Office of the New York State Attorney General Letitia James

Office of Special Investigation

January 16, 2025

Report on the Investigation into the Death of Jose Mejia Martinez

SUMMARY

New York Executive Law Section 70-b (Section 70-b) authorizes the Attorney General's Office of Special Investigation (OSI) to investigate and, if warranted, to prosecute offenses arising from any incident in which the death of a person is caused by a police officer or peace officer. When, as in this case, OSI does not seek charges, Section 70-b requires issuance of a public report. This is the public report of OSI's investigation of the death of Jose Augusto Mejia Martinez, who died on June 10, 2021 from a drug overdose while incarcerated in the George R. Vierno Center (GRVC), a New York City Department of Correction (DOC) jail on Rikers Island, Bronx County.

OVERVIEW

On the morning and afternoon of June 10, 2021, in the section of GRVC where Mr. Mejia Martinez was incarcerated, Correction Officer Jonathan Padilla was the assigned "B" post (or floor) officer. From 11:15 a.m. through 11:44 a.m. surveillance video showed that Mr. Mejia Martinez grew increasingly disoriented and unsteady on his feet as he alternated between sitting, standing, and staggering around the housing area dayroom. Throughout this period CO Padilla was in close proximity to Mr. Mejia Martinez, had an unobstructed view of him, and likely observed him in his disorientated condition. At 11:56 a.m. video showed that CO Padilla watched Mr. Mejia Martinez inside a stairwell as he struggled to stand and used the railing for support. At 12:11 p.m. video showed that two people physically assisted Mr. Mejia Martinez into his cell as CO Padilla and another CO watched the interaction from the CO desk a few feet away. (In this report, references to a "person" or "people" mean incarcerated people, unless otherwise indicated.) Despite his training and DOC rules that required him to do so, CO Padilla did not call a medical emergency for Mr. Mejia Martinez or otherwise render aid, such as by administering Narcan. From 12:22 p.m. through 3:05 p.m. video showed that CO Padilla went to Mr. Mejia Martinez's cell nine times and looked inside, seeming to check on Mr. Mejia Martinez. At 3:38 p.m. video showed that other people seemed to become alarmed by Mr. Mejia Martinez's condition and alerted CO Padilla, who was in the control room. CO Padilla responded to Mr. Mejia Martinez's cell, seemed to understand the gravity of his condition, and began the process of obtaining medical aid. Although aid began at 3:44 p.m., Mr. Mejia Martinez was declared dead at 4:39 p.m.

The autopsy report stated the cause of Mr. Mejia Martinez's death as "acute methadone intoxication" and the manner of death as "accident (substance abuse)." The medical examiner, in an interview with OSI, would not opine on whether earlier medical intervention could have saved Mr. Mejia Martinez.

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

OSI concludes that CO Padilla failed to perform his duty to obtain medical care for Mr. Mejia Martinez when he saw Mr. Mejia Martinez increasingly disoriented and unsteady on his feet. CO Padilla's failure to call a medical emergency or otherwise render aid was legally an omission – a failure to perform a duty imposed by law – and therefore there is a substantial question whether CO Padilla caused Mr. Mejia Martinez's death by omission. An outstanding question whether an officer caused a death brings a case within the scope of Executive Law Section 70-b, which states, in part, that OSI "shall investigate and, if warranted, prosecute any alleged criminal offense committed by [an officer, as defined] … concerning any incident in which the death of a person, whether in custody or not, is caused by an act or omission of such [officer] or in which the attorney general determines there is a question as to whether the death was in fact caused by an act or omission of such [officer] [emphasis added]."

However, OSI concludes that a prosecutor would not be able to prove beyond a reasonable doubt at trial that CO Padilla's omission caused Mr. Mejia Martinez's death, and therefore would not be able to prove beyond a reasonable doubt that CO Padilla committed a crime. For this reason, OSI closes the matter with this report rather than by seeking criminal charges.

The New York City Board of Correction's "Report and Recommendations on 2021 Suicides and Drug-Related Deaths in New York City Department of Correction Custody," which addressed the death of Mr. Mejia Martinez, may be accessed here.

FACTS

Mr. Mejia Martinez arrived on Rikers Island on May 13, 2021, after being charged with Petit Larceny and pursuant to a parole hold. On May 26, 2021, Mr. Mejia Martinez was housed in Housing Area 9B at GRVC in general population and assigned to cell #1, a single occupancy cell on the lower tier of the housing area.

Medical Records

According to Mr. Mejia Martinez's Correctional Health Services (CHS) medical records from May 15, 2021 (CHS is part of the New York City Health + Hospitals Corporation), during his initial assessment he admitted to using cocaine and reported a prior mental health diagnosis; Mr. Mejia Martinez's urine toxicology upon admission was positive for cocaine. The intake clinician reviewed his electronic mental health records (from a system called PSYCKES) and prior DOC admissions records, which detailed an extensive history of hospitalizations for mental health and substance abuse, and diagnosed Mr. Mejia Martinez with Schizoaffective Disorder-Bipolar Type and Cocaine Abuse. He was housed in general population with mental health follow-up and prescribed daily medications related to his mental health.

Mr. Mejia Martinez was not prescribed methadone, which is a substitute drug for morphine and heroin. His urine toxicology was negative for methadone, and he denied taking methadone within the last year.

On June 10, 2021, at 5:47 a.m., Mr. Mejia Martinez requested a sick call visit through nursing telehealth for a scalp irritation. The records do not indicate whether he was seen by the medical staff for this condition.

DOC Staff Incident Reports

OSI reviewed the Incident Report Forms of Correction Officers Jonathan Padilla, Shakea Smith, Albert Fontecchio, Belinda Roberts, Jason Dixon, Luis Hernandez, Jr., Victor Luna, Augusto Delarosa, Wilson Rodriguez, Christopher Robinson, and Anneka Corlette, and Correction Captains Mohammed Islam, Beverley Fields, Aaliyah Kelly, Elana Miller, and Kemba Holder.

CO Padilla wrote in his incident report that on June 10, 2021, at 3:55 p.m., he was assigned to 9B and made a notification to the control room of a medical emergency for Mr. Mejia Martinez. According to his incident report, CO Padilla responded to Mr. Mejia Martinez's cell with CO Dixon and observed him "laying [sic] down with slow reaction and little movement" to verbal commands. CO Padilla said he stood by Mr. Mejia Martinez's cell and secured the area as CO Dixon and another CO performed chest compressions on Mr. Mejia Martinez until the medical staff arrived.

CO Smith wrote in her incident report that on June 10, 2021, at 11:55 a.m., she was assigned to "17 mini clinic" and went to 9B "to afford Inmate Mejia sick call." According to CO Smith, Mr. Mejia Martinez was sitting in the day room, refused the sick call, and went into his cell.

CO Fontecchio wrote in his incident report that on June 10, 2021 he was assigned to 9 Control for the 7:00 a.m. through 3:31 p.m. tour and, at 3:35 p.m., was relieved by CO Roberts. CO Fontecchio said, "Up until this time there was nothing unusual to report."

CO Roberts wrote in her incident report that on June 10, 2021, at 3:35 p.m., she arrived in the control room and was briefed on the day's events by CO Fontecchio and CO Padilla. While in the control room, CO Dixon entered from the B side. According to CO Roberts, at 3:36 p.m., a person came to the control room window on the B side and advised them of a medical emergency. CO Roberts said she told CO Dixon to confirm the medical emergency, that CO Dixon confirmed the medical emergency, and that she contacted the clinic while CO Dixon and CO Hernandez performed chest compressions on Mr. Mejia Martinez.

CO Dixon wrote in his incident report that on June 10, 2021, at 3:37 p.m., he and CO Hernandez were in 9B to escort persons to the main clinic when he was informed that Mr. Mejia Martinez was unresponsive. CO Dixon said he entered Mr. Mejia Martinez's cell and Mr. Mejia Martinez appeared to be unconscious. According to his incident report, CO Dixon requested a medical emergency and CO Hernandez began chest compressions on Mr. Mejia Martinez. CO Dixon and CO Hernandez continued chest compressions until the medical staff arrived and assumed medical care.

CO Hernandez wrote in his incident report that on June 10, 2021, at 3:35 p.m., he and CO Dixon went to 9B to escort inmates to the clinic and when they arrived CO Padilla called a

medical emergency for Mr. Mejia Martinez. According to CO Hernandez, Mr. Mejia Martinez was unresponsive and did not have a pulse and he, CO Hernandez, commenced chest compressions on Mr. Mejia Martinez.

CO Luna wrote in his incident report that on June 10, 2021, at 3:41 p.m., he was assigned to the main clinic security post when CO Roberts called to activate a medical emergency for Mr. Mejia Martinez, who was unresponsive in his cell. CO Luna said the medical emergency was activated and the medical staff left the clinic at 3:46 p.m.

CO Delarosa wrote in his incident report that on June 10, 2021, at 3:45 p.m., he escorted the medical staff to 9B and subsequently called urgent care and EMS.

CO Rodriguez wrote in his incident report that on June 10, 2021, at 4:00 p.m., he responded to a medical emergency in 9B, secured cell #1 for the medical staff, and assisted in securing the housing area.

CO Robinson wrote in his incident report that on June 10, 2021, at 4:30 p.m., he escorted paramedics to 9B and, at 4:50 p.m., the paramedics left the housing area.

CO Corlette wrote in her incident report that on June 10, 2021, at 4:00 p.m., she escorted Deputy Warden Morale to 9B for an unresponsive person; CO Corlette did not see the unresponsive person.

Capt. Islam wrote in his incident report that on June 10, 2021, he was assigned as the 7A, 7B, 9A, and 9B supervisor and that, at 9:30 a.m., he conducted a tour of the housing area with CO Padilla and was informed by CO Padilla that Mr. Mejia Martinez wanted to meet with him (Capt. Islam). Capt. Islam said he met with Mr. Mejia Martinez and they discussed an infraction. According to Capt. Islam, Mr. Mejia Martinez did not complain of any health issues. Capt. Islam said that, at 1:35 p.m., he conducted another tour of the housing area and was not advised by CO Padilla of any health issues concerning Mr. Mejia Martinez. According to Capt. Islam, he toured other housing areas and then returned to 9 Control for approximately one hour before leaving at 3:20 p.m. to escort a person to intake. Capt. Islam said while he was in intake with the other person, he became aware of the medical emergency in 9B. Capt.

Islam said during the hour he was in 9 Control CO Padilla never told him that Mr. Mejia Martinez was sick.

Capt. Fields wrote in her incident report that on June 10, 2021, at 3:46 p.m., she departed the clinic and responded to a medical emergency in 9B. Capt. Fields said when she arrived at Mr. Mejia Martinez's cell he was lying on his bed and the medical team was performing chest compressions on him. According to Capt. Fields, Dr. Okonta informed her that Mr. Mejia Martinez had a slight pulse and that the medical staff was unable to intubate him, prompting Capt. Fields to activate EMS.

Capt. Kelly wrote in her incident report that on June 10, 2021, she was the crime scene supervisor. Capt. Kelly documented relevant times pertaining to the crime scene in her report, including when the paramedics arrived, and when the crime scene was dismantled.

Capt. Miller wrote in her incident report that on June 10, 2021 CO Padilla was initially assigned to the 17C post but subsequently reassigned to 9B to relieve another CO. Capt. Miller said she did not authorize CO Padilla to exit the facility and that she left the facility at 10:00 a.m., relinquishing the post to Capt. Lindsay-Smith.

Capt. Holder wrote in their incident report that on June 10, 2021 they were assigned to central control and provided a timeline of the events from 3:37 p.m., when the medical emergency was activated in 9B, to 4:39 p.m., when Mr. Mejia Martinez was declared dead.

Interviews of DOC Correction Officers

OSI interviewed Correction Officers Shakea Smith, Albert Fontecchio, Belinda Roberts, Louis Hernandez, and Victor Luna. Raoul Zaltzberg, Esq., of Joey Jackson Law, the law firm that represents members of the Correction Officers' Benevolent Association (COBA), advised DOC that CO Padilla declined to be interviewed by OSI. James Frankie, Esq., of Frankie & Gentile, P.C., the law firm that represents members of the Correction Captains' Association, advised DOC that Capt. Islam declined to be interviewed by OSI.

CO Shakea Smith said she was working the 8:00 a.m. through 4:00 p.m. shift in the clinic as a clinic escort and that she saw Mr. Mejia Martinez at 9:00 a.m. when he asked for a medical

visit. CO Smith said that she told Mr. Mejia Martinez he had to wait until 12:00 p.m. According to CO Smith, she came back to the housing area at 12:00 p.m., saw Mr. Mejia Martinez sitting at a table, and told him she was ready to take him to the clinic. CO Smith said he did not respond and that another person told her that Mr. Mejia Martinez did not want medication, that he just took some methadone. The person held Mr. Mejia Martinez's arm and walked him to his cell. CO Smith said Mr. Mejia Martinez's head was down and she thought he was high on the methadone. CO Smith went on to say that nurses were in the bubble giving out methadone, that it was not unusual for persons to be high on methadone, and that Mr. Mejia Martinez "looked normal high." CO Smith said CO Padilla pointed out Mr. Mejia Martinez to her, but no discussion was had about him.

CO Albert Fontecchio said he was working the "bubble" (the control room) during CO Padilla's shift and "did not see anything to cause an alarm or medical emergency," any evidence of "any inmates assisting another inmate," or any persons smoking during his shift. He said he was relieved by CO Roberts and "no inmate came to the window" when he and CO Roberts were in the bubble together.

CO Belinda Roberts said she entered the area to relieve CO Fontecchio from "the bubble" around 3:30 p.m., and that CO Fontecchio, CO Padilla, and she were debriefing the day's events when CO Dixon entered the post. She said an individual came to the window of the post on the B side and told the officers to call a medical emergency. She said CO Dixon went to cell #1, assessed Mr. Mejia Martinez, and called a medical emergency. She said she spoke to the clinic as COs Dixon and Hernandez performed chest compressions on Mr. Mejia Martinez. CO Roberts said CO Padilla claimed he was watching Mr. Mejia Martinez, but she questioned whether that was true. According to CO Roberts, "Padilla was in the bubble, not actually watching the inmate," and she recalled "Padilla coming back to the bubble" and telling him that she thought he was watching Mr. Mejia Martinez. CO Roberts said Padilla just looked at her in response. CO Roberts said she was "trained for medical emergencies but it's really a personal thing" as to whether a CO will intervene in an emergency. She went on to say that if she sees a person high she would always call medical, and that she has called medical in the past for persons that appeared "high."

CO Louis Hernandez told OSI that he and CO Dixon were partners, and that CO Padilla sought his and CO Dixon's help when they were in the bubble between 3:35 p.m. and 3:40 p.m. He said CO Dixon called for a medical emergency and then he and CO Dixon went to Mr. Mejia Martinez's cell. CO Hernandez said he attempted CPR, but found no pulse, and that Mr. Mejia Martinez "felt cold." He instructed CO Dixon to continue chest compressions while he returned to the bubble to call for more assistance. CO Hernandez said that in his experience "inmates do take drugs and are high," that he has overruled a person's refusal of emergency medical assistance, and that COs are trained to get assistance for someone in distress. According to CO Hernandez, their training dictates that you are required to get medical assistance for someone in distress. He said if an inmate is not alert or responding, the CO should attempt to speak with the inmate, assess the situation, and call medical if necessary.

CO Victor Luna said that he was instructed by his supervisor to report to Upper 9 to assist with a medical emergency and that when he arrived the medical team was already in the cell trying to revive Mr. Mejia Martinez. CO Luna said that "when an inmate is seen in distress medical must be called" and that he didn't know if that "was taught in the academy but as a human being [he] would call medical." He also related that "Padilla was scared and looking around" and asked if Mr. Mejia Martinez was okay.

Search of Mr. Mejia Martinez's Cell

On June 10, 2021 OSI Detective Brian Metz was present in GRVC cell #1, Mr. Mejia Martinez's cell, when DOC Investigation Division (ID) Investigators Patel and Delgado searched the cell and recovered the following:

1. a blue asthma pump;
2. white 4mg Narcan nasal spray;
3. clothing;
4. shoes;
5. food;
6. artwork;
7. parole documentation;
8. three paper cups containing unidentified pills;
9. one black sharpened piece of plastic, approximately eight inches long.

Interviews of Incarcerated People

OSI interviewed six people: JM, CV, CU, GC, KC, and KG. (OSI does not publish the names of civilian witnesses.) OSI also reviewed the written statements they gave to DOC ID.

JM told OSI he took Mr. Mejia Martinez to his cell and that the "CO locked him in." He also said that earlier in the day Mr. Mejia Martinez was "approached by sick call from the day before," but "Mejia refused" and "said come back later" when CO Smith was at the desk. In his written statement to DOC ID, JM said Mr. Mejia Martinez was high and dozing off at the table at around 2:00 p.m. so he and another inmate took Mr. Mejia Martinez to his cell, put him on his bed, took off his shoes, and left the cell; at 3:00 p.m., the CO was conducting his tour and found Mr. Mejia Martinez in his cell; JM believed Mr. Mejia Martinez was high on methadone.

CV told OSI he and JM walked Mr. Mejia Martinez to his cell and that Mr. Mejia Martinez could not speak at that time. He said he was upstairs when he heard CU yell "he's dead." CV believed that Mr. Mejia Martinez mixed drugs and said that everyone in that housing area smoked. In his written statement to DOC ID, CV said he saw Mr. Mejia Martinez dozing off; he helped the other inmate take him to his cell.

CU told OSI he was told that Mr. Mejia Martinez was not feeling well at around 9:00 a.m. or 10:00 a.m., but CO Padilla told Mr. Mejia Martinez to go into his cell to rest. He said he "touched [Mr. Mejia Martinez] and shook him," his "body was pale," his arm was "cold," and his "lips were white like he was dehydrated." In his written statement to DOC ID, CU said, "At 3pm, I went to check on my bro. He was cold and I told the officer on the floor."

GC told OSI he was one of the incarcerated persons who carried Mr. Mejia Martinez to his cell. According to GC, CO Padilla asked what was going on with Mr. Mejia Martinez when he was being led to his cell; GC told him that Mr. Mejia Martinez was alright, and CO Padilla left. He said he checked on Mr. Mejia Martinez and his heart was racing and he was sweating. GC said he went to the bubble, but the female CO didn't believe there was really an emergency and "waited about five minutes or so, and when inmates started to get agitated and threatened to hit the glass with garbage cans," she called medical. GC said the "Spanish officer" was "intimidated and didn't know to call ESU" because he was afraid inmates would

retaliate. GC said when he and JM walked Mr. Mejia Martinez to his cell the officers may have seen, but he did not know if the COs saw Mr. Mejia Martinez acting disoriented. According to GC, he and JM checked on Mr. Mejia Martinez as CO Padilla stood outside the cell and they then went to the bubble and slammed on the window. CO Padilla stood outside the cell as CO Dixon and another CO performed chest compressions and then left to retrieve Narcan.

KC told OSI CO Padilla told the COs in the bubble that Mr. Mejia Martinez was ill when he was taken to his cell, but the COs didn't do anything and "told inmates that they were too short staffed to bring [Mr. Mejia Martinez] to the clinic."

KG told OSI he did not see Mr. Mejia Martinez nod off or see when he was taken to his cell but went to check on Mr. Mejia Martinez when he heard from another incarcerated person that he was dead. When he went into the cell Mr. Mejia Martinez was on his back and unresponsive; KG lifted his hand, and it dropped straight down. He said he told the CO to call medical, but the CO thought they were joking so the CO checked on Mr. Mejia Martinez and then called medical. After Mr. Mejia Martinez was discovered unresponsive, KG heard CO Padilla say "I should have left him outside. I never should have told them to put him in his cell."

Interviews of Correctional Health Services Staff

OSI interviewed Dr. Benjamin Okonta, Dr. Carol Comas, and Physician Assistant Nana Asare.

Dr. Okonta said he responded to the medical emergency alert and, when he got to the cell, Mr. Mejia was lifeless and clammy, had no pulse, was "pale, no signs of life, cold" and was not breathing. He did not believe Mr. Mejia Martinez died shortly before his arrival because his "jaw was stiff already—sign of rigor." Dr. Okonta said he performed chest compressions on Mr. Mejia Martinez and administered Narcan; he said a defibrillator was not used because it was "not applicable."

P.A. Asare told OSI that when the emergency call came in she was in the clinic and went immediately to the cell with one nurse. When she arrived CPR was in process and "alternative nurses" were doing compressions; soon after, she got IV access. She said when she was at

the cell the monitor showed "flat line" which she took to mean Mr. Mejia Martinez was "most likely dead."

Dr. Comas told OSI that when she arrived at the cell there were already several people present, including the warden, CPR was in progress, and Mr. Mejia Martinez's body was "lifeless." Dr. Comas said she attempted to intubate Mr. Mejia Martinez but could not open his jaw. She said if there were an earlier call she might have been able to intervene with "medication or IV to stabilize and transport to the hospital because methadone can be reversed with Narcan if early enough." Dr. Comas said if she sees an inmate that appears to be high on drugs she would take their vitals, administer Narcan, and the patient should be sent to a hospital emergency room for treatment. She said a person that is wobbly, unable to stand, or talk, should elicit a medical emergency. According to Dr. Comas, she saw Mr. Mejia Martinez two days prior to his death and prescribed him an albuterol pump. (The pump was found in the cell during the search, as noted above.)

Dr. Comas explained, during a subsequent interview, that a medical emergency requires the staff to respond to the location of the emergency, the inmate is not brought to the clinic. According to Dr. Comas, when the medical staff suspects that an inmate is high they administer Narcan. Regarding the effects of methadone, Dr. Comas said the focus is on a person's opioid tolerance. She explained that opioid use builds tolerance to methadone, while a small dose can be fatal to a patient who is "methadone naïve." Dr. Comas said Narcan should be administered as soon as possible to be effective and that Narcan can be administered to a conscious person. When asked if Mr. Mejia Martinez could have survived the fatal dose of methadone in his system if he received medical attention sooner, Dr. Comas was not able to provide a response because, as she explained, the answer was dependent on Mr. Mejia Martinez's opioid tolerance level.

Logbook Review

OSI reviewed the logbook entries made in GRVC's "9B" logbook. On June 10, 2021, at 9:00 a.m., CO Padilla assumed the GRVC 9B B post (the floor post, as opposed to the A post or control room post) and noted in the "9B" logbook, "Active supervision tour conducted all doors are unsecure at this time." CO Padilla's subsequent logbook entries state he conducted an

active supervision tour every thirty minutes from 9:30 a.m. through 3:00 p.m., noting that all doors were either "obstructed," or "unsecure," for each tour. At 12:00 p.m., CO Smith made an entry in the logbook which read, "C/O Smith #6463 on post affording medical services. Individual Mejia, Jose refused." According to CO Luna's logbook entries, at 3:37 p.m., a medical emergency was called for Mr. Mejia Martinez and, at 3:45 p.m., the medical staff arrived.

On June 10, 2021, at 7:00 a.m., CO Fontecchio assumed the GRVC 9 Control post and his logbook entries in the "9 Control" logbook state that, at 7:30 a.m., he conducted a general supervision tour with nothing unusual to report, and, every thirty minutes from 8:00 a.m. through 3:30 p.m., he conducted an active supervision tour with nothing unusual to report. At 3:32 p.m., CO Fontecchio wrote, "CO Fontecchio #8996 off post relieved by CO Roberts #1106."

On June 10, 2021, at 3:37 p.m., CO Roberts's logbook entry in the "9 Control" logbook states, "Medical Emergency called by Officer Dixon. Roberts #1106 on 9 control. Just arrived when floor officer stated called medical emergency D.O.T. Officer Dixon went to check cell (1) B side Mejia Jose…This writer called clinic to tell medical emergency to come quickly." According to CO Roberts's logbook entry the medical staff arrived at 3:45 p.m.

Surveillance Video Review

Surveillance video from Mr. Mejia Martinez's housing area showed the housing area and the cell doors but did not provide a direct view into cell interiors; the video did not have audio. The following is a summary of surveillance video from June 10, 2021, beginning at 10:08 a.m.:

- 10:08 a.m.: Mr. Mejia Martinez and another person, each holding a cup, stood next to a table in the dayroom; the person poured the contents of his cup into Mr. Mejia Martinez's cup; Mr. Mejia Martinez put his finger in his cup, seemingly stirred the contents, and drank from the cup. CO Padilla and another CO stood next to the CO post desk a few feet away.
- 11:15 a.m.: Mr. Mejia Martinez stood next to a table in the dayroom, rubbed his eyes and face, and appeared unsteady on his feet. CO Padilla was seated at the CO post desk a few feet away.

- 11:20 am: Mr. Mejia Martinez continuously rubbed his face and swayed his body as he stood in the middle of the dayroom for several minutes. CO Padilla was in the dayroom a few feet behind him.
- 11:26 a.m.: Mr. Mejia Martinez sat down at a table in the dayroom, rested his elbows on the table, and propped his head up with his hands. CO Padilla stood directly in front of Mr. Mejia Martinez.
- 11:27 a.m.: as Mr. Mejia Martinez walked toward the dayroom staircase he appeared unsteady on his feet and continuously rubbed his face with his hands. CO Padilla was in the dayroom.
- 11:32 a.m.: Mr. Mejia Martinez continuously rubbed his face and swayed his body as he stood in the middle of the dayroom for several minutes before he sat down at a table. CO Padilla was seated at the CO post desk a few feet away.
- 11:42 a.m.: Mr. Mejia Martinez sat at a table in the dayroom, hunched over with his elbows on the table and his head in his hands. He appeared to fall asleep and started to slip off the seat before he adjusted himself. CO Padilla walked around the dayroom a few feet away.
- 11:43 a.m.: Mr. Mejia Martinez stood in the middle of the dayroom, swayed from left to right, appeared as if he was about to fall but steadied himself, then walked past the CO post desk. CO Padilla was at the CO post desk. Several people were in the dayroom and appeared to watch Mr. Mejia Martinez.
- 11:44 a.m.: Mr. Mejia Martinez entered a stairwell and used both the left and the right handrails as he walked up the stairs. When he arrived at the top of the stairs he leaned over the railing, held his head in his hands, could barely stand up straight, and used the railing for support.
- 11:47 a.m.: Mr. Mejia Martinez, while still in the stairwell, continuously swayed and nearly fell several times; he continued to use the railing for support.
- 11:54 a.m.: a medical team entered the housing area with two COs.
- 11:55 a.m.: a person spoke with Mr. Mejia Martinez in the stairwell.
- 11:56 a.m.: CO Padilla entered the stairwell, appeared to speak with another person in the stairwell, stared at Mr. Mejia Martinez for several seconds as Mr. Mejia Martinez

was noticeably unsteady on his feet and using the railing for support, and left the stairwell without Mr. Mejia Martinez.

- 11:57 a.m.: CO Padilla returned to the housing area and walked out of the housing area with the medical staff.
- 12:02 p.m.: a person entered the stairwell, grabbed Mr. Mejia Martinez by the arm, assisted him down the stairs, and sat him at a table in the dayroom.
- 12:04 p.m.: CO Padilla returned to the housing area and sat at the CO post desk in the dayroom.
- 12:04 p.m.: Mr. Mejia Martinez sat at the table, hunched over, with his head nestled in his hands. CO Padilla sat at the CO post desk nearby.
- 12:10 p.m.: a CO entered the housing area and sat at the CO post with CO Padilla.
- 12:11 p.m.: two people grabbed Mr. Mejia Martinez by each arm, lifted him from his seat, and walked him to his cell. Mr. Mejia Martinez's cell, cell #1, was the cell closest to the CO post desk. CO Padilla and another CO were at the post desk and appeared to watch as people physically escorted Mr. Mejia Martinez to his cell.
- 12:12 p.m.: the second CO left the housing area; CO Padilla remained at the CO post desk.
- 12:22 p.m.: CO Padilla looked into Mr. Mejia Martinez's cell through the cell door window and walked away.
- 12:23 p.m.: CO Padilla looked into Mr. Mejia Martinez's cell through the cell door window, walked away, and sat at the CO post desk.
- 12:36 p.m.: a person looked into Mr. Mejia Martinez's cell through the cell door window.
- 12:56 p.m.: three COs entered the housing area and stood at the CO post desk with CO Padilla.
- 1:02 p.m.: the three COs left the housing area; CO Padilla remained at the CO post desk.
- 1:06 p.m.: a person looked into Mr. Mejia Martinez's cell through the cell door window.
- 1:16 p.m.: CO Padilla looked into Mr. Mejia Martinez's cell through the cell door window and walked away.

- 1:18 p.m.: CO Padilla looked into Mr. Mejia Martinez's cell through the cell door window and walked away.
- 1:25 p.m.: a person knocked on Mr. Mejia Martinez's cell door and looked into the cell through the cell door window.
- 1:34 p.m.: two people looked into Mr. Mejia Martinez's cell through the cell door window.
- 1:47 p.m.: CO Padilla looked into Mr. Mejia Martinez's cell through the cell door window and walked away.
- 2:30 p.m.: a person looked into Mr. Mejia Martinez's cell through the cell door window, walked over to CO Padilla at the CO post desk, and both walked back to Mr. Mejia Martinez's cell and opened the door. CO Padilla stood in the doorway holding the cell door open with his body as the person went into the cell. CO Padilla did not enter the cell.
- 2:31 p.m.: the person walked out of Mr. Mejia Martinez's cell and CO Padilla locked the door.
- 2:34 p.m.: CO Padilla looked into Mr. Mejia Martinez's cell through the cell door window and walked away.
- 2:53 p.m.: CO Padilla looked into Mr. Mejia Martinez's cell through the cell door window, turned around, started to walk away, turned back, and looked into the cell again.
- 3:05 p.m.: CO Padilla looked into Mr. Mejia Martinez's cell through the cell door window and walked away.
- 3:16 p.m.: CO Padilla left the housing area and entered the control room.
- 3:38 p.m.: a person entered Mr. Mejia Martinez's cell, came out two minutes later, spoke with other people in the dayroom, and several people went into Mr. Mejia Martinez's cell.
- 3:42 p.m.: a person came out of Mr. Mejia Martinez's cell and walked over to the control room. Several people remained in and around Mr. Mejia Martinez's cell.
- 3:42 p.m.: CO Padilla entered Mr. Mejia Martinez's cell, rushed out of the cell, ran to the control room, and returned to the cell.

- 3:43 p.m.: two COs entered the housing area and walked over to Mr. Mejia Martinez's cell.
- 3:44 p.m.: CO Padilla walked out of Mr. Mejia Martinez's cell and the two COs entered the cell.
- 3:53 p.m.: the medical staff arrived.
- 4:51 p.m.: the medical staff left the housing area without Mr. Mejia Martinez.

Discipline of DOC Correction Officers by NYC DOC

CO Jonathan Padilla

On July 11, 2021, DOC placed CO Padilla on modified duty prohibiting inmate contact and the possession of a personal firearm.

DOC initiates departmental disciplinary proceedings against DOC uniformed staff members with a memorandum of complaint (MOC). On August 2, 2022, DOC filed an MOC against CO Padilla alleging he "failed to efficiently perform [his] duties and provide care, custody, and control to PIC Mejia" [PIC means person in custody]. The MOC filed against CO Padilla cited the following Rules and Regulations:

> 2.30.010: Correction Officers shall be held responsible for safety, sanitation, and security of their posts, for the proper care, custody, control and treatment of inmates, and the enforcement of the Rules and Regulations of the Department and the command;
>
> 3.05.120: Members of the Department are responsible for the efficient performance of their duties and for the proper supervision of any inmates under their direction;
>
> 3.20.030: Members of the Department found guilty of any of the following offenses may be dismissed from the Department or suffer such other punishment as the commissioner may direct. 1. Violation of the rules and regulations, 2. Failure to abide by the provisions of any order;
>
> 3.20.300: Though not specifically mentioned in these rules and regulations, all behavior which threatens the good order and discipline and all conduct of a nature to

> bring discredit upon the Department shall be acted upon by the Department according to the nature and degree of the offense and punished at the discretion of the Commissioner.

On November 16, 2022, DOC filed formal charges and specifications against CO Padilla, charging that he violated the rules cited in the MOC as well as these additional rules:

> 3.20.010: Members of the Department shall present a professional demeanor and as an employee of the City of New York shall act in a dignified manner;
>
> 7.10.040: Whenever an inmate complains or appears to be injured or sick, prompt action shall be taken to ensure that the inmate is examined by authorized medical personnel.

On June 16, 2023, in satisfaction of all disciplinary charges, CO Padilla resigned from his position as a correction officer with the DOC pursuant to a negotiated agreement.

CO Shakea Smith

On August 2, 2022, DOC filed an MOC against CO Smith alleging that CO Smith provided false and misleading statements in her incident report when she claimed she offered Mr. Mejia Martinez a sick call service and that he refused. According to the MOC, CO Smith did not interact with Mr. Mejia Martinez. The MOC also alleged that CO Smith "failed to efficiently perform her duties and provide care to PIC Mejia" when he was slumped over a table and escorted to his cell by other people. The MOC cited the following Rules and Regulations:

> 3.05.120: Members of the Department are responsible for the efficient performance of their duties and for the proper supervision of any inmates under their direction;
>
> 3.20.030: Members of the Department found guilty of any of the following offenses may be dismissed from the Department or suffer such other punishment as the commissioner may direct. 1. Violation of the rules and regulations, 2. Failure to abide by the provisions of any order, 5. Making a false official statement;

3.20.300: Though not specifically mentioned in these rules and regulations, all behavior which threatens the good order and discipline and all conduct of a nature to bring discredit upon the Department shall be acted upon by the Department according to the nature and degree of the offense and punished at the discretion of the Commissioner;

4.30.020: Members of the Department shall not make any false entries or notations or render any false reports concerning the business of the Department;

8.05.030: Members of the Department, either individually, collectively or through an organization, shall not issue any verbal or written statement embodying misleading, or false information.

On January 3, 2023, DOC filed formal charges and specifications against CO Smith, charging violations of Rules and Regulations 2.30.010, 3.05.120, 3.20.010, 3.20.030, and 7.10.040. As of the date of this report, the disciplinary proceedings against CO Smith are still pending.

First Aid Training for Correction Officers

OSI interviewed the DOC academy's first-aid instructor, Christopher Hennessey, in connection with another case. Instructor Hennessey said that COs are given eight hours of first-aid training while in the academy, provided a first-aid manual, and shown a training video; a refresher course is given every two years after recruits graduate from the academy. OSI was provided with a copy of the first-aid manual and training video, which are not specific to correctional institutions and do not provide guidance on the use of Narcan or treatment for drug overdose.

The training is primarily focused on CPR, AED and first aid. New recruits are given a DOC Learner Guide for medical emergencies and a CPR/First Aid & Medical Emergencies handout; these are specific to medical emergencies in DOC facilities and reference DOC rules and regulations. The CPR/First Aid & Medical Emergencies handout provides an overview of the procedures staff are to follow when presented with a medical emergency, which are to call the medical staff and a supervisor, commence CPR until medical staff arrive, and make a logbook entry of the incident. The Learner Guide defines a medical emergency as a "sudden injury, illness, or ailment that requires immediate medical attention; condition that, if not treated

with prompt medical care, could be life-threatening," and includes "suspected overdose" in a list of examples.

The Learner Guide lists situations that warrant medical attention, including disorientation, and advises correction officers on the appropriate response to medical emergencies: officers are to contact the medical unit and their supervisors, perform CPR if appropriate, clear the incident area, make logbook entries, and complete an incident report.

Instructor Hennessey said correction officers are trained to always call medical in a medical emergency. The only time officers are instructed to render aid is when a person is hanging from a ligature (the officer must cut the ligature) or is unresponsive (the officer must perform CPR and administer Narcan). Instructor Hennessey said officers are trained to look for signs of overdose when tending to an unresponsive person, namely blue tinted skin and not breathing; officers are trained on the use of Narcan for suspected overdose. Instructor Hennessy said officers are trained to administer Narcan only to unconscious people, or to people who have requested it. He said if a person appears "high," the officers are to monitor the person and "keep an eye" on them. According to Instructor Hennessey the officers are not trained on the signs of intoxication short of overdose, either by drugs or alcohol, and the only guidance they are provided on disorientation is to call the medical staff. Instructor Hennessy acknowledged that drugs are prevalent in the facility and that officers have complained that far too often many incarcerated people appear to be under the influence of controlled substances.

DOC Rules on Medical Intervention by Correction Officers

The following DOC Rules and Regulations, among others, govern medical intervention by correction officers:

> 7.05.010: "It shall be the duty of members of the Department to look after the inmate's welfare and to ensure that the inmates receive proper food, clothing, and medical treatment. . . . Complaints made by inmates with regard to their welfare shall be investigated and reported immediately to a superior officer".

7.05.060: “The officer taking the count must observe ‘signs of life’ in each inmate on the post. A sign of life is any observation of the inmate that assures the officer the inmate is alive. For example, the rise and fall of the chest indicating the inmate is breathing, snoring, or some body movement, etc. If, after observing the inmate, no such ‘sign of life’ is observed, the officer is to make a reasonable attempt to obtain such a sign. This can be accomplished by making noise, such as jiggling keys or tapping cell bars/windows. The officer must continue these efforts until it is assured that the inmate is alive. If the officer reaches a point in these efforts where the officer feels the inmate may be in need of medical attention/assistance, the officer will alert the officer on post to notify the Control Room Captain and request medical assistance. The officer conducting the count shall remain in close proximity of the inmate or the inmate's cell, in order to keep the inmate under close observation, and shall render emergency first-aid as appropriate. The Control Room Captain shall direct immediate notification to a member of the medical staff and a superior officer to report to the area concerned”.

7.10.040: “Whenever an inmate complains or appears to be injured or sick, prompt action shall be taken to ensure that the inmate is examined by authorized medical personnel. In instances where there are no authorized medical personnel within the facility, an ambulance shall be summoned. In the event that the urgency of the situation precludes first notifying a supervisor because a delay in obtaining medical treatment could cause a worsening of the inmate’s condition, the member of the Department shall take action to ensure that the inmate is examined by authorized medical personnel and shall notify the supervisor as soon as possible, either while the inmate is being treated or immediately thereafter. In an emergency situation, when time is of the essence, the member of the Department shall contact authorized medical personnel or, where there are no authorized medical personnel within the facility, an ambulance. (Emergency health care is defined as any circumstance, other than the standard sick call or follow-up, necessitating a face-to-face encounter between medical staff and an inmate patient, to prevent loss of life, disfigurement and/or placing of an inmate in imminent danger.)”

DOC Directive 4516R-D: "Injury to Inmate Reports" states in part: "Inmates who appear to have any of the following conditions or complain of any of these conditions must be brought directly to the Clinic location for medical attention and shall not be escorted to any intake location:

a. Loss of Consciousness
b. Respiratory or Breathing Issues
c. Seizures
d. Fractures
e. Swelling and/or Bruising to the Head or Face
f. Bleeding from the Head or Face
g. Bleeding from Eyes or Ears
h. Any bleeding that appears excessive to a reasonable person
i. Disorientation
j. Any other Class A injury as defined in Directive 5006R-D, 'Use of Force.'"

DOC Directive 4517R: "Inmate Count Procedures: <u>During all inmate counts, officers must observe each inmate for signs of life</u>. A sign of life is any behavior that assures the officer that the inmate is alive. Signs of life include breathing (chest rising and falling), audible cues such as snoring, and other bodily movements. Absent an observable sign of life, officers may make reasonable attempts to stir an inmate such as making noise, tapping on the cell, window or bed frame, jingling keys, shining a flashlight above the inmate's head, and/or calling the inmate by name. If, at any time, an officer deems an inmate is not exhibiting any signs of life or may be in need of medical attention, the officer will immediately alert the other officer(s) on post (or the nearest officer), who shall immediately notify the control room captain and request medical assistance. The counting officer shall remain in close proximity to the inmate's cell or bed, keep the inmate under close observation, and render emergency first aid as appropriate. Officers must be alert for any indication that the inmate may be attempting to lure him/her to open the cell as a ploy to injure a staff member or another inmate. The control room captain shall ensure immediate notification is made to facility medical staff and then the area's direct supervisor to report to the area. The control room captain shall then immediately notify the tour commander."

DOC Directive 4021: "Constant Supervision" states in part: "The Department shall place individuals in custody under Constant Supervision in order to protect the health and safety of the individuals in custody or the good order of the facility." The following criteria are noted:

"1. Individuals in custody may be placed on Constant Supervision due to:
   a. Self-harm, risk of self-harm, suicide attempt or threat of;
   b. Recent substance use or abuse, either stated or witnessed;
   c. Medical status;
   d. Mental Health status; or
   e. Security concerns.
2. Placement may be based on past history, current presentation or behavior, and/or the inmate's own verbal statements.
3. The individual shall be evaluated by Health Services Clinical Staff to determine if Constant Supervision is required."

The procedures for identifying individuals at risk and in need of constant supervision indicate that "staff shall conduct routine tours of their assigned posts, observing the individuals in their custody for unusual incidents, behavior, or conditions. During tours of inspection, staff must remain alert for any behavior displayed by an inmate that may indicate the need for an evaluation for Constant Supervision."

Autopsy

Dr. Sophia Rodriguez, Medical Examiner with the New York City Office of Chief Medical Examiner (OCME), performed the autopsy of Mr. Mejia Martinez. The autopsy report states the cause of death as "acute methadone intoxication" and the manner of death as "accident (substance use)." Toxicology results show that the concentration of methadone in Mr. Mejia Martinez's blood was 653 ng/mL.

OSI interviewed Dr. Michael Greenberg, Medical Examiner with OCME. Dr. Greenberg said the approximate time Mr. Mejia Martinez ingested the methadone cannot be determined, but Mr. Mejia Martinez's observed intoxication—beginning between 11:00 a.m. and 11:30 a.m.—indicates that he likely consumed the methadone shortly before 11:00 a.m. According to Dr.

Greenberg, a fatal dose of an opioid, like methadone, is dependent on one's tolerance to that drug, as well as their age and weight. Dr. Greenberg opined that methadone is one of the more difficult drugs to interpret. He said the fatal range for methadone is 400 to 1800 ng/mL but explained that the range overlaps with its normal dosage level because of the factors previously mentioned (tolerance, weight, and age). Dr. Greenberg said that while the concentration in Mr. Mejia Martinez's blood, 653 ng/mL, was high and within the fatal range, and certainly a fatal dose for him, many individuals have survived higher dosage levels. Regarding the use of Narcan, Dr. Greenberg said it can be administered to unconscious individuals to counteract the effect of an opioid and prevent cardiac arrest, but, he said, a person could have a quantity of methadone in their system that is too high to counteract with Narcan. Dr. Greenberg said the sooner Narcan is administered the more likely it is to be successful, but also said there is no way to determine precisely how soon after ingesting the drug a person would need to take Narcan for it to be successful. When asked about Mr. Mejia Martinez's likelihood of survival had he been administered Narcan promptly, Dr. Greenberg said there was no way to know if Narcan would have saved his life.

LEGAL ANALYSIS

Under Penal Law 125.10, "A person is guilty of criminally negligent homicide when, with criminal negligence, he causes the death of another person."

"Criminal negligence" is defined in Penal Law Section (PL) 15.05(4): "A person acts with criminal negligence with respect to a result [in this case, death] ... when he fails to perceive a substantial and unjustifiable risk that such result will occur .... The risk must be of such nature and degree that the failure to perceive it constitutes a gross deviation from the standard of care that a reasonable person would observe in the situation."

A person can be convicted of criminally negligent homicide for an "omission" when the person (1) failed to perform an act as to which a duty of performance is imposed by law, which is the definition of "omission" in PL 15.00 (3); (2) the failure of performance was blameworthy conduct that created or contributed to a substantial and unjustifiable risk that a person's death would occur, *NY Criminal Jury Instructions 2d* on PL 125.10, and *People v Cabrera*, 10 NY3d 370, 376 (2008); (3) the blameworthy conduct was in fact a contributory cause of the

person's death, *People v Fitzgerald*, 45 NY2d 574, 579 (1978); (4) the person's death was a reasonably foreseeable result of the conduct, *People v Stan XuHui Li*, 34 NY3d 357, 369 (2019); and (5) the defendant's failure to perceive the risk of death was a gross deviation from the standard of care of a reasonable person, *Cabrera* at 376.

Duty

As mentioned, an omission is a failure to perform a duty imposed by law. The Court of Appeals has held that the state and its agents have a duty of care to the persons in their custody. *Sanchez v State of New York*, 99 NY2d 247, 250 (2002) ("having assumed physical custody of inmates, who cannot protect and defend themselves in the same way as those at liberty can, the State owes a duty of care to safeguard inmates"). This duty of care is found in the Correction Law, which explicitly states that the chief administrator of a jail has a duty to "receive and safely keep…each person lawfully committed to his custody." Correction Law Section 500-c. The Correction Law also requires that each facility be established and maintained with "due regard to the health and safety of every person in the custody of the department" and "the right of every person in the custody of the department to receive humane treatment." Correction Law Section 70. The duty of care is further defined in the regulations established by the local correctional facilities. As described above, DOC Rules and Regulations 7.05.010 states, "It shall be the duty of members of the Department to look after the inmate's welfare and to ensure that the inmates receive proper food, clothing, and medical treatment," and 7.10.040 states, "Whenever an inmate complains or appears to be injured or sick, prompt action shall be taken to ensure that the inmate is examined by authorized medical personnel." DOC Directive 4516R-D, "Injury to Inmate Reports," noted above, requires correction officers to transport incarcerated people experiencing specified medical conditions, including "loss of consciousness" and "disorientation," directly to a clinic for medical attention.

The scope of the duty of care is limited to protecting incarcerated people from risks of harm that are reasonably foreseeable i.e., "those that [correction officers] knew or should have known." *Vasquez v State*, 68 AD3d 1275, 1276 (3d Dept 2009), citing *Sanchez*, 99 NY2d 247, 255. This duty does not make a correction officer "an insurer of inmate safety." *Sanchez*, 99 NY2d 247, 253. The courts look to a facility's regulations, policies, past experience, and

expertise to determine whether a harm was foreseeable. The duty of care includes providing reasonable care that an inmate showing signs of suicidal ideation does not take his or her own life, *Gordon v. City of New York*, 70 NY2d 839, 840 (1987), and providing timely and adequate medical care to an inmate who personnel are aware is experiencing a medical emergency, *Kagan v State*, 221 AD2d 7, 16 (2d Dept 1996) ("it is beyond cavil that the State owes a duty to provide medical care and treatment to its prisoners").

Blameworthy Conduct and Causation

Criminally negligent homicide requires proof the defendant engaged in "'blameworthy conduct' so serious that it creates or contributes to a substantial and unjustifiable risk that another person's death will occur." *NY Criminal Jury Instructions 2d* on PL 125.10, and *People v Cabrera*, 10 NY3d 370, 376 (2008). Blameworthy conduct must cause a person's death to sustain a conviction for criminally negligent homicide. *People v Fitzgerald*, 45 NY2d 574, 579 (1978). A person causes the death of another person when "(1) ... [the] defendant's actions were an actual contributory cause of the death, in the sense that they forged a link in the chain of causes which actually brought about the death; and (2) ... the fatal result was reasonably foreseeable." *People v Stan XuHui Li*, 34 NY3d 357, 369 (2019), quoting *People v. Davis*, 28 NY3d 294, 300, (2016) (internal quotation marks omitted). The defendant's actions need not be the only cause of death; "it is enough that the defendant's conduct set in motion" or continued in motion the events which ultimately resulted in death. *People v Matos*, 83 NY2d 509, 511 (1994).

If the decedent could not have been saved with prompt medical intervention, there is no causation, as the defendant's failure to seek medical care did not contribute to his death. *See People v. Dlugash*, 41 NY2d 725, 730-31 (1977) (defendant not guilty of homicide because the People did not prove beyond a reasonable doubt that the victim was alive at the time defendant shot him). Proof on this issue is usually provided by physicians. In *People v Henson*, 33 NY2d 63, 71 (1973), for example, the Court of Appeals cited a doctor's testimony that "the injuries suffered by [the decedent], even complicated, as they were...could have been treated almost up to the last moment of his life."

Failure to Perceive

To convict a person of criminally negligent homicide, a prosecutor must prove that the defendant had the mental state of criminal negligence.

The Court of Appeals described the mental state as "the failure to perceive the risk in a situation where the offender has a legal duty of awareness. It, thus, serves to provide an offense applicable to conduct which is obviously socially undesirable." *People v Haney*, 30 NY2d 328, 334 (1972). What separates negligence from criminal negligence is the magnitude of the failure to perceive the risk, in that "the carelessness must be such that its seriousness would be apparent to anyone who shares the community's general sense of right and wrong." *Cabrera*, 10 NY3d 370, 376.

To determine whether the defendant's failure to perceive the risk was criminally culpable, courts look to the training, experience, and expertise of the defendant, as what would be obvious to a doctor may be imperceptible to a parent with no medical training, *People v Wong*, 81 NY2d 600, 608 (1993). In *Wong*, two caregivers contracted to care for a three-month-old infant; the evidence showed that one of the caregivers forcefully shook the infant, leading to the baby's death. There were no external injuries, and it was unclear which defendant shook the baby. As an initial matter, the Court held that the defendants had a duty of care, arising out of their contract with the parents. *Wong*, 81 NY2d 600, 608. The court then overturned the convictions for manslaughter and dismissed the indictments. The court found that the evidence did not demonstrate whether the "passive" (i.e. non-shaking) defendant was aware the other defendant had shaken the baby. Further, the court observed that while "there are situations where the need for prompt medical attention would be obvious to anyone—a child bleeding profusely, for example," that was not the case in *Wong*, where the baby had no external injuries and the baby's symptoms of a coma could be mistaken for ordinary sleep to someone without medical training. *Id*. at 608, quoting *People v Steinberg,* 79 NY2d 673, 681 (1992).

In *People v. Mayo*, 4 AD3d 827, 828 (4th Dept 2004), the court sustained the conviction of a mother who was found guilty of criminally negligent homicide for failing to seek medical care for her child, who had suffered a broken rib, puncturing his intestines; the child would have

exhibited signs of excruciating pain, which would have worsened as peritonitis set in. In *People v Goddard*, 206 AD2d 653, 655 (3d Dept 1994), the court dismissed an indictment charging a babysitter with criminally negligent homicide because his failure to perceive that a baby was severely dehydrated and needed medical attention was not a gross deviation from the standard of care of a reasonable person, considering that the babysitter had no medical training and limited knowledge of the baby's medical condition.

CONCLUSIONS

Based on the New York Correction Law and case law, CO Padilla was legally responsible for the care of Mr. Mejia Martinez, and had a duty to call for medical assistance when it became evident (as shown by video surveillance, commencing at 11:15 a.m.) that Mr. Mejia Martinez was increasingly disoriented and unsteady on his feet as he staggered around the dayroom and in the stairwell. CO Padilla continued to violate the duty of care from 12:22 p.m. through 3:05 p.m., when he seemed to be aware of the seriousness of Mr. Mejia Martinez's condition, repeatedly returning to his cell to check on him, but continued to fail to call the medical staff for assistance. As a result, Mr. Mejia Martinez was not provided medical attention until he was found unconscious in his cell, over four hours after CO Padilla first saw him showing significant disorientation.

According to Dr. Greenberg, the concentration of methadone in Mr. Mejia Martinez's blood was a fatal dose, and prompt medical attention, including the use of Narcan, might not have guaranteed his survival.

Although CO Padilla failed to perform the duty imposed on him by law to obtain emergency medical aid for Mr. Mejia Martinez when he initially saw him in a disoriented state at 11:15 a.m. in the dayroom, or at 11:56 a.m. when he saw Mr. Mejia Martinez unable to stand independently in the stairwell, or from 12:22 p.m. through 3:05 p.m. when he repeatedly looked into Mr. Mejia Martinez's cell seemingly checking on his condition, OSI concludes that the evidence is not sufficient to prove beyond a reasonable doubt at trial that any medical intervention would have saved Mr. Mejia Martinez. Therefore, as the evidence is not sufficient to prove that CO Padilla committed, by omission, the crime of Criminally Negligent Homicide,

OSI will not seek charges against CO Padilla and closes the matter with the issuance of this report.

Dated: January 16, 2025.