Office of the New York State Attorney General Letitia James

Office of Special Investigation

February 3, 2026

Report on the Investigation into the Death of King Crittenden

OVERVIEW

New York Executive Law Section 70-b (Section 70-b) directs 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. When OSI does not seek charges against the officer, Section 70-b requires OSI to issue a public report describing its investigation. This is the public report of OSI's investigation of the death of King Crittenden, who died when he was physically restrained while having a seizure by correction officers (COs) at Wyoming Correctional Facility (WCF) on January 14, 2024.

At 11:00 a.m. on January 14, 2024, King Crittenden suffered a seizure in his dormitory unit at WCF and became unresponsive but was still breathing. WCF medical personnel and COs responded and administered medical care. After a third dose of Narcan, Mr. Crittenden became responsive and combative. COs Michael Kaczmarowski, Kenneth Marx, Robert Aikin, Logan Spike, John Hewitt, Zachary Magin, Shawn Sauer, and Douglas Sherman, and Sergeant Jason Barrett 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. WCF medical personnel and emergency medical services personnel began life-saving measures, but Dr. Daniel Fahey, of Wyoming County Community Hospital, pronounced Mr. Crittenden dead at 12:18 p.m.

The autopsy report said that the cause of death was physical restraint in the setting of seizure disorder, hypertensive and atherosclerotic cardiovascular disease, and morbid obesity. The report stated that the manner of death was homicide.

Based on the investigation, OSI concludes that a prosecutor would not be able to prove beyond a reasonable doubt at trial, as would be required for proving either Manslaughter in the Second Degree or Criminally Negligent Homicide, that the COs' use of force was unjustifiable or constituted a gross deviation from the standard of care or conduct that a reasonable person in the COs' position would have observed in the same situation. Mr. Crittenden was a danger to himself and others and had to be restrained to receive care. The investigation does not indicate that the restraint was excessive or that the COs administered blows or caused asphyxiation.

Therefore, OSI will not seek charges and closes the matter with this report.

King Crittenden was 34 years old when he died.

FACTS

At the time of Mr. Crittenden's death, WCF did not have fixed video surveillance cameras, and WCF's COs were not equipped with body-worn cameras. Mr. Crittenden was housed in a dormitory where each incarcerated man was assigned to a cubicle. OSI obtained and reviewed Mr. Crittenden's WCF medical records, logs corresponding to rounds COs conducted, and summary reports written by WCF staff, and interviewed Monroe County Medical Examiner's Office Associate Medical Examiner, Dr. Christine Yoo, Sgt. Barrett, WCF facility nurses Kristen Spring and Emily Falleti, and incarcerated individuals.

According to CO James Wrotniak's summary report, on January 14, 2024, at 11:00 a.m., he conducted a count of the people in Mr. Crittenden's dormitory unit and saw Mr. Crittenden standing next to his locker during the count. (References to people mean incarcerated people unless otherwise indicated.) OSI spoke to other people who were in the dorm area who said that after count concluded and the lights were turned off, they saw Mr. Crittenden lie down, heard a loud bang, and saw Mr. Crittenden on the floor shaking, appearing to have a seizure. A man yelled for help, and COs responded. According to CO Wrotniak's summary report, at 11:02 a.m., he responded, saw Mr. Crittenden lying on the floor, having what appeared to be a seizure, and radioed for a medical response.

OSI reviewed WCF facility medical records and interviewed Sgt. Barrett and Nurses Falleti and Spring. Sgt. Barrett said that he and Nurses Falleti and Spring responded to Mr. Crittenden's dormitory unit and found Mr. Crittenden unresponsive but breathing. Sgt. Barrett said that he performed a sternum rub while Nurse Falleti administered a dose of Naloxone (Narcan) to Mr. Crittenden's right nostril, and then to Mr. Crittenden's left nostril, neither of which produced the desired effect. Sgt. Barrett said Mr. Crittenden was placed on a gurney and loaded into the facility ambulance to be transported to the facility's emergency room. COs Sherman, Magin, and Sauer rode along with Sgt. Barrett and Nurses Spring and Falleti in the ambulance.

Sgt. Barrett said that at 11:10 a.m., in the ambulance, Nurse Falleti administered another dose of Narcan to Mr. Crittenden's right nostril, and he became responsive. He said Mr. Crittenden firmly grabbed Nurse Spring's wrist; she pulled herself away. He said Mr. Crittenden swung his arms, kicked his legs, and attempted to bite Sgt. Barrett, CO Magin, and Nurse Falleti. Sgt. Barrett said that COs used restraint holds to gain control of Mr. Crittenden. To prevent Mr. Crittenden from biting, Sgt. Barrett said he used both hands to control Mr. Crittenden's head. Sgt. Barrett said that COs Sherman, Magin, and Sauer used body holds on Mr. Crittenden's arms and legs to control his movements. Sgt. Barrett said that Mr. Crittenden continued to struggle, and so the officers continued the holds until the ambulance arrived at the facility's emergency room, where they were met upon arrival by COs Aikin, Kaczmarowski, and Marx, who helped bring Mr. Crittenden into the emergency room. As Mr. Crittenden was removed from the ambulance, CO Kaczmarowski used both hands to control Mr. Crittenden's left arm, and CO Spike used both hands to hold Mr. Crittenden's right arm; he continued to use

downward pressure on Mr. Crittenden's right arm as they entered the emergency room. CO Hewitt arrived at the emergency room and used both hands to assist CO Spike hold Mr. Crittenden's right arm to his side. Nurse Spring said that she and Nurse Falleti left the emergency room for their safety, as the large number of COs in the room left little space for them. Sgt. Barrett said he forcibly handcuffed Mr. Crittenden as Mr. Crittenden continued to struggle. Sgt. Barrett said Mr. Crittenden bit Officer Magin's left hand and spat blood in Sgt. Barrett's face. Sgt. Barrett said that he forcibly applied a spit net over Mr. Crittenden's head and then continued to use force to gain control of Mr. Crittenden's head. Nurse Spring said that, from outside the emergency room, she heard Mr. Crittenden making noises, indicating he was still breathing and responsive. Nurse Falleti said that the struggle between Mr. Crittenden and COs lasted about thirty minutes, with several COs exiting the room complaining of various injuries. However, according to Sgt. Barrett, suddenly, Mr. Crittenden became unresponsive, and all force ceased, and the spit net was removed. At that time, 11:30 a.m., Sgt. Barrett said he called for Nurses Spring and Falleti to return to the emergency room. Nurse Spring said that she and Nurse Falleti entered the emergency room and found Mr. Crittenden pulseless and breathless. Nurse Spring said she administered a dose of Narcan intranasally, and Nurse Falleti applied the automated external defibrillator (AED), with no shock advised. Cardiopulmonary resuscitation (CPR) was performed in rotation by Nurses Spring and Falleti and COs Marx, Spike, Aikin, Sherman, Sauer, Andrew Merkel, and Cory Weber. Nurse Spring administered eleven more doses of Narcan. Mr. Crittenden did not respond to any life-saving measures.

According to ambulance records, at 12:01 p.m., Paramedic Gared Roessel and Emergency Medical Technician James Bongiovanni from Wyoming County Emergency Medical Services arrived and assumed care of Mr. Crittenden. Paramedic Roessel contacted Dr. Daniel Fahey with Wyoming County Community Hospital (WCCH), who pronounced Mr. Crittenden dead at 12:18 p.m.

Seven COs, Sauer, Aiken, Sherman, Hewitt, Kaczmarowski, Barrett, and Magin, along with Nurse Spring were evaluated and treated for bruises, abrasions, swelling, and shoulder, knee and back pain. CO Magin was treated at WCCH for a bite wound to his left hand.

Medical Examiner

On January 16, 2024, Dr. Terra Cederroth, Associate Medical Examiner at the Monroe County Medical Examiner's Office, conducted the autopsy of Mr. Crittenden; the autopsy report was issued more than a year later, on February 11, 2025. The report stated that the cause of Mr. Crittenden's death was physical restraint in the setting of seizure disorder, hypertensive and atherosclerotic cardiovascular disease, and morbid obesity. The report stated that the manner of death was homicide.

On February 27, 2025, OSI met with Monroe County Medical Examiner's Office Associate

Medical Examiner Dr. Christine Yoo, who assisted Dr. Cederroth with the autopsy of Mr. Crittenden. Dr. Yoo explained that there was evidence that Mr. Crittenden had a seizure based upon contusions found on his tongue. Dr. Yoo said that it is common that a person coming out of a seizure can be in a "postictal state," which is a period of altered consciousness; persons in this state can be confused, incoherent, and disoriented. Dr. Yoo said this state typically lasts five to 30 minutes but can extend for hours. Dr. Yoo said Mr. Crittenden was probably in a postictal state when he became combative with WCF's staff, and that the restraint of Mr. Crittenden and his struggle against the restraint, coupled with his other medical issues, caused an arrhythmia which led to his death. Dr. Yoo explained that Mr. Crittenden lived with his other medical issues, but the struggle against the restraint was the only new event and therefore the reason for the homicide determination. Dr. Yoo said that the autopsy did not show any signs of asphyxiation or trauma to Mr. Crittenden's body.

LEGAL ANALYSIS

The investigation indicates that the COs restrained Mr. Crittenden when he became combative in the context of a medical emergency; in the course of a struggle, he injured seven COs and a nurse. In evaluating whether officers have unlawfully restrained a person in such cases courts have applied a three-prong test:

1. Was the person experiencing a medical emergency that rendered him incapable of making a rational decision under circumstances that posed an immediate threat of serious harm to himself or others?
2. Was some degree of force reasonably necessary to ameliorate the immediate threat?
3. Was the force used more than was reasonably necessary under the circumstances?

Estate of Corey Hill v Miracle, 853 F3d 306 (6th Cir 2017). See also Verponi v City of New York, 31 Misc3d 1230 (A) (Supreme Court, Kings County, 2011) (the question is "whether the officers had a reasonable objective basis to believe that [the person] was a danger to herself or others"). Under these cases, the evidence supports the conclusion that the COs had a reasonable basis to restrain Mr. Crittenden and did not use more force than reasonably necessary.

Mr. Crittenden reasonably appeared to be experiencing a medical emergency and to be a danger to himself and others, including medical staff. Some degree of force was necessary to restrain him so he could receive medical attention. The COs used their hands and handcuffs to restrain Mr. Crittenden's head and arms and legs. The COs said that when they noticed he was unresponsive, all force ceased and WCF staff immediately initiated life-saving measures.

The evidence does not support charging the COs with a homicide offense. As there is no evidence the COs *intended* to cause Mr. Crittenden's death (which would fall within the definition of Murder in the Second Degree, Penal Law Section (PL) 125.25) or *intended* to cause him serious physical injury (which would fall within the definition of Manslaughter in the First Degree, PL 125.20), OSI analyzes the case under the definitions of Criminally Negligent Homicide, PL 125.10, and Manslaughter in the Second Degree, PL 125.15 (1).

Criminally Negligent Homicide requires proof beyond a reasonable doubt that a person caused the death of another with criminal negligence. Under the definition of criminal negligence in PL 15.05 (4), and in the context of Criminally Negligent Homicide, "A person acts with criminal negligence with respect to [death] when he fails to perceive a substantial and unjustifiable risk that [death] will occur.... The risk [of death] must be of such nature and degree that the failure to perceive it constitutes a gross deviation from the standard of care that a reasonable person would observe in the situation."

Manslaughter in the Second Degree requires proof beyond a reasonable doubt that a person recklessly caused the death of another. Under the definition of recklessly in PL 15.05 (3), and in the context of Manslaughter in the Second Degree, "A person acts recklessly with respect to [death] when he is aware of and consciously disregards a substantial and unjustifiable risk that [death] will occur…. The risk [of death] must be of such nature and degree that disregard thereof constitutes a gross deviation from the standard of conduct that a reasonable person would observe in the situation."

Based on the investigation, OSI concludes that a prosecutor would not be able to prove beyond a reasonable doubt that the COs' use of force was "unjustifiable" or that it constituted a "gross deviation from the standard" of care or conduct that a reasonable person in the COs' position would have observed in the same situation. Mr. Crittenden was a danger to himself and others and had to be restrained to receive care. The investigation does not indicate that the restraint was excessive or that the COs administered blows or caused asphyxiation.

For these reasons, OSI concludes that a prosecutor at trial would not be able to prove beyond a reasonable doubt that any of the COs committed a crime. Therefore, OSI will not seek charges against them and closes the matter with this report.

RECOMMENDATION

As noted above, when this incident occurred, WCF did not have stationary video cameras, and WCF's COs were not equipped with body-worn cameras. OSI has learned that COs at WCF are now equipped with body-worn cameras.

While OSI recognizes that Governor Hochul recently signed legislation requiring Department of Corrections and Community Supervision (DOCCS) facilities to install, operate, and maintain fixed or stationary cameras sufficient to capture the activities and movement of all people within each DOCCS facility, we note that there is still no law requiring that DOCCS COs be equipped with body-worn cameras. In OSI's view, transparency and accountability in correctional facilities are essential to maintain the public trust. Video enhances transparency, and transparency enhances trust. Accordingly, OSI continues to urge the Legislature to pass legislation requiring that DOCCS COs be equipped with body-worn cameras.

Dated: February 3, 2026