reports, OSI has recommended that New York require additional training of officer-drivers. New York's training requirements for officer-drivers are lower than those of other states, with only 21 hours of emergency vehicle operations training required for new officers and no mandated in-service training. In contrast, California requires 40 hours of training for new police officers and four hours of refresher training every two years. In 2024 a bill was introduced in the state Senate, which would have increased New York's requirements to a minimum of 40 hours of initial training and four hours of in-service training. The bill, however, did not pass. A similar bill was introduced in the Senate in 2025 but has not been voted on by the Assembly or the Senate. (See the 2025 bill [here](#).)

Officer Discipline in the DOCCS System

The Wilmer Hale Report

DOCCS correction officers beat Robert Brooks to death on December 9, 2024, at Marcy Correctional Facility. OSI recovered standby BWC of the beating, which revealed the brutal nature of the officers' conduct, and when the Attorney General released the recovered video, people around the state and the country were horrified. In the wake of the conduct revealed by the video, the Governor commissioned a law firm, Wilmer Hale, to do a comprehensive review of DOCCS and make recommendations. The assignment was later expanded to include the fatal beating of Messiah Nantwi, which occurred on March 1, 2025, at the Mid-State Correctional Facility.

Wilmer Hale's report was published on June 29, 2026, [here](#), and covers many important areas, but OSI focused on the report's description of DOCCS's disciplinary system, especially regarding discipline relating to officers' uses of force, or UOFs.

In the report Wilmer Hale estimates that over the 10 years from 2015 to 2024 reported UOFs more than tripled, from "6000" to "22,000" (an increase of 367%), despite a decline in the inmate population. (According to published numbers, the DOCCS inmate population was 52,344 in 2015 and 33,677 in 2024, a decline of over 35%; [DCJS Fact Sheet](#).)

According to the report, under the correction officers' collective bargaining agreement, the DOCCS internal investigation group refers substantiated cases of officer misconduct to the DOCCS Bureau of Labor Relations (BLR). BLR can either institute or decline to institute a disciplinary proceeding. If it institutes a proceeding, the result can be reached either through settlement or by formal arbitration.

From the report: “The Union Agreements provide that the arbitration decision-maker must be neutral—either a single neutral arbitrator or a panel of three arbitrators. According to DOCCS leadership, in practice, the process of identifying a neutral arbitrator involves DOCCS and the union each eliminating and ranking arbitrators from a shortlist. One DOCCS executive explained that this selection process creates incentives for arbitrators to establish a reputation for not deciding overwhelmingly for one side or the other; as a result, ‘basically, an arbitrator who decides about 50/50.’ Based on public reporting in late 2023, following an investigation into the process, just two arbitrators handled over half of the cases reviewed.”

The report says that in 2025 the DOCCS internal investigation group received 1,189 complaints for excessive force, 5.4% of all reported UOFs and, of those, the investigation group only substantiated 40 for “Use of Force: Excessive/Unnecessary.” In a different section, the report says that in 2024 the DOCCS internal investigation group substantiated 94 incidents of “staff abuse” against inmates (presumably referring to UOFs), and that in “approximately one third” of those cases, BLR declined to initiate a disciplinary process.

The report says that in 2023-24 BLR opened 140 cases of “Inmate Abuse” but declined to pursue discipline in 36 of the 140, and settled 54 of the 140 for lesser discipline, despite the original notice of discipline having sought termination in 50 of the 54 settled cases. Twelve cases of the 140 resulted in resignation before disciplinary decisions were made, and one case resulted in a termination during a probationary period (and therefore did not require arbitration). Only eight of the 140 cases went to arbitration. (These numbers add up to 111 cases; Wilmer Hale was apparently unable to obtain the results of the remaining cases.)

According to the report, in none of the eight cases that went to arbitration in 2023-24 did the arbitrators impose termination, even though the notice of discipline sought termination in all eight. Not only were four officers were given lesser penalties, but the other four were found “not guilty” (in the words of the report) and, presumably, received no penalties at all.

The report points out that many officers involved in the Brooks and Nantwi cases were previously accused of excessive force but were still on the job when Brooks and Nantwi died.

Legislation

Because the DOCCS disciplinary system is based on the collective bargaining agreement, legislation would be required to strengthen it. The Wilmer Hale report describes a pending bill, Senate Bill S1671, which would establish a new disciplinary procedure for allegations of “serious misconduct” and grant the DOCCS Commissioner final decision-making authority in cases of “serious misconduct,” which would include any excessive use of force, sexual abuse, false reporting of excessive use of force, intentional failure to report excessive use of force, introduction of contraband into facilities, and inappropriate sexual relationships. A hearing officer would conduct a hearing and make a recommendation to the Commissioner, who

would then make a final decision on discipline; there would be no right to arbitration. Employees could appeal by filing suit in court. The law would permit security staff involved in disciplinary proceedings for serious misconduct to be suspended without pay during the pendency of proceedings (today DOCCS cannot suspend security staff unless the employee has been charged with a crime or unless there is probable cause that the employee's continued presence on the job would severely interfere with operations, a determination that is reviewable by an arbitrator). The bill would prohibit security staff removed for serious misconduct from maintaining civil service eligibility for purposes of future employment and benefits.

OSI views this bill as an important option for improving the disciplinary system for DOCCS employees.

7. OSI'S DATA

Overall Number of OSI Cases, Current Year and Prior Years

OSI's [Data Tables](#) list every incident of which OSI has been notified (and for which OSI initiated a matter, even when not notified) from April 1, 2021, the effective date of Section 70-b, through August 31, 2026, the end of OSI's most recent data year. The data include the date of the incident, the name and demographic information of the person who died, the county in which the incident occurred, the police or correction agency involved, and the status of the matter. If the status of a matter is "closed," the tables say whether it was closed because: there was no death; there was no defined officer; OSI did not find that an officer caused the death; OSI issued an Investigation Report or Notification of Investigative Findings; or OSI obtained an indictment or otherwise pursued criminal charges. If the status of a matter is "open," the tables say whether the matter is "pending preliminary assessment" (meaning the question whether an officer caused the death is not yet clear), or "pending investigation" (meaning it is clear that an officer caused the death, but OSI has not yet determined whether to present evidence to a grand jury).

The numbers in the data tables and in the text of this section reflect the status of matters as of August 31, 2026. Please note that some numbers from past data years have been adjusted to correct errors or to reflect incidents we have re-categorized and will therefore be different from the corresponding numbers in prior Annual Reports.

The overall number of cases OSI opened in each *full* data year (not counting the initial period from April 1 to August 31, 2021), and the number of cases OSI has closed, are as follows:

Data Year (12 months ending August 31)	Matters Opened	Closed
2022	234	234
2023	281	280
2024	340	331
2025	296	262
2026	320	105
Total	1,471	1,212

Criminal Charges Since Inception

Since inception on April 1, 2021, OSI has pursued criminal charges in 11 cases, not including the Brooks and Nantwi cases, which were handled by a special prosecutor as described above in Section 3 of this Report, and not including People v Baldner, which arose in December 2020 and in which OSI obtained a conviction after trial in March of 2026, as described above in Section 2. The table below summarizes OSI's criminal cases arising since inception:

Case Type	Number of Charged Cases	Disposition
Shooting	4 (3 off duty, 1 on duty)	1 guilty plea (off duty) 2 acquittals after trial (1 on duty, 1 off duty) 1 pending (off duty)
Motor Vehicle	6 (all off duty)	3 guilty pleas, 3 pending
Other (struck a motorbike rider)	1	Conviction after trial
Total	11	1 trial conviction 4 guilty pleas 2 acquittals after trial 4 pending

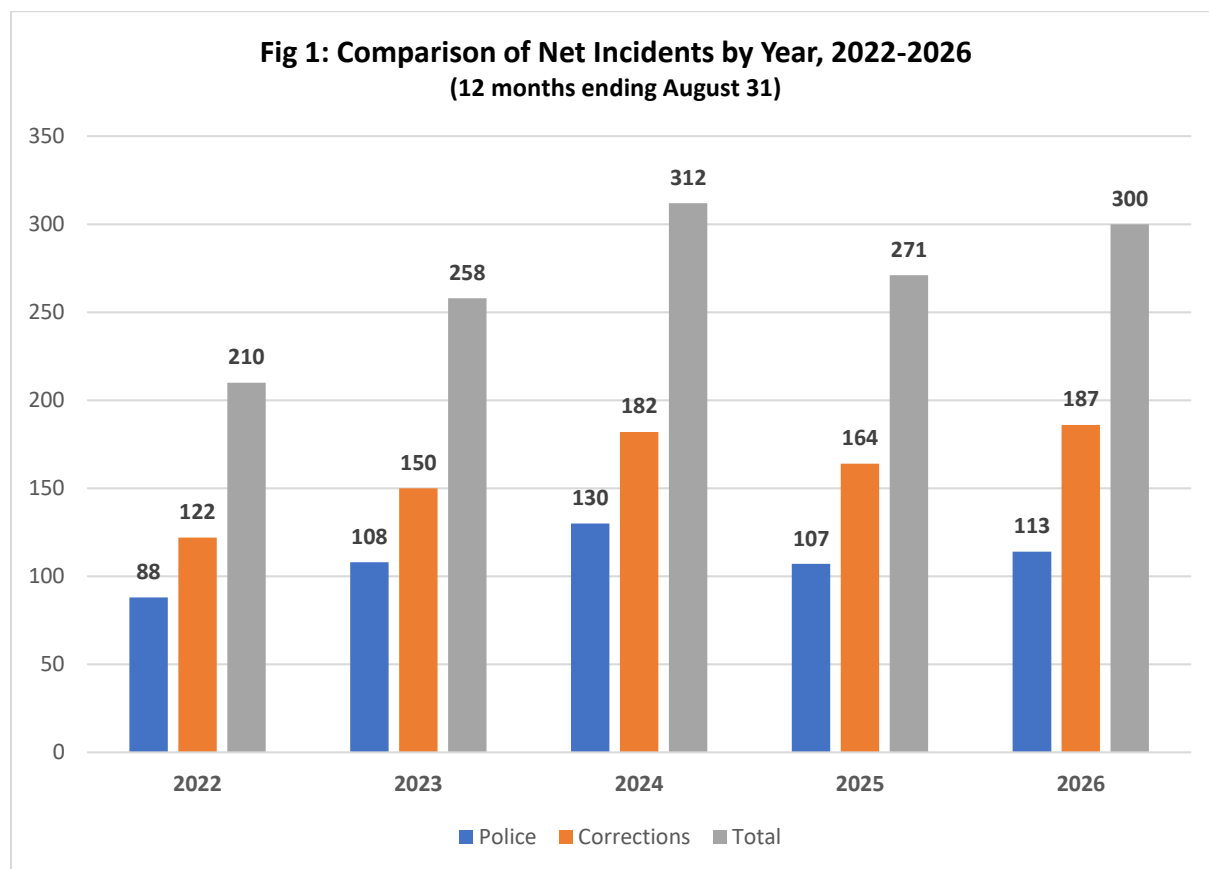
Net Incidents

Of all the incidents that are reported to OSI each year, there are almost always some that do not result in a death, or do not involve a defined officer, or do not otherwise fall under OSI jurisdiction. We take those incidents, as well as murder-suicides, out of the total number of reported incidents to arrive at *net incidents*. All data discussed from this point on will be based on *net incidents*.

Net Incidents in the 2026 Data Year

Of the total of 320 reported incidents in the 2026 data year, 19 did not result in a death, or did not involve a defined officer, or did not otherwise fall under OSI jurisdiction, and one was a murder-suicide, leaving 300 *net incidents* for the year.

Of the 300 net incidents in the 2026 data year, 187 involved deaths of people incarcerated in jails and prisons, and 113 were deaths in other situations involving police officers. See Figure 1 for a comparison of overall net incidents in OSI's five full data years. (In the chart below OSI counts an event as a single "incident" even if more than one death occurred.)



Police Shootings

Of 113 non-incarceration net incidents in the 2026 data year, 25 were shootings. This was the same number as the previous year. In the 2024 data year there were 31 shootings; in the 2023 data year there were 20 shootings; and in the 2022 data year there were 22 shootings. See Figures 2a through 5 for comparisons of shootings in the current and prior data years, broken down by the gender, ethnicity, and age of the decedent, and whether the decedent was armed or unarmed.

Fig 2a: Shooting Deaths by Race, 2022
(22 incidents, 12 months ending Aug 31)

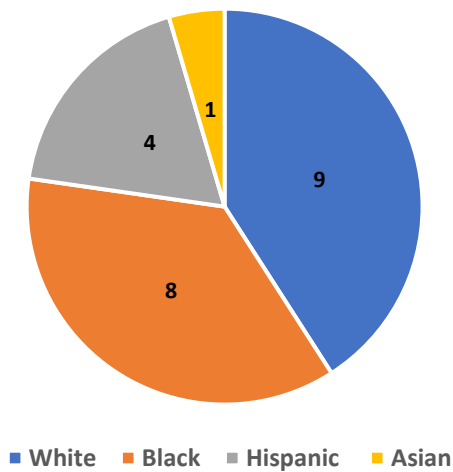


Fig 2b: Shooting Deaths by Race, 2023
(20 incidents, 12 months ending Aug 31)

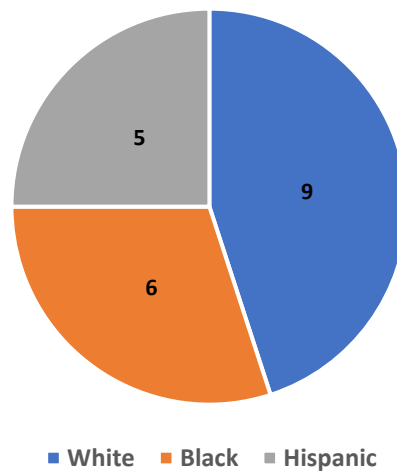


Fig 2c: Shooting Deaths by Race, 2024
(31 incidents, 12 months ending Aug 31)

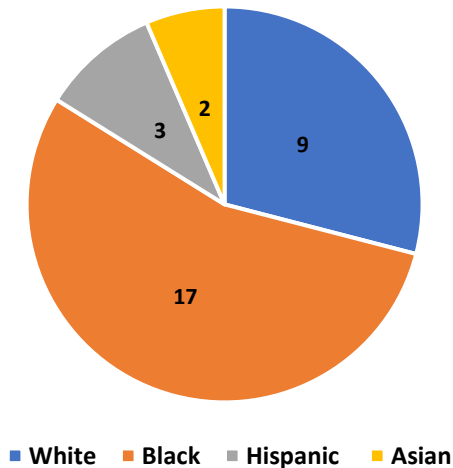


Fig 2d: Shooting Deaths by Race, 2025
(25 incidents, 12 months ending Aug 31)

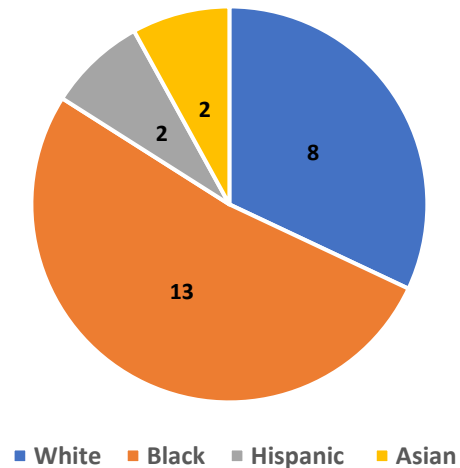


Fig 2e: Shooting Deaths by Race, 2026
(25 incidents, 12 months ending Aug 31)

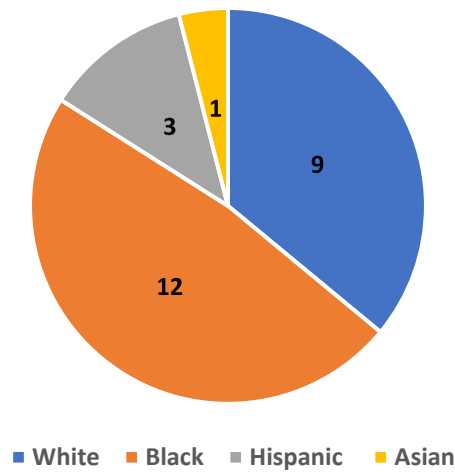


Fig 3: Shooting Deaths by Age, 2022-2026
(12 months ending August 31)

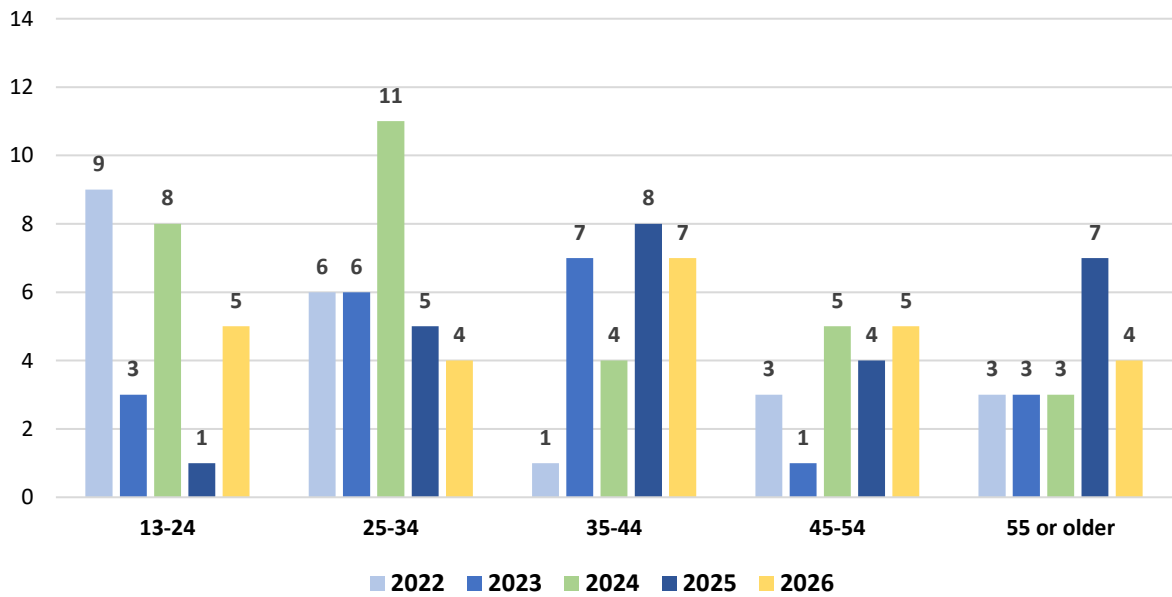


Fig 4: Shooting Deaths by Gender, 2022-2026
(12 months ending August 31)

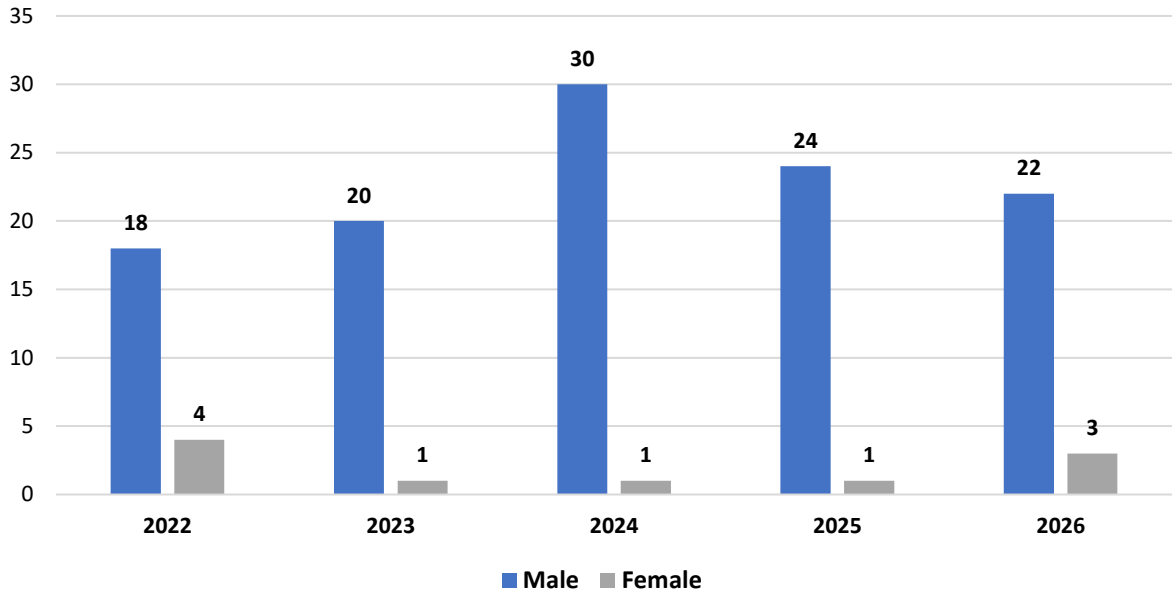
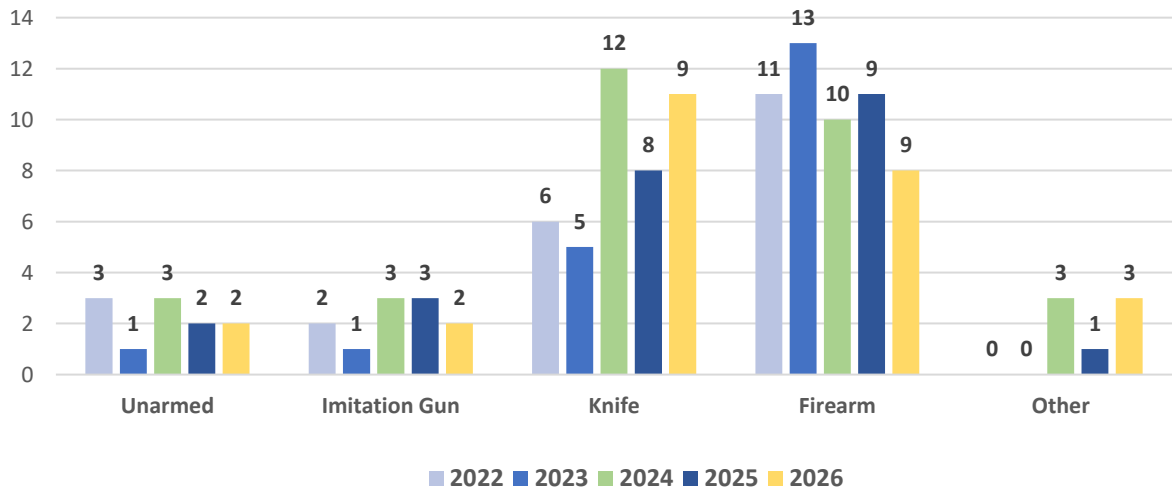


Fig 5: Shooting Deaths: Armed/Unarmed, 2022-2026
(12 months ending August 31)



Note: The "Other" weapons in 2026 were 1 meat cleaver, 1 "sharp" object, and 1 pair of scissors. The 2026 Imitation Gun category includes 1 incident involving both an imitation gun and knife.

Motor Vehicle Incidents

Incidents Following Attempted Car Stops

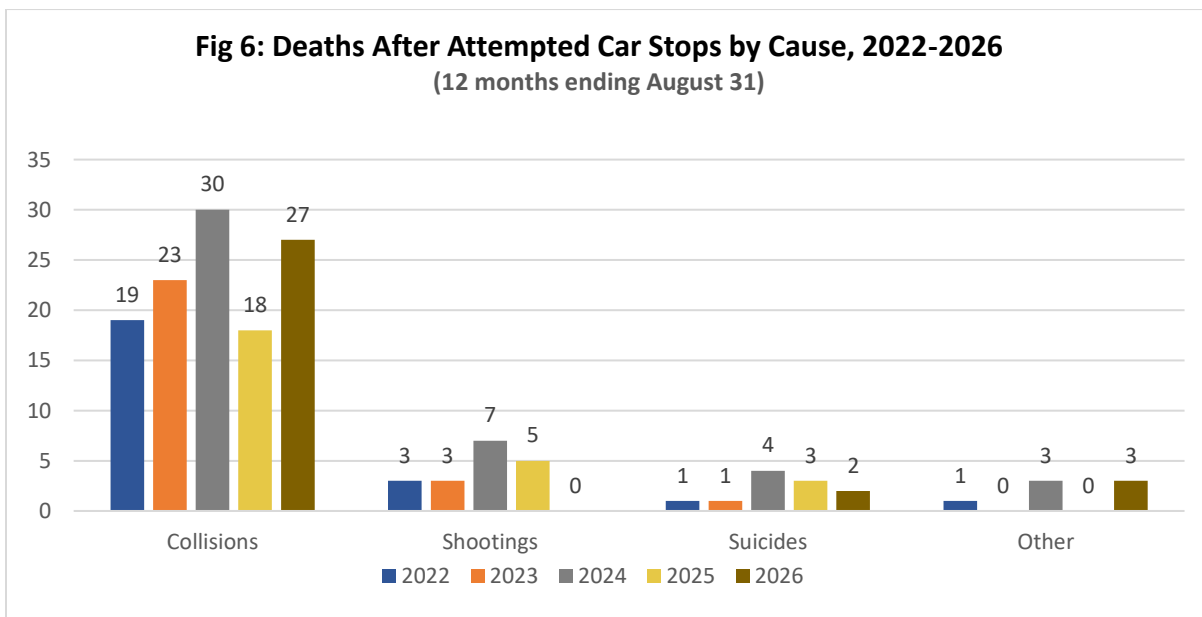
Of the 113 non-incarceration net incidents in the 2026 data year, 32 were related to attempted car stops, an increase from the 26 in the 2025 data year, but fewer than the 43 in the 2024 data year. There were 27 such incidents in the 2023 data year and 24 in the 2022 data year.

In 27 of the 32 attempted car-stop incidents in the 2026 data year, the driver of the car the officer attempted to stop fled and caused a fatal collision – by killing themselves or another occupant of their car, or by killing an occupant of another car, or by killing a pedestrian.

(When a civilian driver flees a traffic stop, causes a death, and survives, OSI usually “carves out” jurisdiction over them to the relevant District Attorney, under Paragraph 4 of Section 70-b. These incidents sometimes involve more than one death.)

In two of the 32 incidents, an occupant of the car the officer attempted to stop committed suicide. In three of the 32 incidents an occupant died in another way (drove into water and drowned; fled by jumping into water and drowned; crashed, then was handcuffed by officers, then died). None of the 32 incidents in the 2026 data year led to a shooting in which an officer killed an occupant of the car; last year there were five such shootings.

The data on deaths related to attempted car stops from the current and prior data years are shown in Figure 6 below.



Incidents in which Officer-Drivers Caused Deaths

In a category separate from attempted car stops are incidents in which officers, on duty or off duty, were driving and were *directly* involved in collisions that resulted in death. These collisions occurred in many different ways, and the fact of a fatal collision does not necessarily imply that the officer-driver committed a crime or was otherwise at fault.

In the 2026 data year there were nine incidents in which an officer-driver caused the death of another person. Two of those incidents resulted in criminal charges: as described in Section 2 of this Report, OSI obtained an indictment against the defendant who caused the death of Manuel Boitel, and she has pleaded guilty; the case resulting from the death of Jennifer Hathorn is pending.

In the 2025 data year there were seven incidents in which an officer-driver directly caused the death of a person; in the 2024 data year there were eight such incidents; in the 2023 data year there were 11 such incidents; and in the 2022 data year there were four such incidents.

As shown in the table earlier in this Section, OSI has brought criminal charges in six cases to date in which an officer-driver directly caused a death with a vehicle. Three of those cases have resulted in guilty pleas and three are pending. (Again, these six cases do not include *People v Baldner*, in which the death occurred prior to April 1, 2021, and in which OSI obtained a conviction after trial in March 2026.)

Incidents in Jails and Prisons

Of the 187 deaths OSI investigated in the jails and prisons in the current data period:

- 152 deaths were in DOCCS facilities, an increase of 14 over the prior year;
- 11 deaths were in NYC DOC facilities, the same as the prior year; and
- 24 deaths were in county jails, an increase of nine over the prior year.

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

Fig 7: Jail and Prison Deaths by Agency, 2022-2026
(12 months ending August 31)

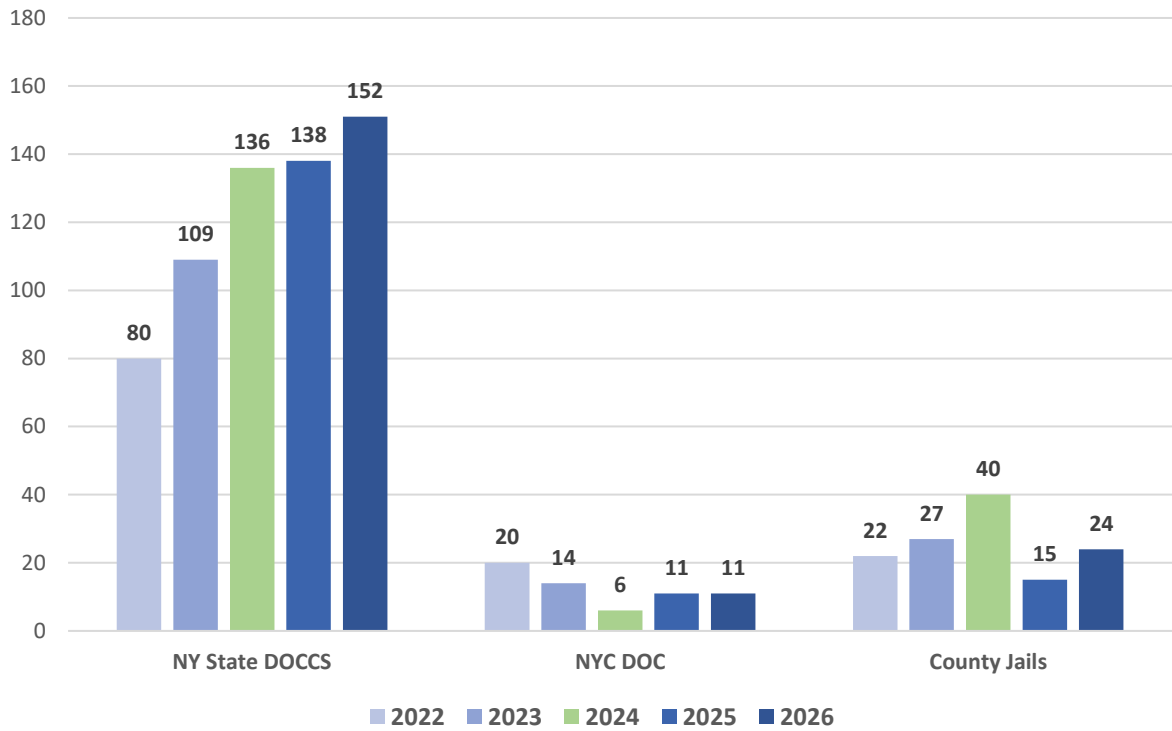


Fig 8a: Jail/Prison Deaths by Cause, 2022
(122 incidents, 12 months ending Aug 31)

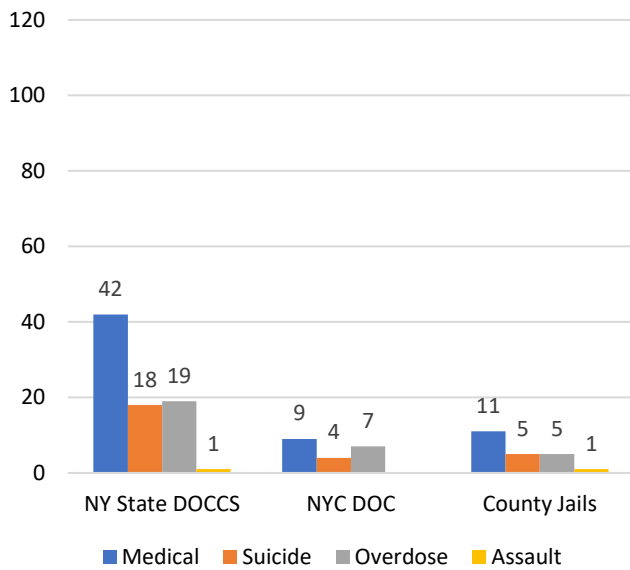


Fig 8b: Jail & Prison Deaths by Cause, 2023
(150 incidents, 12 months ending Aug 31)

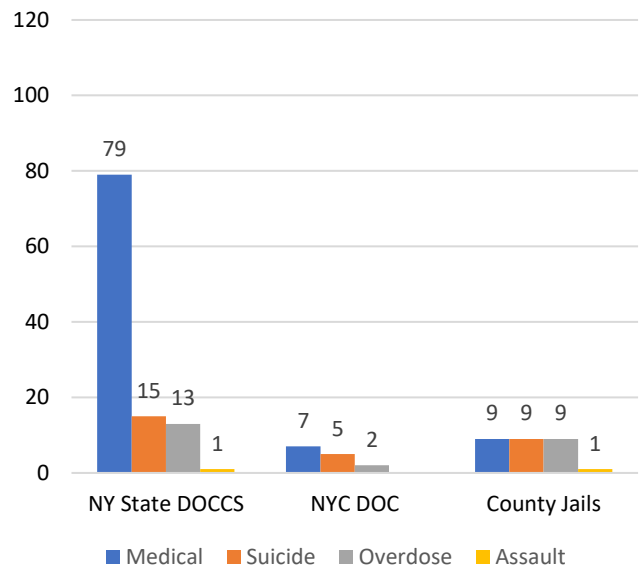


Fig 8c: Jail & Prison Deaths by Cause, 2024
(182 incidents, 12 months ending Aug 31)

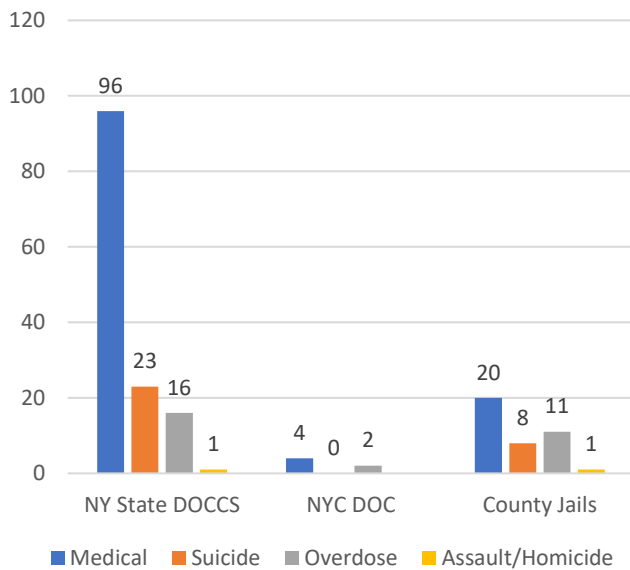
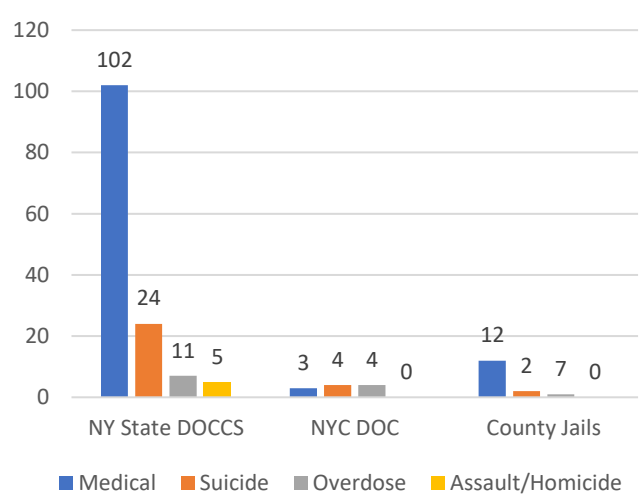
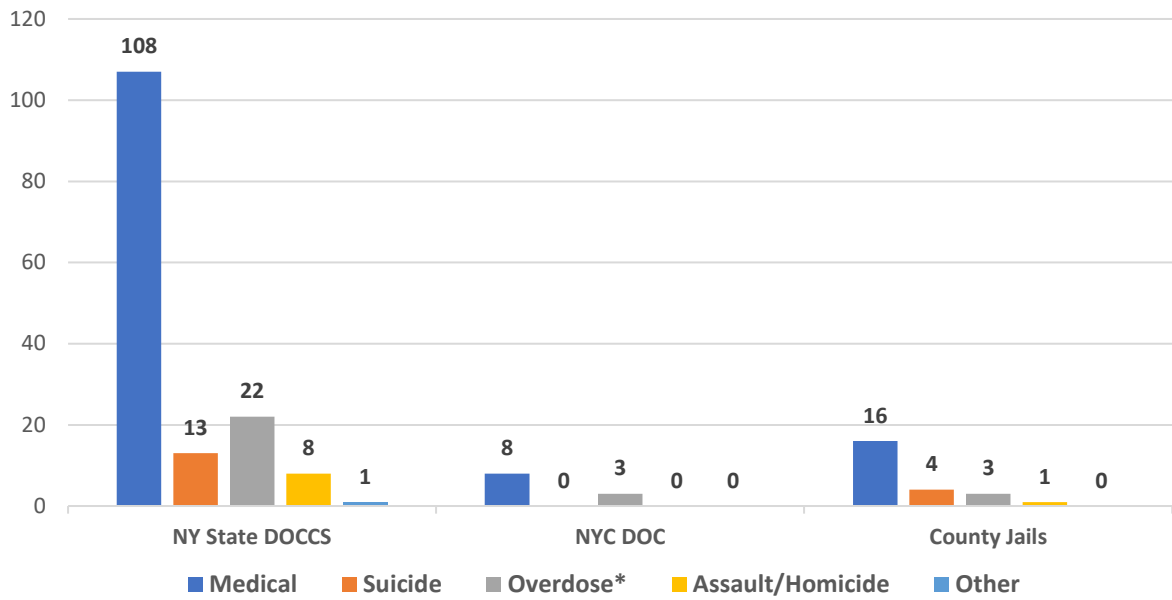


Fig 8d: Jail & Prison Deaths by Cause, 2025
(164 incidents, 12 months ending Aug 31)



Note: DOCCS "Assault/Homicide" in 2025 included the Brooks and Nantwi deaths, caused by DOCCS employees.

Fig 8e: Jail & Prison Deaths by Cause, 2026
(187 incidents, 12 months ending August 31)



Note: *Overdose includes 2 suspected overdoses (no final autopsy). "Other" was a fire in a cell.

Fig 9: Jail & Prison Deaths by Age, 2022-2026
(12 months ending August 31)

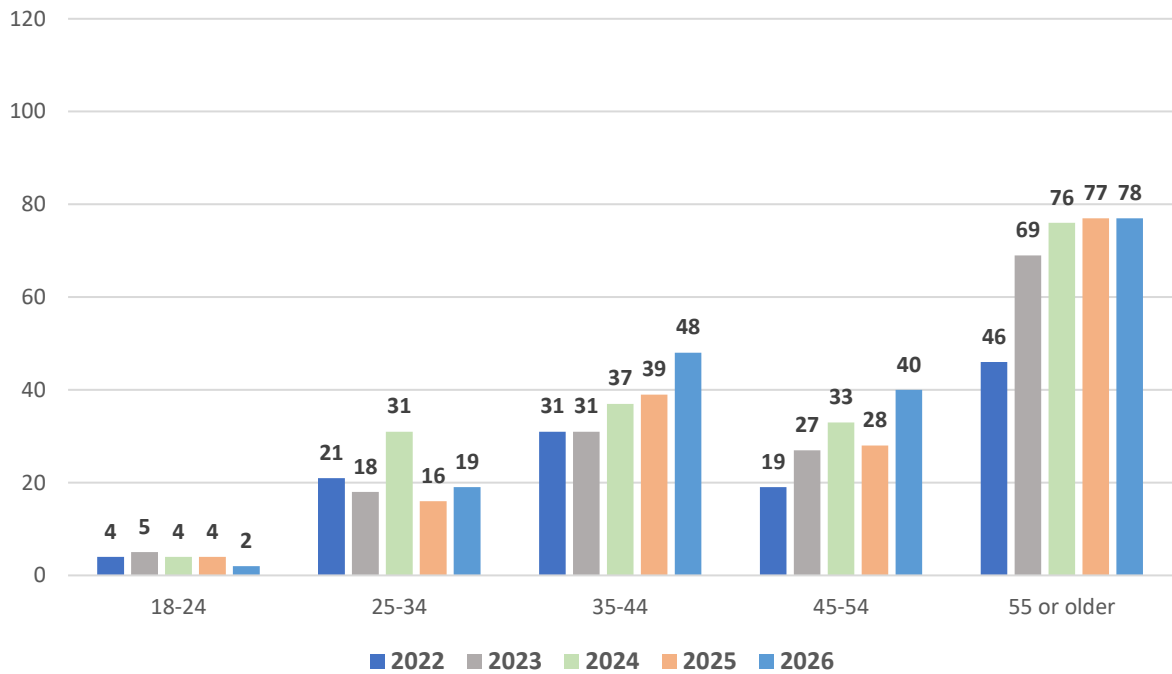


Fig 10a: Jail & Prison Deaths by Race, 2022
(122 incidents, 12 months ending Aug 31)

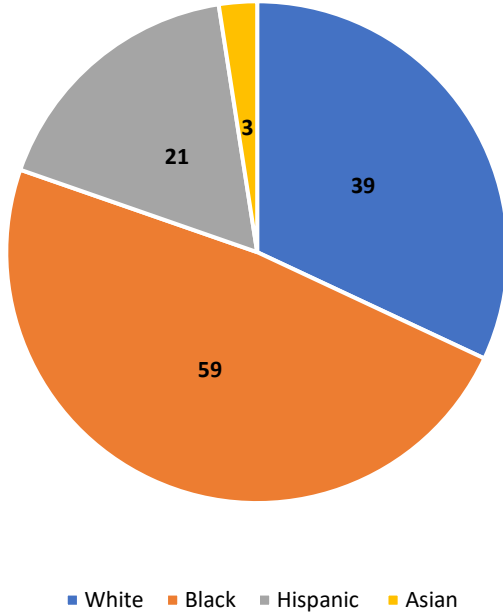


Fig 10b: Jail & Prison Deaths by Race, 2023
(150 incidents, 12 months ending Aug 31)

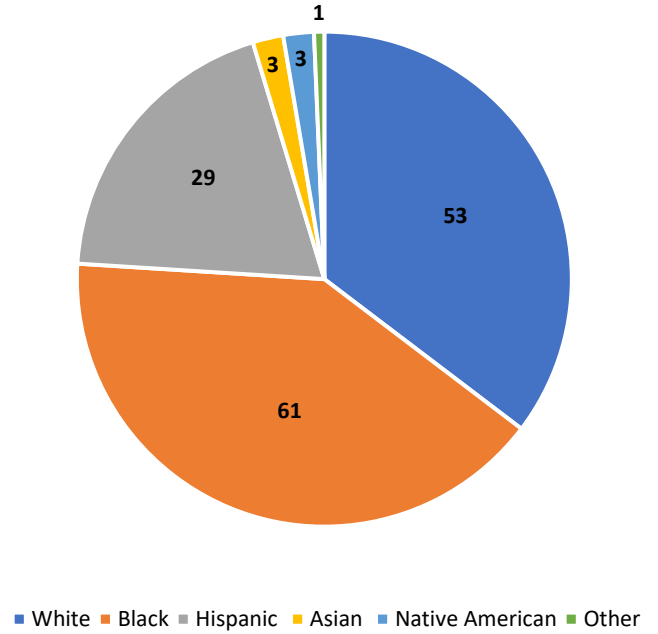


Fig 10c: Jail & Prison Deaths by Race, 2024
(182 incidents, 12 months ending Aug 31)

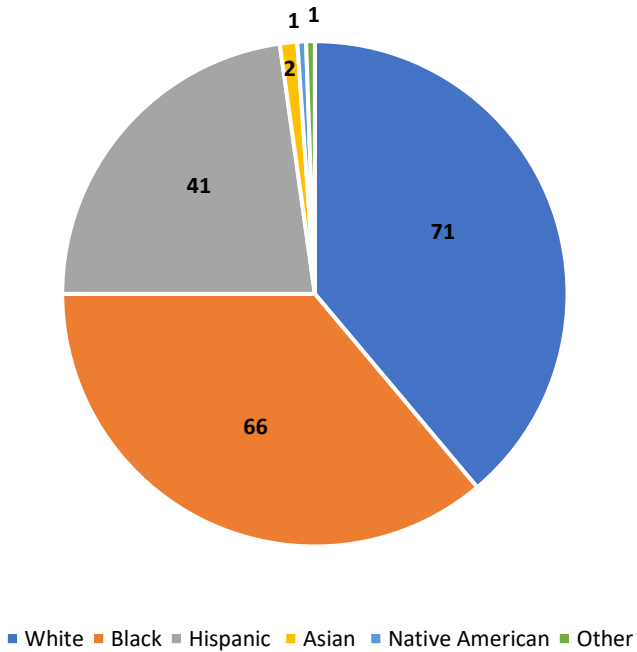


Fig 10d: Jail & Prison Deaths by Race, 2025
(164 incidents, 12 months ending Aug 31)

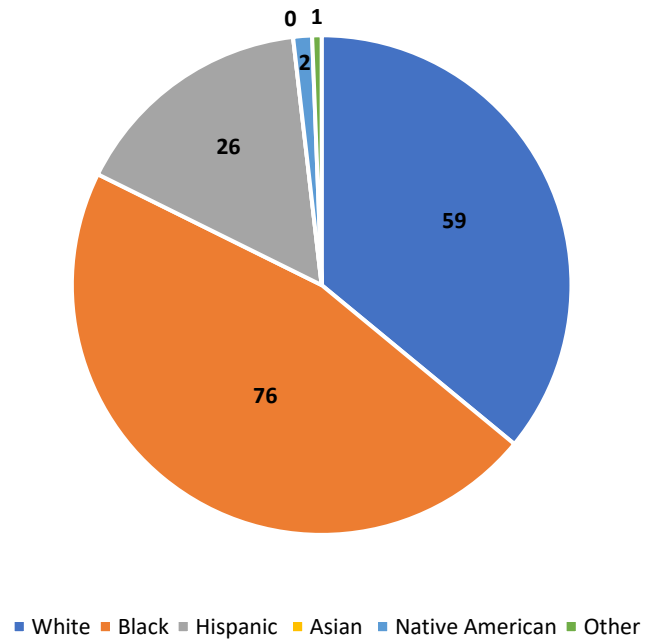
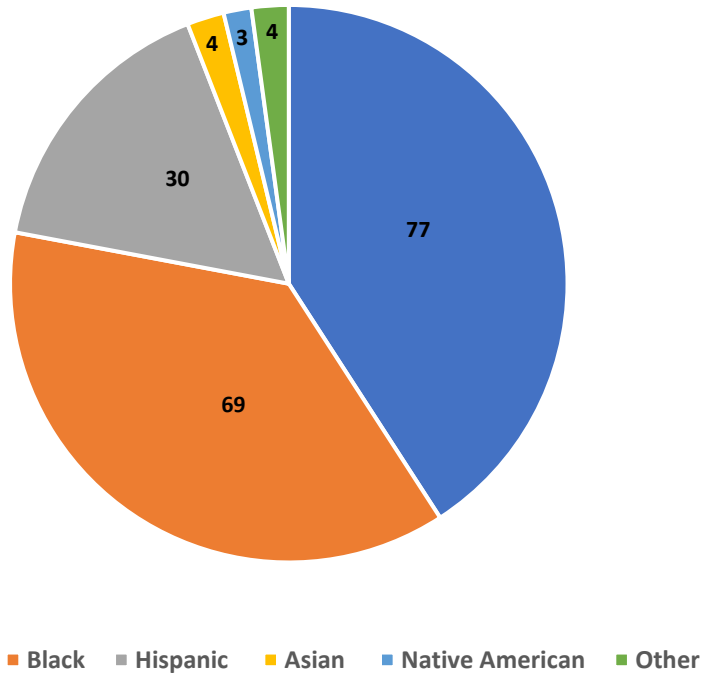


Fig 10e: Jail & Prison Deaths by Race, 2026
(187 incidents, 12 months ending Aug 31)



October 1, 2026