Office of the New York State Attorney General Letitia James
Office of Special Investigation

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Report on the Investigation of the Death of Matthew Brown

OVERVIEW

New York Executive Law Section 70-b (Section 70-b) authorizes the New York 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 Matthew Brown, which occurred in an incident involving two New York State Police (NYSP) troopers and an Oneida County Sheriff's Office (OCSO) deputy, in Oneida County, on March 25, 2025.

On March 24, 2025, at 11:13 p.m., Witness A, a family member of Mr. Brown's (OSI does not publish the names of civilian witnesses), called Oneida County 911 and said Matthew was having a "psychotic attack," and "something has gotten way off." Witness A gave the address of a house in the town of Trenton, and the 911 operator told Witness A that help was on the way. At 11:31 p.m. two NYSP troopers, Daniel Rotach and Branden Gokey, arrived at the house. The troopers, dressed in uniform, activated their body-worn cameras (BWCs) and knocked on the front door. Matthew Brown opened the door, and the troopers entered the house. During the troopers' attempt to speak with him, Mr. Brown said, "The bullet," and moved toward Trooper Rotach, who grabbed Mr. Brown's arms and pushed him away. Mr. Brown again moved toward Trooper Rotach and moved his hand toward Trooper Rotach's handgun. At that point, Troopers Rotach and Gokey forced Mr. Brown to the ground and handcuffed him behind his back. The troopers radioed for an ambulance. An OCSO deputy, Thomas Bronson, arrived at the house and assisted the troopers in keeping 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, he was pronounced dead at 1:05 a.m. on March 25th. He was 30 years old.

Chief Medical Examiner Carolyn Revercomb, performed the autopsy of Mr. Brown, concluded "bupropion toxicity" caused his death, with prone restraint being a contributory factor, and deemed the manner of death to be "homicide." When OSI interviewed Dr. Revercomb, she said the bupropion toxicity was "the underlying reason for the whole incident" and that, although the prone restraint was "pretty distinct" from the bupropion toxicity, it added to the stressful nature of the incident. Although she did not find that Mr. Brown had been asphyxiated, she said that if there is "any external activity by another person" during the incident leading to a death the manner becomes classified as homicide.

Having thoroughly investigated the matter and analyzed the law, OSI concludes that a prosecutor would not be able to prove beyond a reasonable doubt that Trooper Daniel Rotach, or Trooper Branden Gokey, or Deputy Thomas Bronson committed a crime in connection with the death of Mr. Brown. As a result, OSI will not seek charges and closes the matter with this report.

OSI makes recommendations, described at the end of this report, that NYSP train its members on the risks of prone restraint, and that the agencies involved improve their capacity to respond to mental health crises.

FACTS

The 911 call

According to 911 records, on March 24, 2025, at 11:13:04 p.m., Witness A called and said that Matthew Brown was having a "psychotic attack," and that "he thinks the world is blowing up or something, [and is] upsetting and destroying things in the house…. He's not normally violent, but he's having a psychotic attack right now, and he's f-ing stuff up." Witness A said that Matthew was diagnosed with a mental illness and "something has gotten way off." Witness A gave the address of a house in the town of Trenton, and the 911 operator told Witness A that "we're gonna have help there as soon as possible…. Good luck." The call was labeled as both a "Mental Health Law" and "psychiatric" incident to the officers who were dispatched.

The Incident

According to 911 records, NYSP and OCSO records, OSI's interviews, and BWC recordings, the first responding officers to the house were NYSP Trooper Daniel Rotach, at 11:31:48 p.m., and NYSP Trooper Branden Gokey at 11:32:35 p.m.

Trooper Rotach's BWC recorded Matthew Brown opening the door at 11:32:22 p.m.

As recorded on BWC, after Trooper Rotach knocked on the door, Matthew Brown opened the door, and Rotach asked Brown, "How's it going, what's going on man?" Mr. Brown spoke to Rotach, but his statements did not seem to be responsive to the questions. As recorded on BWC, at 11:32:53 p.m., while Troopers Rotach and Gokey are still outside the house's front door, Witness A said, "He probably needs to go into the hospital," while standing next to Matthew Brown, and Brown turned and walked away into the house. Trooper Rotach said, "Okay, we're gonna talk to him real quick," and walked into the house, followed by Trooper Gokey. As recorded on BWC, at 11:33:02 p.m. Trooper Rotach followed Matthew Brown into the living room area and asked, "So, what is going on tonight buddy?" Matthew

Brown turned and reached toward Rotach, and Rotach told Brown, “Hold on, sit down for me.” At 11:33:11 p.m. Matthew Brown moved toward Rotach and said, “The bullet.” Trooper Rotach replied, “I don’t know what you are talking about but you got to sit down.” Trooper Rotach grabbed each of Matthew Brown’s arms, pushed him back, and said, “Hey No.”

Trooper Gokey’s BWC at 11:33:14 p.m. recorded Trooper Rotach grabbing Mr. Brown’s arms.

Trooper Rotach’s BWC at 11:33:15 p.m. recorded Mr. Brown apparently looking at Trooper Rotach’s handgun.

Trooper Gokey's BWC at 11:33:16 p.m. recorded Mr. Brown reaching toward Trooper Rotach's handgun.

As recorded on BWC, at 11:33:16 p.m. Matthew Brown moved back toward Trooper Rotach, appeared to look at Trooper Rotach's holstered handgun, and moved his left hand toward the handgun. Troopers Rotach and Gokey grabbed Brown's arms, which began a struggle which lasted five seconds, as they wrestled Matthew Brown to the floor and onto his stomach.

As recorded on BWC, at 11:33:56 p.m. Trooper Rotach straddled Matthew Brown's waist, held his wrists behind his back, and told Trooper Gokey, "Get your cuffs on him." At 11:33:59 p.m. Matthew Brown's hands were cuffed behind his back. At 11:34:47 p.m. Trooper Rotach radioed, "One in custody." At 11:35:26 p.m. Trooper Rotach radioed, "Can you have medical make their way." In response to the 911 operator's request for a description of the call, Troopers Rotach and Gokey said, "It'll be an eval for an MHL," apparently meaning custody pursuant to Mental Hygiene Law (MHL) Section 9.41. When interviewed by OSI, both Troopers said that because of Mr. Brown's behavior they intended to have him checked by ambulance personnel and expected him to be transported to a hospital, pursuant to MHL 9.41, for a psychological evaluation.

At 11:35:53 p.m. Trooper Gokey's BWC recorded Trooper Rotach straddling Mr. Brown, with Witness A standing nearby.

As recorded on BWC, at 11:36:22 p.m. Trooper Rotach told Witness A, "I'm just gonna keep him like this." As recorded on BWC, at 11:40:54 p.m. OCSO Deputy Bronson entered the house and went to where Trooper Rotach was holding Mr. Brown, as Witness A stood next to them. Trooper Rotach told Deputy Bronson, "We'll wait until the ambulance gets here and then we'll get him up." As recorded on BWC, Matthew Brown struggled several times against being held down, and Trooper Rotach, assisted by Trooper Gokey and Deputy Bronson, used physical force and at times their body weight to prevent Matthew Brown from kicking them, or getting up, or moving to a different position. At 11:47:03 p.m. Trooper Rotach said, "We'll keep him down for now until medical gets here, [I don't want him to] hurt himself." As recorded on BWC, at 11:50:18 p.m. Trooper Rotach asked 911, "You got an ETA on medical?" At 11:51:05 p.m. a 911 operator replied, "It is going to be zero-five." As recorded on BWC, at 11:51:36 p.m., as the officers struggled with Brown, Trooper Rotach said, "All right man, stay down, medical is almost here. You're all right just breathe."

At 11:54:06 p.m. Matthew Brown appeared to have involuntary movements, and Deputy Bronson asked, "Is he good? Matt you good?" At 11:54:50 p.m. Witness A said, "He's having trouble. I wonder if you should let him turn over." Deputy Bronson said, "You wanna try, a sit him up?" As Trooper Rotach said, "Get him on his side," Trooper Rotach and Deputy Bronson rolled Matthew Brown onto his right side, and Brown made some noise but was not responsive.

From 11:33:56 p.m., when Trooper Rotach first straddled him, until the officers rolled him onto his side, 21 minutes later, Mr. Brown was continuously in a prone position.

Trooper Rotach radioed to 911, "Step up medical." When a 911 operator asked, "Is there an update on the nature?" Rotach responded, "Having trouble breathing." As recorded on BWC, at 11:56:00 p.m. Deputy Bronson opened the front door and tried get the ambulance crew's attention, and yelled, "He's

having trouble breathing," and Trooper Rotach yelled "Have them hurry up." Deputy Bronson told the EMT, "He's not breathing, come on let's go," as Trooper Rotach, yelled, "Get in here." According to 911 records and as recorded on BWC, at 11:56:51 p.m. forty-three minutes after the original 911 call, and seventeen minutes after they were dispatched, Star Ambulance personnel entered the house and began to aid Matthew Brown.

The three officers' BWCs, redacted according to the Attorney General's published video release policy, are here: Trooper Rotach: HERE, Trooper Gokey: HERE, and Deputy Bronson: HERE.

Statement and OSI Interview of Witness A.

On March 25, 2025, in a type-written sworn statement provided to NYSP, Witness A said he and Matthew Brown both lived at the house, and Matthew had been diagnosed with asthma and a mental illness. Witness A said he decided to call 911 on March 24, 2025, because Matthew was "agitated," and "making incoherent statements," knocking over furniture, and "throwing items," and damaging the house. Witness A said Matthew was "wet from the shower that he destroyed," when they answered the door, and "met with the Troopers." Witness A said:

> "I saw the two Troopers placing Matthew into handcuffs but were struggling with him as he was resisting.... They had Matthew on the ground at this point. The Troopers were leaning over the top of Matthew trying to hold him down as he attempted to get up despite the Troopers [sic] orders telling him to stop. He kept trying to get up and I told Matthew to just breathe. I think he was struggling to breathe but I did not realize it.... Matthew was handcuffed behind the back at this point but still rocking his body trying to get up. The one Trooper was trying to control Matthew by placing his hand on the back of his neck area. After an extended period of time of Matthew trying to get up he all of a sudden stopped resisting and appeared to be asleep."

When OSI interviewed Witness A, he said Matthew's behavior on March 24th was very unusual, his speech "did not make sense," he threw things and moved furniture, and Witness A had "never seen Matthew that distressed, ever." Witness A said at that moment he was not concerned for his own safety or for Matthew's safety, but thought Matthew "wasn't self-aware enough to realize he was out of it." Witness A said, months prior, in December 2024, he had called 911 because Matthew was having a problem breathing, due to asthma, "and the EMTs arrived to the house shortly thereafter," and when he called on March 24th, he was expecting "some kind of a response that was helpful to him." Witness A said he did not see the interaction between the Troopers and Matthew immediately after they entered the house, but heard "sounds like thud, thud, and ... they had him on the ground already." Witness A said when the Troopers were holding Matthew down, "He was trying to get up." "All of a sudden he stops breathing." Witness A said, as he saw it, the Troopers' actions "aggravate[d] his [Matthew's] condition." Witness A said Matthew's most recent prior heath care was an appointment to get him established with a regular doctor, on March 14, 2025, and he was prescribed medication for cigarette nicotine dependence, and continued a once-a-month injection of paliperidone palmitate for managing symptoms related to his mental health diagnosis.

OSI's Interviews of the Troopers

At that time of the incident on March 24, 2025, both Trooper Daniel Rotach and Trooper Branden Gokey had been with NYSP for 21 months. Trooper Rotach had previously been an Oneida County Sheriff's deputy for four years. Both Troopers said that because of Brown's behavior they intended to have him checked by ambulance personnel and expected him to be transported to a hospital, pursuant to MHL 9.41, for a psychological evaluation.

Trooper Rotach

Trooper Rotach said the information he received from 911 was that Matthew Brown was destroying things in the home, and, when Brown answered the door, he was "all wet." Trooper Rotach said Mr. Brown kept repeating the same words "over and over," and, after Witness A said Mr. Brown needed to go to the hospital, Mr. Brown turned and walked away, so he (Rotach) followed him. Trooper Rotach said that Brown repeatedly said, "Gun – bullet," and, "He kinda went at me.... I pushed him back to make space, ... he looked at my gun and lunged towards me, and lunged towards my weapon." Trooper Rotach said Mr. Brown appeared to need to medical help, seemed to be on drugs and to be a danger to himself, so he was going to be an MHL 9.41 case, and "as soon as we had him secured, I asked for EMS." Trooper Rotach said, because Brown kept being aggressive, "trying to buck me off," and kick us, and "hitting his head on the floor," that there was no time to let him up, or move him to a different position, because he was a threat himself, to Witness A, and to the officers. Trooper Rotach said he never saw Matthew Brown having trouble breathing. They were waiting for EMS so they could secure Mr. Brown to a gurney to transport him. Trooper Rotach said that as soon as it became obvious that Mr. Brown might be having trouble breathing, "we immediately flipped him on to his side."

Trooper Gokey

Trooper Gokey said he heard over the radio that Witness A called for Matthew "acting erratically," and that it was a dispatch for a mental health call. Trooper Gokey said Matthew was "soaking wet" when he answered the door. Trooper Gokey said, as soon as they were into the kitchen area,

> "Brown went right for Trooper Rotach's chest, [and Rotach] swatted his hands away [and] immediately he went for [Rotach's] gun seconds after, and that's when we took him to the ground." ... At that point I believed it was a MHL, getting him into custody, so that way he could get evaluated, get the help he needed."

Trooper Gokey said, shortly after Brown was handcuffed, Trooper Rotach and he radioed for an ambulance for an MHL evaluation. Trooper Gokey said,

> "[Brown was] resisting the whole time, kind of fighting with us.... He kept moving his body up and down, moving his head up and down [at risk of hitting] the floor.... I had to hold his legs, [be]cause [he] kept kicking [Rotach], he was trying to get up."

Trooper Gokey said the officer tried to maintain everyone's safety; "We didn't want him to harm himself in any way;" and as soon as Mr. Brown stopped resisting and making noise, "[Witness A] mentioned, 'hey, something is going on,' so immediately we turned him to his side [and] attempted to perform life-saving measures." Trooper Gokey said the wait for the ambulance "was pretty long," longer than normal, and he expected them sooner.

Statement of Deputy Bronson

Deputy Bronson refused OSI's request for an interview.

According to Deputy Bronson's written report for OCSO, he was dispatched on March 24th, 2025,

> "For an MHL complaint" [and when he] entered the house [he] saw Matthew [Brown] hand cuffed behind his back and on the ground face down on his stomach. Trooper Rotach was in a full mount position in the area of Matthew's hip/belt line…. I observed Matthew to be in a rather excited state, breathing heavy and seemed to be sweating profusely. Matthew quickly became agitated and aggressively trying to resist being detained. Matthew was kicking his feet, yelling and pushing his upper body up with his chest…. Trooper Rotach [told me] that EMS was enroute for an evaluation so I moved in to assist the Troopers to restrain Matthew until EMS arrived…. I assisted the Troopers by holding Matthews [sic] left arm and left foot while he was squirming, kicking and yelling. Matthew continued to yell and repeat things but did not make any sense. Matthew went from an aggressive resisting behavior to what seemed to be a snoring, sleeping and unresponsive state in a matter of seconds. Trooper Rotach directed and assisted in getting Mathew rolled onto his side. At this time Trooper Rotach told dispatch to expedite medical and advised of trouble breathing. Star Ambulance advised that they had a two-minute ETA to the scene and Trooper Rotach asked me to go open the door for them and direct them in…. I noticed the medical personnel did not have an AED with them…. They began CPR immediately. I [ran to my car] and retrieved my AED unit…. The AED unit advised no shock three times. Kunkel Ambulance … and Barneveld also arrived on the scene to assist. Matthew was loaded into Kunkel Ambulance and transported to Wynn Hospital."

The Medical Response

According to 911 records and the records of Star Ambulance (STAR) (as of July 1, 2025, operating as NorthStar EMS), on March 24, 2025, twenty-six minutes after the original 911 call, at 11:39:17 p.m. STAR "was dispatched to an MHL transport uncooperative and combative patient"; 911 "updated the ambulance crew that the patient was having difficulty breathing." STAR EMTs Wendy Urich and Jake Foster went into house and found Mr. Brown with "no pulse, not breathing, unresponsive, and cyanotic" (blue), and started CPR.

At 11 :59 p.m. Barneveld Volunteer Fire Department EMS (BVFD) was dispatched for a "30 y/o male not conscious and not breathing," and Kunkel Ambulance was also dispatched. STAR EMT Urich noted, "No major injuries or obvious cause for cardiac arrest were seen. [Brown] was on his side and was placed on his back with pillow under shoulders to maintain airway." According to BVFD records, and

as partially recorded on BWC, EMTs Cody Minnig, Brian Lange, and Alexander Leggett arrived and were aiding Matthew Brown at 12:10 a.m., and their impression was that Mr. Brown was in "critical condition," not breathing; they provided support to STAR. According to STAR records, and as partially recorded on BWC, BVFD EMTs assisted with CPR. An AED was placed on Brown and no shocks were advised. After Kunkel ambulance personnel took over care, Mr. Brown was placed on an automated CPR device, carried to a stretcher, wheeled into Kunkel's ambulance, and transported to Wynn Hospital.

According to Kunkel Ambulance Service's records, Paramedic Heather Mundrick, and EMT Nicole Kern were dispatched as advanced life support for a cardiac arrest, to "link" with STAR and BVFD. They arrived at the house at 12:15 a.m., took over from STAR at 12:18 a.m., and, at 12:35 a.m., left with Matthew Brown. Mundrick wrote, "Matthew [Brown] was unresponsive and not breathing [and] manual cpr [had been started; Brown was] was on Star's cardiac monitor and was asystole." He was "placed on mechanical cpr machine … and brought to rig on stretcher." Advanced cardiac life support protocols continued as Brown was "transported to Wynn" Hospital in Utica, arriving at 12:53 a.m., and "taken to trauma room" as care was transferred to hospital staff.

According to Wynn Hospital's records, and the typewritten deposition of Dr. Sebastian Roque:

> "[The] 30-year-old male with past medical history of [mental illness] presents via EMS in cardiac arrest. Patient has been down with persistent compressions for the past hour prior to arrival [and he] has been asystole the whole time. [Matthew Brown] came into the hospital on the LUCAS device [mechanical CPR device]. I checked the patient's eyes, and they were fixed and dilated. The patient was cold…. When I assumed care of the patient from EMS he had no cardiac activity…. The patient had no pulse after the LUCAS device was removed and there was no cardiac activity [and despite medical efforts to revive him, the] time of death was called at 1:05 [a.m.]."

Medical Examiner

On March 25, 2025, the Chief Medical Examiner, Dr. Carolyn Revercomb, performed an autopsy on the body of Matthew A. Brown and issued an autopsy report, which said in part:

> "[Matthew Brown] became unresponsive after being restrained prone and was transported to an emergency department amid continued resuscitation efforts before being pronounced dead early on March 25, 2025…. Toxicologic analysis of blood showed a high concentration of bupropion, a medication that can have stimulant effects, and of its metabolite hydroxybupropion…. Per records, the decedent had a past history of being prescribed bupropion for smoking cessation and had been prescribed extended-release bupropion on March 14, 2025, for the same indication. In consideration of the circumstances surrounding the death, examination findings, review of reports and records including body camera footage, and laboratory analysis, the death of Matthew A. Brown is best ascribed to Bupropion toxicity. Contributing to death was Prone restraint. The manner of death is Homicide."

OSI interviewed Dr. Revercomb on July 23, 2025. During that interview Dr Revercomb said the bupropion toxicity was, in her opinion, "the underlying reason for the whole incident," and while the prone restraint was "pretty distinct" from the bupropion toxicity, if there is "any external activity by another person" during the incident leading to a death the manner becomes classified as homicide.

In the interview Dr. Revercomb said the analysis of Mr. Brown's blood found an accumulation of bupropion, which became toxic at those high levels, and the stimulant effects of the toxicity "set in motion the chain of events." Dr. Revercomb said that based on all the circumstances, including the BWC, ambulance records, and the apparent suddenness of his death, Matthew Brown may have experienced a heart arrhythmia, but because a heart monitor was not attached to Brown at that time there could be no certainty of that conclusion.

OSI asked Dr. Revercomb what evidence in the autopsy showed that prone restraint contributed to Mr. Brown's death. Dr. Revercomb said, "It is all the circumstances," as recorded in the BWC video, the "20 minute" period of restraint, and the position of being face down and handcuffed behind the back, which would have been "inherently stressful," and that the troopers did not roll the handcuffed person onto his side, which "has been the standard protocol for decades." Dr. Revercomb added that even if the troopers had moved Mr. Brown to a different position, there was no way to know if that would have changed the outcome. Dr. Revercomb said no evidence of asphyxiation was found during the autopsy.

According to Matthew Brown's medical records and OSI's interviews, Mr. Brown was being treated with a medication, Paliperidone palmitate for a mental illness; in OSI's interview Dr. Revercomb said the toxicological analysis did not test for that drug. According to Matthew Brown's medical records and OSI's interview of Witness A, Matthew Brown's most recent prior medical visit was March 14, 2025, at which he was prescribed extended-release bupropion, for cigarette nicotine dependence, and received a once-a-month injection of paliperidone palmitate.

Bupropion Toxicology

OSI interviewed the Onondaga County Forensic Toxicologist, Kristie Barba, regarding the analysis of Matthew Brown's blood sample. She said the levels found in Brown's sample were "really high" and not typical. Ms. Barba said each person metabolizes uniquely and will experience toxicity and physical effects of toxicity (such as tachycardia, agitation, seizures) differently; just having a specific measured amount in a person's blood would not necessarily equate to the same manifestations of toxicity among different people. She said the results for Matthew Brown were in her opinion consistent with fatal toxicity, but was only basing that on the toxicology, and a complete medical opinion would have to be based on all known information and circumstances.

According to the medical literature on bupropion, there is no antidote for toxicity due to an overdose; medical providers are limited to treating symptoms, including increased heart rate, irregular heart rhythm, cardiac arrest, altered mental states, or seizures, including prolonged seizures with a loss of consciousness. Effective treatment of these life-threatening effects requires both an awareness of the

toxin causing them and prompt medical intervention in an emergency room or intensive care hospital setting. [1]

Community Mental Health Crisis services.

The services of a 24-hour crisis line and Mobile Crisis Assessment Team were available in Oneida County.[2] OSI's investigation found no evidence that anyone tried to get in touch with these resources for Mr. Brown on March 24, 2025.

LEGAL ANALYSIS

Having analyzed the evidence in this case and the law, OSI concludes there is insufficient evidence to prove beyond a reasonable doubt that Trooper Daniel Rotach, Trooper Branden Gokey, or Deputy Thomas Bronson committed a crime.

Police officers in New York are authorized to "take into custody any person who appears to be mentally ill and is conducting himself or herself in a manner which is likely to result in serious harm to the person or others." MHL 9.41. Federal and state case law recognizes a police officer's authority to detain a person who is an immediate danger to themselves or others, or when the person's behavior demonstrates the need for urgent action. In evaluating whether police have unlawfully used force to detain a person in cases of medical emergency, courts ask three questions:

> "(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 reasonably necessary under the circumstances?"

Estate of Corey Hill v Miracle, 853 F3d 306,314 (6th Cir 2017). Also see, *Greene v City of New York*, 725 F Supp 3d 400, 417 (SDNY 2024), *Guan v City of New York*, 37 F4th 797 (SDNY 2022). See also, *Verponi v City of New York*, 31 Misc3d 1230(A) (Supreme Court, Kings County, 2011) (the primary question to determine the lawfulness of detention and force used during a medical emergency is "whether the officers had a reasonable objective basis to believe that [the person] was a danger to [themselves] or others"). Under these cases and MHL 9.41, the evidence indicates that the officers had a reasonable basis to believe Matthew Brown was a danger to himself or to others, and thus a reasonable basis to restrain him.

911 informed the responding officers the call was for "an MHL," and that "Matthew Brown was "having a psychotic episode [and] believes the world is ending around him and is destroying things," and "has been diagnosed with [a mental illness]."

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[1] https://www.ncbi.nlm.nih.gov/books/NBK580478/

[2] https://oneidacountyny.gov/departments/mental-health/crisis-services/
https://www.neighborhoodctr.org/behavioral-health-care-services/emergency-mental-health-services/

BWC showed that Trooper Rotach tried unsuccessfully to communicate with Mr. Brown. Troopers Rotach and Gokey said Mr. Brown did not respond to Witness A's or the officers' attempts at communication, that the officers were unable to verbally de-escalate the situation, and that Mr. Brown was trying to grab Trooper Rotach's handgun; the BWC was consistent with those statements.

The Troopers said they restrained Matthew Brown because they believed he was a danger to himself, Witness A, and/or the officers, that they believed he was having a mental health emergency, and that they wanted him to get medical attention; the BWC and other evidence were consistent with those statements as well.

Although the officers restrained Mr. Brown in a prone position on the floor for more than twenty minutes while awaiting the ambulance, the autopsy report and OSI's interview of Dr. Revercomb do not show that the officers' actions caused asphyxiation or any other injury to Matthew Brown that contributed to death. Soon after Witness A said Mr. Brown did not appear well, the officers changed Mr. Brown's position, tried to accelerate the medical response, and attempted to assist the EMTs. According to Witness A's written statement and interview with OSI, and consistent with the BWC, Witness A did not perceive Matthew Brown's physical well-being to be in danger until he became unconscious.

The Medical Examiner, Dr. Revercomb, said that the cause of death was bupropion toxicity. Although Dr. Revercomb classified the death as a homicide because the officers' restraint of Mr. Brown was an "external activity by another person … during the incident leading to a death," she also said the restraint was "pretty distinct" from the bupropion toxicity. Notably, Dr. Revercomb said the restraint was "inherently stressful," but did not say that the officers' actions caused asphyxia or positional asphyxia. In light of the above, OSI concludes that a prosecutor would not be able to prove that the officers caused Mr. Brown's death beyond a reasonable doubt at trial.

OSI analyzed the elements of Criminally Negligent Homicide under Penal Law Section [PL] 125.10, and Manslaughter in the Second Degree under PL 125.15(1). Criminally Negligent Homicide requires proof beyond a reasonable doubt that a person caused the death of another and did so with criminal negligence, which is defined as the defendant's failure to perceive a substantial and unjustifiable risk of death, when "the risk is of such nature and degree that the failure to perceive it constitutes a gross deviation from the standard of care that a reasonable person would observe in the situation." New York Criminal Jury Instructions 2d (CJI), Criminally Negligent Homicide. The crime of Manslaughter in the Second Degree requires proof beyond a reasonable doubt that a person recklessly caused the death of another by engaging in conduct which "creates or contributes to a substantial and unjustifiable risk that another person's death will occur … when he or she is aware of and consciously disregards that risk, and when that risk is of such a nature and degree that disregard of it constitutes a gross deviation from the standard of conduct that a reasonable person would observe in the situation." CJI, Manslaughter 2nd Degree.

A person may only be found guilty of a homicide crime if the evidence proves beyond a reasonable doubt that the person caused the death. A person is deemed to cause the death of another person when his or her "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); see, *People v Davis*, 28 NY3d 294, 300 (2016). The standard to apply in determining causation is whether the defendant's conduct was a "sufficiently direct cause" of the death. *People v Kibbe*, 35 N.Y.2d 407 (1974). "A person's conduct is a sufficiently direct cause of such injury when: one, the conduct is an actual contributory cause of such injury; and two, … the injury was a reasonably foreseeable result of the conduct." CJI, General Applicability, Causation.

Even if causation could be proven, Criminally Negligent Homicide and Manslaughter in the Second Degree require proof that the person engaged in conduct which created a substantial and unjustifiable risk of death. In this case, the evidence is consistent with the officers' statements that they restrained Mr. Brown because they believed him to be a danger to himself and others, and because they were waiting for EMTs to evaluate him or bring him to a hospital for treatment. Therefore, the evidence does not establish that the officers' actions were unjustifiable or that the officers would have anticipated that their actions created a substantial risk of death.

The evidence does not support charges under the more serious homicide statutes, Manslaughter in the First Degree under PL 125.20(1) and Murder in the Second Degree under PL 125.25(1), because there is no evidence that the officers *intended* to cause serious physical injury (Manslaughter in the First Degree) or death (Murder in the Second Degree).

For these reasons, OSI concludes that the evidence is insufficient to charge Trooper Rotach, Trooper Gokey, or Deputy Bronson with a crime and will close this matter with the issuance of this report.

RECOMMENDATIONS

Prone Restraint

As noted above, Dr. Revercomb's opinion was that the "20 minute" period of restraint, as recorded in the BWC video, in the position of being face down and handcuffed behind the back would have been "inherently stressful" when the troopers did not roll Mr. Brown onto his side, which, she said, "Has been the standard protocol for decades." Dr. Revercomb did not say in her report or in her discussion with OSI that the troopers' actions caused asphyxia or positional asphyxia.

OSI's investigation determined that NYSP trains recruits on life-support skills at the academy, with the objective that they will, "Understand how EMS plays a role in the job tasks of a State Trooper and how to properly treat an injured person until EMS arrives to take over patient care." Topics such as CPR, tourniquet usage, drug overdose and Naloxone, and use of an AED are included in this "EMS for Law Enforcement" course. NYSP recruits are also trained in recognizing and responding to a person experiencing mental health crises and MHL custody procedures. Both Troopers Gokey and Rotach received such training at the NYSP academy.

During their interviews with OSI, both Troopers Gokey and Rotach said they believed moving Matthew Brown to a different restraint position to be dangerous and risked injury to Matthew or someone else. When asked about positional asphyxia training, they said their responses are handled on a "case by

case basis" – it was not clear that either trooper remembered specific training on positional asphyxia or the use of the recovery position. OSI's investigation was unable to obtain from the NYSP the full content of its academy's training curriculum. Although OSI has found a slide from NYSP training materials saying that troopers should be "cognizant of positional asphyxia" and must turn the subject to the recovery position, OSI could not find any further detail as to whether NYSP's training specifically addresses the risks of positional asphyxia or how to manage those risks by alternative positions of restraint.

On June 3, 2026, New York State Division of Criminal Justice Services (DCJS) published a draft of its Model Policy on the Emergency Transport of Persons Experiencing an Emotional Crisis. MH transport Draft Model Policy. The Model Policy includes the following at Section VI-G:

> "If force or restraint other than compliant handcuffing is required to take an individual into custody… [r]equest EMS to scene immediately… [and i]f a person has been placed into a prone position after being taken into custody, the individual should be moved from that position as soon as safely possible."

Therefore, OSI recommends that NYSP enhance existing training, including its life support skills training and use of force training, to ensure that members learn and retain an understanding of the risks of positional asphyxia due to prone restraint, and how to manage those risks by alternative positions of restraint. NYSP should adopt the DCJS Model Policy on the Emergency Transport of Persons Experiencing an Emotional Crisis, and its recruit training should fully incorporate its principles.

Emergency Response

In this case there was a delayed response by EMS, and, although both the original call to 911 and the officers' later call for EMS clearly indicated a mental health crisis, no mental health service provider was engaged.

Therefore, OSI recommends that when a 911 call provides reason to believe that a person is experiencing a mental health emergency, the Oneida County operators' protocol (and all 911 protocols statewide) should require that the operators send the information to the available emergency mental health services provider as soon as possible, to supplement the police response.

OSI also recommends that NYSP (and all police agencies statewide) develop procedures for alerting and coordinating response efforts with mental health agencies and train their members on those procedures. This should include, but not be limited to, adopting and creating protocols to implement the DCJS Model Policy on the Emergency Transport of Persons Experiencing an Emotional Crisis.

Dated: September 2, 2026