

**Special Investigations and
Prosecutions Unit**

**Report on the Investigation into
The Death of Ferdy Jacinto-Martinez**



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EXECUTIVE SUMMARY

On July 8, 2015, Governor Andrew Cuomo signed Executive Order No. 147 (the “Executive Order”), appointing the Attorney General as special prosecutor “to investigate, and if warranted, prosecute certain matters involving the death of an unarmed civilian . . . caused by a law enforcement officer.” On July 25, 2019, at about 2:53 p.m., Ferdy Jacinto-Martinez (“Mr. Jacinto-Martinez”) died in an Englewood, NJ, hospital, to which he had been transported after becoming unresponsive immediately following an encounter with corrections officers in the Rockland County Correctional Facility (“RCCF”).¹ Governor Cuomo subsequently issued Executive Order No. 147.26, expressly conferring jurisdiction on the Office of the Attorney General (“OAG”) to investigate any potential unlawful acts or omissions by law enforcement related to Mr. Jacinto-Martinez’s death.²

The Office of the Attorney General’s investigation of this matter included the following steps, among many others:

- Review of Spring Valley Police Department (“SVPD”) records related to the investigation and arrest of Mr. Jacinto-Martinez, including video of SVPD interview of Mr. Jacinto-Martinez;
- Review of internal RCCF documents, including booking, housing, precautionary watch, and restraint chair logs;
- Review of comprehensive surveillance footage from inside RCCF;
- Review of Mr. Jacinto-Martinez’s medical records, including records from RCCF, responding paramedics and emergency medical services, Montefiore Nyack Hospital, and Englewood Hospital and Medical Center;
- Interview of approximately 20 witnesses, including RCCF corrections officers, supervisors, and medical staff, as well as responding EMTs and paramedics;
- Autopsy report from the Office of the Bergen County (NJ) Medical Examiner;
- Interview of Dr. Zhengxue Hua, Bergen County Medical Examiner; and
- Consultation with independent forensic pathologist Dr. James Gill, current Chief Medical Examiner for the State of Connecticut and a Clinical Associate Professor of Pathology for the Yale School of Medicine.

Ferdy Jacinto-Martinez (D.O.B. 12/15/86), died on July 25, 2019, in an Englewood, NJ, hospital, hours after being formally released from the custody of the Rockland County Sheriff’s Department. Mr. Jacinto-Martinez had been held on bail in the Rockland County Correctional Facility since July 21, 2019. On July 23, following an incident in which Mr. Jacinto-Martinez began acting in an erratic fashion and refused to return to his cell, Mr. Jacinto-Martinez was forcibly placed in a restraint chair at the facility for approximately two-and-a-half hours. When his erratic behavior showed no sign of abating, and his mental health seemed to be deteriorating, an ambulance was called to the jail. Shortly after Mr. Jacinto-Martinez was forcibly transferred from the restraint chair to a gurney for transport to the hospital, he became unresponsive. While

¹ The Rockland County Correctional Facility is operated by the Rockland County Sheriff’s Department. Corrections officers at the facility are deputy sheriffs and therefore “law enforcement officers” pursuant to CPL § 1.20(34).

² Executive Order 147.26 is attached as Exhibit 1.

still in the legal custody of the Rockland County Sheriff's Department, Mr. Jacinto-Martinez was taken to Nyack Hospital in Rockland County, then subsequently to Englewood Hospital in New Jersey. Although the first hospital was able to restore Mr. Jacinto-Martinez's heartbeat, he had suffered significant brain injury due to lack of oxygen. On July 25, 2019, Mr. Jacinto-Martinez died in Englewood Hospital in New Jersey.

Having completed its investigation of this incident, the OAG has found that there is insufficient evidence to conclude that any crime was committed in connection with the death of Mr. Jacinto-Martinez. As discussed in some detail below, although the medical examiner who conducted the initial autopsy identified injuries that led him to believe that Mr. Jacinto-Martinez's death had been caused by compression of the neck (leading to a fatal heart attack) during that final encounter with the corrections officers, neither the video footage of that encounter nor the testimony of any eyewitnesses to the encounter (including numerous medical personnel) could conclusively support this finding. In addition, an independent forensic pathologist consulted by the OAG reached an altogether different conclusion as to the likely cause of Mr. Jacinto-Martinez death: namely, that his encounter with the corrections officers placed sufficient stress on Mr. Jacinto-Martinez, whose body was in an exceedingly vulnerable condition at the time, to trigger the fatal heart attack. Because it appears questionable whether Mr. Jacinto-Martinez's death was indeed caused by compression of the neck – which in any event it would be impossible to prove beyond a reasonable doubt – and because there is no conclusive evidence that the corrections officers otherwise engaged in any criminal conduct in their interaction with Mr. Jacinto-Martinez, the OAG will not be pursuing a criminal prosecution in connection with this matter.

Although the OAG finds no criminal culpability in Mr. Jacinto-Martinez's tragic death, we have concerns about the RCCF's handling of the incident and make the following recommendations to address these concerns:

- RCCF should mandate training for its correctional staff in how to identify and properly handle inmates who exhibit symptoms of “agitated delirium” or “excited delirium”;
- Officers should be directed not to make contact with neck and ensure all force is proportionate to circumstances;
- RCCF should ensure that the entire period during which an inmate is held in a restraint chair is audio-recorded as well as video-recorded, and that cameras are positioned to avoid obscuring view of inmate;
- RCCF should improve language access practices; and
- RCCF should amend its policies with respect to the use of four-point restraint chairs to ensure compliance with ABA standards

STATEMENT OF FACTS

On the evening of July 20, 2019, the Spring Valley (Rockland County) Police Department arrested Mr. Jacinto-Martinez on allegations of having had sexual contact with a minor living in the house where he was renting a room. At approximately 11:40 pm on that date, Mr. Jacinto-Martinez was interviewed by a Spring Valley detective on video. At that time, he displayed no obvious signs of medical distress or physical injury.

Mr. Jacinto-Martinez was held in a cell at the Spring Valley Police Department until approximately 6:25 pm the following day, at which point he was escorted to court for arraignment. Mr. Jacinto-Martinez was ordered held in on bail and was then returned to his cell at the police department until members of the Rockland County Sheriff's Department arrived, at approximately 7:45 pm, to transport him to the county jail. Mr. Jacinto-Martinez arrived at the jail at approximately 8:00 pm.

RCCF is operated by and is under the authority of the Rockland County Sheriff's Department. RCCF has the capacity to house 280 inmates and is generally staffed with approximately 175 deputy sheriffs of various ranks. There were approximately 122 inmates housed at RCCF while Mr. Jacinto-Martinez was there.

An initial medical assessment of Mr. Jacinto-Martinez conducted upon intake at the jail the evening of his arrival did not detect any evidence of medical distress or physical injury. Mr. Jacinto-Martinez did state that he had previously visited a hospital because his left hand was shaking, and that he drank alcohol occasionally. During risk-assessment questioning at 10:00 pm, Mr. Jacinto-Martinez denied he was currently suffering from any medical problems.

On July 22, 2019, starting at about 12:30 am, the jail medical staff conducted a more thorough medical assessment. At that time, Mr. Jacinto-Martinez notified the staff that he had been diagnosed with hypertension three months earlier, but otherwise denied – and the medical staff did not observe signs of – any additional medical problems, physical injuries, mental illness, or substance abuse. (Mr. Jacinto-Martinez repeated that he drank occasionally on weekends.) Mr. Jacinto-Martinez also indicated that he was taking medication for hypertension but did not know the name of that medication. Mr. Jacinto-Martinez was then escorted by corrections officers (all of whom are technically deputy sheriffs) to his cell in the facility, where he remained for various stretches of time during his stay at the jail. At all times, he was housed alone, without a cellmate.

At 9:30 am that same morning, Mr. Jacinto-Martinez was called to the jail clinic for a follow-up appointment, but refused to go. At or around 4:00 pm, Mr. Jacinto-Martinez was seen by the medical staff and was administered a blood-pressure medication (Norvasc). The medical staff subsequently confirmed via Mr. Jacinto-Martinez's pharmacy that no prescriptions had been filled on Mr. Jacinto-Martinez's behalf. At or around 8:00 pm, Mr. Jacinto-Martinez was seen by the medical staff and was administered another dose of blood-pressure medications (Norvasc and Hygroton) along with a sedative (Vistaril). At 11:24 pm, Mr. Jacinto-Martinez again refused to go to the clinic for blood-pressure monitoring.

On July 23, 2019, about 12:15 am, Mr. Jacinto-Martinez indicated to corrections officers monitoring the cellblock that he wished to go to the clinic about his heart, and additional officers were called to escort him there. But after being removed from his cell, Mr. Jacinto-Martinez refused to walk with the escorting officers – and then, once they gave up on efforts to persuade him, Mr. Jacinto-Martinez refused as well to return to his cell. When the officers attempted to forcibly return him to the cell, Mr. Jacinto-Martinez resisted their efforts, and straddled the cell doorway with his legs. With multiple officers now taking part, Mr. Jacinto-Martinez – who by this point had also begun to speak in a nonsensical, incoherent manner³ – was taken to the ground and handcuffed. He was then escorted from the cellblock to a holding area in another part of the facility and he was secured in a restraint chair.⁴ Because Mr. Jacinto-Martinez had previously attempted to spit at officers during the initial struggle, a spit mask was also placed over his head.⁵ (The spit mask remained throughout the period Mr. Jacinto-Martinez remained in the restraint chair.)

Mr. Jacinto-Martinez, while still in the restraint chair, was subsequently attended to by medical staff at 12:35 am, 12:50 am, and 1:30 am; his blood pressure was checked and he was administered blood-pressure medications Norvasc and Vistaril. According to the facility nurses, as well as contemporaneously-kept inmate records, aside from his incoherent speech, Mr. Jacinto-Martinez did not complain of or show any signs of medical distress or difficulty breathing. However, the nurses found that his blood pressure and pulse was significantly elevated. Throughout this period, corrections officers also visited and attempted to speak with Mr. Jacinto-Martinez, checking on and occasionally loosening the straps holding him in the chair. However, neither the nurses nor the officers who interacted with Mr. Jacinto-Martinez during seven of these 12 visits spoke Spanish, and there was no translator present. On several of these visits, Mr. Jacinto-Martinez attempted to communicate with non-Spanish speaking corrections officers assessing his restraints.⁶

³ Mr. Jacinto-Martinez communicated exclusively in Spanish. During fewer than half of his interactions with corrections officers on the morning of July 23, a Spanish-speaking officer was present and served as translator as necessary.

⁴ A restraint chair is a type of physical restraint that is used to force an individual to remain seated in one place to prevent injury and harm to themselves or others. The restraint chair used in this case resembles a typical lawn chair with a ninety degree upright back support and two arm supports. There are straps for the waist and each wrist and ankle to secure an inmate.

⁵ Spit masks are used by law enforcement officers and healthcare providers to protect themselves from the spread of communicable disease by subjects who pose a potential risk of biological exposure by spitting. The spit mask used on Mr. Jacinto-Martinez was made of finely meshed material with a plastic film over the mouth area.

⁶ There was no bilingual translator present for the following restraint and medical checks on Mr. Jacinto-Martinez:

- Correctional Officers' (COs') first check on restraints: 12:44 a.m. -12:45 a.m.;
- COs' second check on restraints: 12:51 a.m. -12:52 a.m.;
- COs' fourth check on restraints: 1:22 a.m. -1:23 a.m. (the CO communicates with Mr. Jacinto-Martinez and Mr. Jacinto-Martinez attempts to communicate with the CO);
- Third medical check-in by two medical professionals: 1:29 a.m. - 1:31 a.m.;
- COs' fifth check on restraints: 1:53 a.m. - 1:54 a.m.;
- COs' sixth check on restraints: 2:08 a.m. - 2:09 a.m.; and
- COs' seventh check on restraints: 2:23 a.m. – 2:24 a.m. (Mr. Jacinto-Martinez appears agitated and attempts to communicate w/ CO).

At 2:25 am, officers informed Mr. Jacinto-Martinez that he could return to his cell and attempted to release him from the restraint chair. As they began to remove the straps, however, Mr. Jacinto-Martinez ignored the officers' instructions to remain still and attempted to spring out of the chair; he was then promptly retrained in the chair again. The medical staff came to check on Mr. Jacinto-Martinez again at 2:35 am. Again, according to the facility nurses and inmate records, he did not complain of or show signs of physical pain or difficulty breathing; but his blood pressure and pulse was unusually high, and over the next half hour or so, according to the attending nurses, he began to display "increase[d] confusion, restless, sweating & agitation." At the suggestion of the facility's chief physician, an ambulance was called to take him to Nyack Hospital, principally over concerns that his pulse was unusually high.

Several paramedics responded before the arrival of the ambulance, and at around 3:05 am checked on Mr. Jacinto-Martinez. None of the jail medical staff or paramedics noticed any obvious signs of physical injury to Mr. Jacinto-Martinez nor did he complain of any at this point. At 3:10 am, Emergency Medical Technicians ("EMTs") entered the holding area with a gurney. The gurney was positioned in an upright sitting position. All non-officers were instructed to wait outside the room until officers safely strapped Mr. Jacinto-Martinez onto the gurney.⁷

Over the next few minutes, seven corrections officers forcibly transferred Mr. Jacinto-Martinez from the restraint chair to the gurney. The precise details of the interaction between Mr. Jacinto-Martinez and the officers are a matter of considerable uncertainty. And it is in connection with this interaction that the prospect of wrongful and potentially criminal conduct on the part of one or more of the officers arises.

However, the broad strokes are clear: With Mr. Jacinto-Martinez rocking forward in the seat, and the officers attempting to keep him still, they removed the chair straps, handcuffed him, and stood him up. As they walked him the few feet to the gurney, Mr. Jacinto-Martinez tried to pull away, at which point the officers lifted him from the ground and forcefully laid him onto the gurney, removed the handcuffs, and – after again lifting Mr. Jacinto-Martinez up and repositioning him on the gurney – together held him down until they were able to fasten straps across his legs and chest. The officers then stepped away from Mr. Jacinto-Martinez, who, with one officer continuing to hold his head down on the gurney (and, for several seconds, his neck), shortly thereafter once more bucked his body and briefly kicked his legs. And then, approximately two minutes after being first placed on the gurney, Mr. Jacinto-Martinez stopped moving entirely.

By this time, the EMTs had reentered the holding area. They observed that Mr. Jacinto-Martinez appeared to be unresponsive, and finding no pulse, began cardiopulmonary resuscitation ("CPR"). A few minutes later, they moved Mr. Jacinto-Martinez to the ambulance, and headed for Nyack Hospital (accompanied by deputy sheriffs), leaving at 3:27 am and arriving at 3:52 am. Emergency room staff at Nyack Hospital were able to restore a pulse, and ultimately determined that Mr. Jacinto-Martinez had suffered from "acute cardiac arrest." While treating Mr. Jacinto-Martinez, Nyack doctors were in contact with Dr. Peter Kaye from

⁷ Although the medical personnel were instructed to wait outside of the holding room, they were still able to observe the events unfolding inside through a large rectangular window. Because of the positioning of the corrections officers, however, their view Mr. Jacinto-Martinez was in large measure obstructed.

Englewood (NJ) Hospital, who agreed to accept the patient for transfer for cardiac catheterization. At approximately 5:36 am, Mr. Jacinto-Martinez was transferred via ambulance to Englewood Hospital (accompanied by deputy sheriffs), arriving at 6:06 am.

Mr. Jacinto-Martinez's condition upon arrival was urgent. A CT scan revealed significant brain injury caused by lack of oxygen to the brain. Englewood Hospital records indicate a history of alcohol abuse, although the source of this information is not clear.⁸ Mr. Jacinto-Martinez was admitted to Englewood Hospital but his condition steadily deteriorated. Mr. Jacinto-Martinez remained formally in custody, under guard and handcuffed to the hospital bed; but on July 25, at about 2:00 pm, the Rockland County DA's office consented to his release from custody, and the restraint was removed. Later that day, still in the hospital, Mr. Jacinto-Martinez passed away.

MEDICAL EXAMINER

On July 26, 2019, Dr. Zhengxue Hua ("Dr. Hua"), medical examiner for Bergen County (NJ), conducted an autopsy of Mr. Jacinto-Martinez. Prior to finalizing his report on August 22, Dr. Hua also had an opportunity to review Mr. Jacinto-Martinez's medical records from RCCF and from Nyack and Englewood Hospitals, as well as law enforcement records related to Mr. Jacinto-Martinez's death. Prior to release of the report, surveillance video footage of Mr. Jacinto-Martinez's interactions with officers from RCCF was unavailable.

The autopsy report⁹ identified the cause of Mr. Jacinto-Martinez's death as "hypoxic-ischemic encephalopathy due to neck compression during physical restraint for agitated behavior." Hypoxic-ischemic encephalopathy is brain injury caused by deprivation of oxygen to the brain. Dr. Hua explained in a meeting with OAG staff that the injury to Mr. Jacinto-Martinez's brain triggered cardiac arrest, which in turn resulted in further oxygen deprivation to the brain. In support of his conclusion that the initial brain injury was due to neck compression, Dr. Hua drew particular attention to three findings: (1) "back and front of neck with multiple muscular hemorrhages;" (2) "thyroid cartilage fracture," that is, a fracture of the "Adam's apple"; and (3) "slight hemorrhage of eye," also known as petechiae. Dr. Hua explained to OAG staff that the injuries to the neck and to the thyroid cartilage would each have required the application of considerable force. He further explained that the petechiae of the eyes was most consistent with a constriction of the flow of blood through the neck. Dr. Hua identified the manner of Mr. Jacinto-Martinez's death as "homicide."

The autopsy report also noted as a "contributing condition" to Mr. Jacinto-Martinez's death: "chronic alcoholism with cardiac hypertrophy and liver steatosis." Liver steatosis is an accumulation of fat in the liver, and is a consequence of excessive alcohol consumption. It was the presence of this condition, along with information in the medical records referencing Mr. Jacinto-Martinez's alcohol consumption habits, which led Dr. Hua to reach a finding of chronic alcoholism. Cardiac hypertrophy is a thickening of the heart muscle, in this case likely due to Mr. Jacinto-Martinez's alcoholism, and is often associated with high blood pressure. However,

⁸ The information may have originated with Mr. Jacinto-Martinez's brother, who – according to jail medical records – told the jail medical staff on July 23 that Mr. Jacinto-Martinez "was a heavy drinker and did not listen to anyone."

⁹ Dr. Hua's findings from his autopsy report are attached as Exhibit 2. A complete copy of the autopsy has been provided to Mr. Jacinto-Martinez's family.

this condition was not particularly advanced. Especially in light of the ample evidence of neck compression, Dr. Hua told OAG staff he saw no reason to believe that any cause other than hypoxic-ischemic encephalopathy was the trigger here.

In February 2020, the OAG renewed its request that Dr. Hua review the video footage from Rockland County Correctional Facility in order to identify, to the best of his ability, when and how Mr. Jacinto-Martinez suffered the injuries to his neck that Dr. Hua found to be associated with his death. Dr. Hua agree to do so, and shortly thereafter responded that, “After reviewing the provided video footage, I have no change of my opinions regarding Mr. Ferdy Jacinto-Martinez’s cause and manner of death.” In a follow-up telephone conversation with OAG staff, Dr. Hua stated in substance that although he could not personally determine from the video exactly when and how Mr. Jacinto-Martinez had been subjected to neck compression, the autopsy findings and the circumstances immediately surrounding his death led to no other conclusion as to its cause.

VIDEO FOOTAGE

RCCF has an elaborate system of video surveillance cameras. And with the exception of periods when he was alone in his cell or with jail medical staff inside one of the examination rooms, virtually all of Mr. Jacinto-Martinez’s time in the facility – including all movements through the facility and interactions with other inmates or staff – is captured on high-definition [video](#), often from multiple angles. However, RCCF does not audio-record these encounters. The video linked above covers the entire approximately three-hour sequence capturing the incident that led to Mr. Jacinto-Martinez being placed in the restraint chair, through the time he was kept in the chair, up to the transfer from chair to gurney, and the immediate aftermath.¹⁰

In light of Dr. Hua’s findings, OAG staff carefully scrutinized the footage capturing the interaction between Mr. Jacinto-Martinez and RCHC corrections officers from the time officers began to release him from the restraint chair until he was secured on the gurney and shortly thereafter became unresponsive – in an effort to identify when, how, and at whose hands he was subjected to compression of the neck.

The entire sequence takes approximately eight minutes, starting at about 3:11:16 (on the RCHC time stamp) and ending at about 3:19:22. Throughout most of the interaction, the footage provides a clear view of Mr. Jacinto-Martinez’s neck area. With the exception of a period of several seconds shortly after Mr. Jacinto-Martinez has been fully restrained (discussed below), at no time does the footage capture what would appear to be any officer making contact with this area, whether holding, pressing down upon, or striking the neck. There is a point as the officers are initially unstrapping Mr. Jacinto-Martinez from the restraint chair (2:26:41 through 2:31:02), when one officer is seen holding the sides of Mr. Jacinto-Martinez’s head from the behind and pressing his fingers under the inmate’s jaw – a so-called hypoglossal hold. But this compliance technique, while apparently painful, does not appear to bring the officer’s hands into contact with

¹⁰ Note the following key stretches in the footage (per the video time stamp): (i) first encounter between Mr. Jacinto-Martinez and corrections officers in the cell block (00:16:40 – 00:20:00), (ii) initial attempt to release Mr. Jacinto-Martinez from the restraint chair (02:26:00 – 02:31:00), and (iii) final transfer of Mr. Jacinto-Martinez from restraint chair to gurney (03:11:13 – 03:24:20).

neck itself. Just before the officers begin trying to strap him down, Mr. Jacinto-Martinez is brought down heavily onto the gurney (3:16:18), and then repositioned and brought down heavily again (3:17:03). Because of these actions, both times the back of his neck appear to make forceful contact with the surface; however, no officer during this stretch can be seen to have his hands in the immediate area of the neck. At a later point, after Mr. Jacinto-Martinez has been secured on the gurney, an officer is seen holding the top of the inmate's head, which is awkwardly turned to one side (3:17:50 through 3:19:08). For a stretch of approximately six seconds (3:18:10 through 3:18:16) during this period, the same officer's hand does appear to make direct contact with the left side of Mr. Jacinto-Martinez's neck before closing into a fist. Otherwise, there is no visible contact with the neck or throat itself.

There is a period of about 94 seconds while the officers are attempting to secure Mr. Jacinto-Martinez to the gurney (3:16:18 through 3:17:52) in which neither the area of Mr. Jacinto-Martinez's neck nor the hands of several officers in his immediate are entirely visible. Accordingly, the video footage cannot establish whether or not force was used during this period.

WITNESS INTERVIEWS

Eight corrections officers (including two sergeants) were present in the holding area and involved in the transfer of Mr. Jacinto-Martinez from the restraint chair to the gurney. In addition, two EMTs and two paramedics, and at least one facility nurse, were immediately outside the holding area, separated by a windowed wall. Interviews with these witnesses – during which each was asked to provide his or her account of events before having an opportunity to view the surveillance video footage – were focused primarily on the nature of the physical interaction between the officers and the inmate, with a particular eye toward determining what took place during the 94 second stretch of video in which Mr. Jacinto-Martinez's neck area cannot be seen.

All of the medical personnel said they could see that Mr. Jacinto-Martinez was resisting the officers' efforts to transfer him to the gurney, but denied observing any of the officers strike or choke Mr. Jacinto-Martinez. The witnesses did acknowledge (in substance), however, that the crowd of bodies surrounding the inmate made it difficult to see clearly what the officers were doing.

As for the corrections officers themselves, they were consistent in their description of Mr. Jacinto-Martinez as lunging out of the restraint chair, kicking, spitting, and attempting to bite them as they attempted to move him from the chair to the gurney. With respect to the period during which Mr. Jacinto-Martinez's neck area and their hands are not visible in the footage, each insisted he was either trying to hold down some part of the inmate's body (legs, shoulder, hip, arm) or trying to secure the straps or both. One officer positioned toward Mr. Jacinto-Martinez's head said he put his knee up on the gurney to improve his leverage, but did not push his knee down onto the inmate. Another officer positioned on the other side of the gurney stated that he did push his thumb into a pressure point behind Mr. Jacinto-Martinez's left ear to gain compliance. All of the officers denied ever striking or otherwise using force in or around Mr. Jacinto-Martinez's neck at any time during the transfer, nor did they observe anyone else do so.

It is of course unsurprising that the corrections officers would say nothing that could implicate themselves or their colleagues, and so it is difficult to assess the reliability of their accounts. (The medical personnel might be expected to be more forthcoming, although they too have ongoing relationships with the facility; in any event, given where these witnesses were standing, it is entirely plausible that they would not have seen any culpable conduct anyway.) Consequently, the witness interviews cannot definitively resolve precisely what happened during the stretch of time during which the officers' interaction with Mr. Jacinto-Martinez is largely hidden from view.

INDEPENDENT FORENSIC PATHOLOGIST

In an effort to reconcile the video footage of the interaction between Mr. Jacinto-Martinez and the officers with Dr. Hua's findings, the OAG retained as independent expert Dr. James Gill ("Dr. Gill"), the current Chief Medical Examiner for the State of Connecticut and a Clinical Associate Professor of Pathology for the Yale School of Medicine. Dr. Gill was provided with a copy of the autopsy report, as well as three-and-a-half hours of video footage of Mr. Jacinto-Martinez, covering the period from just before the initial altercation with corrections officers in the cellblock hallway up until Mr. Jacinto-Martinez was moved into the ambulance for transport to the hospital. Dr. Gill was asked specifically "to review the video footage in order to identify exactly when and how Mr. Jacinto-Martinez suffered the injuries that Dr. Hua found to be associated with Mr. Jacinto-Martinez's death." At his request, Dr. Gill was also provided with RCCF inmate health records for Mr. Jacinto-Martinez; prehospital care reports from the EMTs and paramedics; and records from Englewood Hospital and Montefiore Nyack Hospital – as well as a sample spit mask.

It is important to note that in seeking Dr. Gill's input, the OAG was decidedly *not* asking for a second opinion as to the manner of Mr. Jacinto-Martinez's death. Rather, OAG staff presented Dr. Hua's conclusions (that neck compression had compromised Mr. Jacinto-Martinez's brain function, triggering a cardiac arrest, which in turn caused further injury to the brain) and the principal findings in support of those conclusions (bruising to the neck, a fractured thyroid cartilage, petechiae) as the starting point, and asked Dr. Gill to explain where in the video footage officers could be seen engaging in compression of Mr. Jacinto-Martinez's neck in such a manner as to cause those injuries.¹¹

¹¹ Specifically, OAG staff in writing asked Dr. Gill to: (1) "Provide to the best of your ability a chronological narrative (including relevant time stamps in the video) of what is happening physiologically with Mr. Jacinto-Martinez from the time he is released from the restraint chair up until he is removed from the holding cell on the gurney"; (2) "Identify the specific human conduct (including relevant time stamps) that caused or contributed to the sustained constriction of Mr. Jacinto-Martinez's airway, sufficient to result in the compromised brain function that ultimately triggered the cardiac arrest"; (3) "Explain the physiology of how this human conduct actually caused or contributed to the constriction of Mr. Jacinto-Martinez's airway; what additional factors, if any, may have contributed to that initial compromise of brain function; and how the constriction of the airway, along with any additional factors, would have resulted in such compromised brain function in the time period involved here"; (4) "Address the relevance of each of the three categories of injury to which Dr. Hua draws attention (bruising to back of neck, bruising to front of neck, fracture of thyroid cartilage) – in particular, what you have concluded as to how these injuries were caused"; and (5) If not otherwise covered in discussing the issues above, please clarify what role if any you believe any of the following factors played in the chain of events leading to Mr. Jacinto-Martinez's death: (i) elevated blood pressure; (ii) cardiac hypertrophy; (iii) liver steatosis."

On March 21, 2020, Dr. Gill delivered a final report¹² offering “to a reasonable degree of medical certainty” his “opinions in connection with the death of Ferdy Jacinto-Martinez.” As it turned out, Dr. Gill proved to have serious doubts about the OAG’s underlying premise (and Dr. Hua’s opinion) that Mr. Jacinto-Martinez’s death was initially triggered by compression of the neck. Dr. Gill agreed with Dr. Hua that the nature of the injuries to Mr. Jacinto-Martinez’s neck, along with the proximity in time between the officers’ use of physical force and the inmate’s becoming unresponsive, certainly raised the reasonable possibility that Mr. Jacinto-Martinez had been the victim of asphyxia – that is, unnatural interference with access to oxygen. “The temporal relationship of the physical restraint following transfer to the stretcher (~3:16) with his subsequent loss of consciousness, in conjunction with the autopsy findings (fractured larynx, neck hemorrhage, petechiae), are concerning for an asphyxial injury.”

However, while the injuries in this case certainly constituted persuasive evidence of forceful contact with Mr. Jacinto-Martinez’s neck area, they did not necessarily indicate the sort of sustained neck compression to which Dr. Hua pointed. “Petechiae may be a sign of neck compression, however, they also may be seen with vigorous attempts at resuscitation. The thyroid fracture by itself does not signify for how long the force was applied; it only shows that enough force was applied to cause the fracture. A sudden forceful blow/pressure, without a prolonged (asphyxial) compression, also may cause such an injury.” Likewise, the injuries to the back and side of Mr. Jacinto-Martinez’s neck – while certainly consistent with neck compression – could also have been caused by the application of force in any number of forms, such as contact with a hard surface.

More to the point, a review of the video footage made clear to Dr. Gill that even if compression of the neck had occurred during the transfer of Mr. Jacinto-Martinez from the restraint chair to the gurney, it is highly unlikely to have caused a hypoxic brain injury. After all, with the exception of that obstructed 94-second stretch during which Mr. Jacinto-Martinez is being held down on the gurney, it is clear from the footage that throughout the transfer (aside from the six-second stretch described above), there is no meaningful contact with Mr. Jacinto-Martinez’s neck area. And even if it could be established that, during that entire 94-second stretch, one or more of the officers did put pressure on Mr. Jacinto-Martinez’s neck, this use of force – while it may have been sufficient to leave Mr. Jacinto-Martinez unconscious – would not have done the kind of damage to the brain necessary to trigger a cardiac arrest.¹³ “It generally takes longer than 100 seconds of constant neck compression to cause irreversible brain injury and/or death.... Based on the length of the obscured view (under 90 seconds), it is unlikely that there was enough time for neck compression, even if it were constantly applied, to have caused lethal brain injury.”¹⁴

¹² Dr. Gill’s expert report is attached as Exhibit 3.

¹³ According to Dr. Gill, other evidence from the footage, although not dispositive, further casts this theory into doubt: “At 3:17:41, the guards started to move away from him. At this point, he appeared unconscious with no voluntary movements. At 3:18:05, his feet started twitching and then his head and torso started bucking. This may represent seizure activity or him regaining consciousness. If this is indeed him regaining consciousness, it would further exclude neck compression as the cause of the lethal brain injury.”

¹⁴ Dr. Gill further noted that this principle is “well known in clinical medicine,” and directed OAG staff to both the CPR entry from the MedLine Plus Medical Encyclopedia (“Permanent brain damage begins after only 4 minutes

Taking into consideration the medical evidence and the video footage in its totality, it is Dr. Gill's opinion that the cardiac arrest that ultimately led to Mr. Jacinto-Martinez's death is best explained not by hypoxic brain injury but by the stress of transferring Mr. Jacinto-Martinez into the restraint chair when he was already in a vulnerable physical condition. Dr. Gill cites in particular the cardiac hypertrophy (also noted by Dr. Hua) from which Mr. Jacinto-Martinez suffered, as well as the hypertension that the jail facility nurses diagnosed. Dr. Gill also cites the alcohol withdrawal syndrome (to which individuals with a history of chronic alcohol abuse are susceptible) that Mr. Jacinto-Martinez appeared to be experiencing – as evidenced by his erratic behavior and incoherent speech in the period leading up to that final interaction with the corrections officers. (Dr. Hua had likewise noted Mr. Jacinto-Martinez's "chronic alcoholism.") Both the cardiac condition and the "agitated delirium" associated with alcohol withdrawal were independently capable of causing cardiac arrest, and at the very least made Mr. Jacinto-Martinez's heart vulnerable to additional stress on the body.¹⁵

Ultimately, Dr. Gill concluded: "Given that the video demonstrated insufficient time for fatal neck compression, the uncertainty of whether he had regained consciousness at ~3:18:05, and his current cardiovascular disease with decompensation (hypertension, tachycardia, cardiac hypertrophy/dilation), and his chronic alcohol abuse with withdrawal, it is reasonable that the stress of the transfer along with his heart disease and agitated delirium caused his death without any 'asphyxial' neck compression component." The hypoxic brain injury, then, was likely the consequence of, rather than the cause of, the cardiac arrest. "The subsequent brain injury and EKG and liver changes were all secondary processes, caused by the cardiac arrest at the jail with the subsequent resuscitation. The entire period of the lack of oxygen (hypoxia) lasted over 4 minutes which would have been enough to cause irreversible brain injury."

Like Dr. Hua (and OAG staff), Dr. Gill was unable to determine from the video footage when and under what circumstances the injuries to Mr. Jacinto-Martinez's neck were inflicted. (He does seem to rule out the possibility that the most troubling of the injuries, the fracture of the Adam's apple, was merely a result of medical attention: "Standard attempts at resuscitation would not explain a fractured thyroid cartilage.") In any event, it does not appear that resolving this issue would affect Dr. Gill's analysis.

LEGAL ANALYSIS

The question of whether any RCCF corrections officers are criminally culpable in the death of Ferdy Jacinto-Martinez depends, as a threshold matter, on the degree to which their conduct caused or contributed to (if at all) Mr. Jacinto-Martinez's death. The analysis conducted by the medical examiner in this case, Dr. Zhengxue Hua, quite unequivocally attributes Mr. Jacinto-Martinez's death to sustained compression of the neck, to the point of causing hypoxic-

without oxygen, and death can occur as soon as 4 to 6 minutes later") and a definitive study conducted in the 1940s establishing that a person can experience up to 100 seconds of lack of oxygen to the brain without having brain injury ("Acute Arrest of Cerebral Circulation in Man," by Rossen, Kabat, and Anderson).

¹⁵ Dr. Gill could not exclude the possibility that the awkward manner in which Mr. Jacinto-Martinez's head was being held by one of the officers immediately after that 94-second stretch substantially interfered with Mr. Jacinto-Martinez's breathing. And while this "positional asphyxia" may not have made for enough interference to cause the hypoxic-ischemic injury, it could certainly have contributed to the stress upon Mr. Jacinto-Martinez's body.

ischemic encephalopathy, which in turn triggered a fatal cardiac arrest. If correct, Dr. Hua's analysis has serious implications for the officers involved. It would almost certainly provide grounds for a homicide charge, with the principal legal question then being whether the conduct was intentional, reckless, or criminally negligent under the law.

The evidence pointing to sustained neck compression as the cause of Mr. Jacinto-Martinez's death is considerable, if admittedly circumstantial. The distinctive injuries to the front and back of Mr. Jacinto-Martinez's neck (particularly the fractured thyroid cartilage) and the petechiae to the eyes; the opportunity available to the officers to have inflicted such injuries during their struggle to restrain Mr. Jacinto-Martinez on the gurney; Mr. Jacinto-Martinez's falling into an unresponsive state almost immediately following that struggle; and the absence of any obvious alternative explanation for Mr. Jacinto-Martinez's death all lend support to this conclusion.

The proof here is far from definitive, however. The video footage of the interaction on the gurney, while clearly showing use of force on the officers' part, offers no affirmative evidence of any officer making any direct contact with Mr. Jacinto-Martinez's neck (other than the six-second stretch of contact described earlier), let alone sustained compression. That conclusion relies rather on an inference that the culpable conduct took place during the one 94-second stretch when Mr. Jacinto-Martinez's neck and the officers' hands were blocked from the camera's view, (shortly after which Mr. Jacinto-Martinez became unresponsive. It is certainly plausible that all of the officers involved either were oblivious to what would have to have been some pretty conspicuous mistreatment of Mr. Jacinto-Martinez – or were not altogether forthcoming in their statements to OAG staff about what they observed (or did). What is clear, however, is that none of their testimony affirmatively supports the neck-compression hypothesis either.

More to the point: Based on the analysis offered by Dr. James Gill, the independent forensic pathologist consulted on the case, it is at least questionable whether even if one or more of the officers had engaged in compression of Mr. Jacinto-Martinez's neck during that entire 94-second stretch, it would have done the kind of harm to Mr. Jacinto-Martinez's brain necessary to trigger a cardiac arrest. According to Dr. Gill, sustained neck compression for this length of time might well render a person unconscious, but it would be highly unlikely to so deprive the brain of oxygen to the point of causing any meaningful hypoxic-ischemic injury. Taken together, this contrary evidence at the very least would make it all but impossible to prove beyond a reasonable doubt that neck compression was in fact the cause of Mr. Jacinto-Martinez's death.

In any event, Dr. Gill offers another theory altogether to account for Mr. Jacinto-Martinez's death: namely, that Mr. Jacinto-Martinez's pre-existing conditions – specifically, his alcoholism and cardiac hypertrophy – had independently rendered Mr. Jacinto-Martinez vulnerable to cardiac arrest, and that it was the additional stress placed on his body by the struggle with seven officers that was the final trigger.¹⁶ Mr. Jacinto-Martinez's resistance to

¹⁶ Again, Dr. Gill also draws attention to the awkward angle at which Mr. Jacinto-Martinez's head could be seen to be held on the video once enough of the officers stepped away from the gurney to allow again for an unobstructed view – a position which might itself have meaningfully interfered with Mr. Jacinto-Martinez's breathing. Such interference would have placed further stress on Mr. Jacinto-Martinez's body.

being moved to the gurney and strapped down, and the officers' use of force to overcome that resistance, might well have alone constituted sufficient stress to trigger the cardiac arrest; but that stress could also have been enhanced, perhaps significantly, by any contact with the neck during that 94-second stretch, including contact sufficient to cause those distinctive injuries. Still, even if contact with the neck during that stretch could be definitively proven, it would be nearly impossible to tease out the relative contributions of the various stress factors to Mr. Jacinto-Martinez's cardiac arrest so as to establish a homicide crime under the law.

It is worth noting as well that, even if neck compression could be definitively established as the cause of (or a contributor to) Mr. Jacinto-Martinez's death, the inquiry into possible criminal culpability would face a second major obstacle: determining which officer or officers were responsible for the culpable conduct. As mentioned, the video footage can do no more than establish which officers were in the immediate area of Mr. Jacinto-Martinez's head and neck over the course of the interaction on the gurney; those officers have denied engaging in such conduct, and the other officers claim to have seen nothing. Even where a crime could be shown, proving any specific officers' guilt beyond a reasonable doubt would itself be highly doubtful.

In deciding whether to go forward with a prosecution in any particular case, the OAG is bound by its ethical obligations to the individual or individuals who are the focus of our investigation. Under the American Bar Association's Criminal Justice Standards for the Prosecution Function, "A prosecutor should seek or file criminal charges only if the prosecutor reasonably believes that the charges are supported by probable cause, that admissible evidence will be sufficient to support conviction beyond a reasonable doubt, and that the decision to charge is in the interests of justice." ABA, Criminal Justice Standards for the Prosecution Function, §3-4.3(a) (2017). The National Prosecution Standards issued by the National District Attorneys Association hold that, "Prosecutors should screen potential charges to eliminate from the criminal justice system those cases where prosecution is not justified or not in the public interest," and lists among the factors that may be considered: doubts about the accused's guilt and insufficiency of admissible evidence to support a conviction." National District Attorneys Association, National Prosecution Standards §4-1.3 (3d. ed.).

Because it appears from a close look at all the available evidence that neither of the possible causes of Mr. Jacinto-Martinez's death could be proven beyond a reasonable doubt, and because criminal culpability would be at most dubious under one of those theories anyway, and because it would in any event be impossible to prove beyond a reasonable doubt who specifically engaged in any wrongful conduct, neither homicide nor any other charges would be appropriate. For these reasons, and pursuant to our ethical obligations, the OAG has elected not to seek charges against any of the officers involved in this case.

RECOMMENDATIONS

1. RCCF should mandate training for its correctional staff in how to identify and properly handle inmates who exhibit symptoms of “agitated delirium” or “excited delirium”

RCCF should mandate and provide training for its correctional staff in how to identify and properly handle inmates who exhibit the various symptoms of “agitated delirium” or “excited delirium,” which render an individual unusually susceptible to death under conditions of physical stress. Medical experts have found agitated delirium – defined as the acute onset of agitation, aggression, distress, and possibly sudden death – to be a serious causal factor in-custody deaths, including following the use of mechanical and physical restraints.¹⁷ Experts estimate that about eight to 14 percent of those who experience the syndrome die.¹⁸

This training should provide corrections officers and medical and mental health personnel with critical information on diagnosing and treating agitated delirium, which the OAG’s independent expert stated directly contributed to Mr. Jacinto-Martinez’s death. Corrections staff should be trained consistent with best standards on how to reduce symptoms and the likelihood of death stemming from agitated delirium and if necessary, seeking immediate medical care at a hospital. Further, this training should specifically require RCCF to do a thorough mental health and medical assessment for any such symptoms and inform its staff immediately so they reasonably tailor their use of force to avoid lethal consequences for inmates. Such training is in line with the American Bar Association (ABA) Standards on Treatment of Prisoners, which provides that corrections officers only be assigned responsibilities requiring the use of the force following appropriate training and initial and periodic evaluations for such duties.¹⁹

Corrections staff should also receive crisis intervention training for interacting with inmates who are experiencing a mental health crisis. This training should emphasize de-escalation methods that will protect both inmate and staff and reduce the likelihood that a use of force will be called for. Such training should also include best practices as to when and how to restrain such individuals so as to minimize the risk of harm to themselves and others.

2. Officers should be directed not to make contact with an individual’s neck and to ensure that all force is proportionate to circumstances

We recommend that RCCF develop rules specifically prohibiting corrections officers from making contact with an inmates’ neck unless absolutely essential, and to ensure all force is

¹⁷ *The Use of Restraints and Excited Delirium or Positional Asphyxia: A Review of the Safety and Guidelines.* (2016), <https://www.cadth.ca/sites/default/files/pdf/htis/aug-2016/RC0801%20Positional%20Asphyxia%20Final.pdf>

¹⁸ Asia Takeuchi, et al., *Excited delirium*, *The western journal of emergency medicine* vol. 12,1 (2011): 77-83, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3088378/>. Excited delirium is invoked almost exclusively regarding deaths that occur in a criminal justice context, in cases of death during use of force by police or correctional staff.

¹⁹ ABA Standards on the Treatment of Prisoners § 23-5.6(e).

proportional to circumstances. Although it may not have played a role in Mr. Jacinto-Martinez's death, and however brief it may have been, the direct contact with Mr. Jacinto-Martinez's neck described above is nevertheless troubling.

The video and interviews make clear that seven corrections officers transferred and put pressure on Mr. Jacinto-Martinez to restrain him. Although he resisted the guards' orders by moving back when he was ordered not to do so and pulled away once, he was not violent, did not cause any serious harm, and did not put anyone at risk of serious harm. It is certainly worth considering whether such a large number of corrections officers was necessary and appropriate for the purpose of subduing and restraining Mr. Jacinto-Martinez. In addition, the jail should adhere to the ABA Standards on the Treatment of Prisoners, which provide that jails should adopt "a range of force options and explicitly prohibit the use of premature, unnecessary, or excessive force" and "[c]ontrol techniques should be intended to minimize injuries to both prisoners and staff."²⁰ Further, "[e]xcept in highly unusual circumstances in which a prisoner poses an imminent threat of serious bodily harm, staff should not use types of force that carry a high risk of injury." Given the risks involved with using force to a person's neck, corrections officers should avoid these techniques unless absolutely necessary.

In this case, a measured approach to use of force was even more critical, because he was exhibiting symptoms of "agitated delirium" as described above. In such situations, experts have opined that corrections officers and staff should not engage in any kind of force that would constrict an inmates' breathing as it compounds with the symptoms of agitated delirium and can contribute to their death, as in Mr. Jacinto-Martinez.²¹ Thus, in all circumstances, but especially in circumstances where inmates are exhibiting symptoms of agitated delirium, corrections staff should be required to avoid actions which may result in neck compression or excessive stress, such as sitting, kneeling, or standing on a subject's neck, chest or back, thereby reducing the subject's ability to breathe.

3. RCCF should ensure that the entire period during which an inmate is held in a restraint chair is audio-recorded as well as video-recorded, and that cameras are positioned to avoid obscuring view of inmate

RCCF policy instructs the shift supervisor to ensure that the period during which an inmate is held in a restraint chair is video-recorded. To ensure appropriate oversight of RCCF's use of restraint chairs and use of force, the facility should also audio-record the entire period of restraint, in compliance with the ABA Standards on Corrections, which recommend that "for the entire period of restraint, the prisoner should be video- and audio-recorded."²² As RCCF recognizes, communication between restrained inmates' and correctional and medical staff is critical to ensure the inmate is restrained safely in his/her restraint chair and not suffering from any adverse consequences.

²⁰ ABA Standards on the Treatment of Prisoners § 23-5.6(d)

²¹ Edward Hughes, *Special Panel Review of Excited Delirium*, Pennsylvania State University, Institute for Non-Lethal Defense Technologies National Institute of Justice, 30 (2011), <https://www.hsdl.org/?view&did=804857>

²² ABA Correctional Standard 23-5.9(h)(i) Use of restraint mechanisms and techniques (for the entire period of restraint, the prisoner should be video- and audio-recorded).

Further, when the jail uses video for continuous monitoring, the video must provide a clear and accurate view of the inmate's body, including torso, extremities, and face. To ensure such views are not obscured, a camera positioned on the ceiling may be advisable. This will allow staff to identify emergency conditions on the video immediately when they arise. Unobstructed video recording also helps evaluate the circumstances of the adverse event.

4. RCCF should improve its language access practices

The events leading up to Mr. Jacinto-Martinez's death involved critical junctures where under RCCF policy and ABA Standards, it was essential that Mr. Jacinto-Martinez and the corrections/medical staff communicated with and understood each other with respect to the use of restraints and Mr. Jacinto-Martinez's physical condition. However, although Mr. Jacinto-Martinez communicated exclusively in Spanish, there were no Spanish-speaking correctional officers or medical staff, and no translators or language-lines used, during a number of these junctures. To avoid any misunderstandings between correctional staff and inmate, we recommend that RCCF ensure that it provides qualified, culturally competent interpretation services through staff or a telephonic vendor for any medical-related encounters, including throughout the use of a restraint chair or any other mechanism of sustained restraint.

5. RCCF should amend its policies with respect to the use of four-point restraint chairs to ensure compliance with ABA standards

RCCF should amend its policies on the use of four-point restraints and restraint chairs to ensure they are safely used and monitored, to prevent medical emergencies, and to bring the policies in line with ABA Standards for Correctional Facilities. Further, this policy should be designed to minimize the use of restraint chairs given the risks of adverse outcomes. It appears that Mr. Jacinto-Martinez's condition worsened to the point of crisis while he was secured in the four-point restraint chair and may have contributed to the circumstances that led to his need for hospitalization – and ultimately to his death. Over the three hours he was restrained, his pulse and blood pressure rose significantly and he was apparently experiencing the “agitated delirium,” that Dr. Gill identified as one cause of his death.²³

To ensure the safety of those placed in a restraint chair, RCCF should bring its policy in line with ABA standards by requiring a mental health assessment for all detainees placed in a four-point restraint chair, and authorizing medical and mental health personnel to transfer detainees to the medical unit for constant observation and treatment if the inmate is at risk for (or exhibits symptoms of) a medical or mental health emergency.²⁴ Although the RCCF restraint

²³ The encounter began with him “acting erratically” and speaking in a “nonsensical, incoherent manner,” resisting staff through “erratic action,” and according to medical staff lead to “increase[d] confusion, restless, sweating & agitation” which, with his unusually high pulse, prompted them to call an ambulance – and ultimately contributed to his death.

²⁴ ABA Standards on the Treatment of Prisoners § 23-5.9(e). Mental health experts maintain that if prisoners with mental health conditions require emergency restraint, it should be “in the prison or jail infirmary, which generally have 24-hour coverage by mental health staff who can provide health care assessments and treatment for inmates.” Kenneth L. Appelbaum, M.D., *Commentary: The Use of Restraint and Seclusion in Correctional Mental Health*,

chair policy recognizes “[v]iolent behavior may mask dangerous medical conditions,” RCCF policy does not require a mental health assessment nor provide medical personnel the authority to transfer a detainee in a four-point restraint chair to the medical or mental unit for constant assessment and stabilization. Had RCCF required such an assessment and authority, mental health or medical personnel may have been able to address the underlying symptoms and averted his medical crisis. RCCF should adopt these policies to be in line with the ABA and accepted standards on four point-restraints.²⁵

In addition, to the extent that inmates in restraint chairs are not placed in the medical unit for constant observation, RCCFG should require 15-minute checks by medically trained staff to monitor symptoms and check for circulation. RCCF policy only requires medical checks on prisoners in restraint chairs every hour, and medical personnel monitored Mr. Jacinto-Martinez at inconsistent intervals. Given the risks of rapid adverse outcomes with four-point restraints, as Mr. Jacinto-Martinez suffered, the ABA standard provides the medical staff conduct visual observations and medical checks of the prisoner every 15-minute, and to evaluate any risks and medical issues so they may be treated immediately.²⁶

Finally, to ensure optimum safety for individuals in four-point restraint chairs, RCCF should limit the use of four-point restraint chairs only to exigent circumstances, where a prisoner presents an immediate and extreme risk of serious injury to themselves and others and only after less restrictive forms of restraint have not been effective, in accordance with the ABA and medical standards.²⁷ Medical experts have found that four-point restraint chairs that bind the prisoner’s arms and legs to a stationary object should be used sparingly because they risk subjecting the prisoner to pain and mental stress, and when misapplied can result in cardiac difficulties, aspiration, and positional asphyxia (death by respiratory obstruction).²⁸ Thus, prior to using a restraint chair, RCCF should adopt the ABA’s higher standard and require staff to engage in less restrictive means of control, including de-escalation techniques to calm inmates, and other verbal, environmental, or pharmacological interventions, including mental health treatment.²⁹

Journal of the American Academy of Psychiatry and the Law, vol. 35, No.4, p 431 (2007); Jeffrey L. Metzner et al., *Resources Document on the Use of Restraint and Seclusion in Correctional Mental Health Care*, Journal of the American Academy of Psychiatry and the Law, 419 vol. 35:4 (2007) (“When an inmate is secluded or restrained in a nonhospital setting, the seclusion or restraint should nonetheless occur within a health care setting.”).

²⁵ ABA Standards on the Treatment of Prisoners § 23-5.9(e).

²⁶ *Id.* at 23.59(h)(iv). In addition, the Standards provide that “every two hours, qualified health care staff should check the prisoner’s range of motion.” *Id.* at 23.59(h)(v). See also Michael Champion *Commentary: seclusion and restraint in corrections a time for change*, The Journal of the American Academy of Psychiatry and the Law. 35. 426-30 (2007) (referencing National Commission on Correctional Health Care standards requiring the same).

²⁷ RCCF policy states restraint chairs are only to be used when an inmate is a threat to self, others, or jail security. In contrast, the ABA Standards limit the use of four- point restraints to situations where “a prisoner presents an immediate and extreme risk of serious self-injury or injury to others and only after less restrictive forms of restraint have been determined likely to be ineffective to control the prisoner’s risky behavior.” *Id.* at 23.59(f).

²⁸ Jeffrey L. Metzner et al., *Resources Document on the Use of Restraint and Seclusion in Correctional Mental Health Care*, Journal of the American Academy of Psychiatry and the Law, 419 vol. 35:4 (2007); Joint Comm’n on Accreditation of Healthcare Orgs., *Preventing Restraint Deaths* (Nov 18, 1998), http://www.jointcommission.org/assets/1/18/SEA_8.pdf .

²⁹ Metzner, *Resources Document on the Use of Restraint and Seclusion in Correctional Mental Health Care*; U.S. Department of Justice, *Investigation of the State Correctional Institution at Cresson and Notice of Expanded Investigation* (May 31, 2013), http://www.justice.gov/crt/about/spl/documents/cresson_findings_5-31-13.pdf.

EXHIBIT 1



State of New York

Executive Chamber

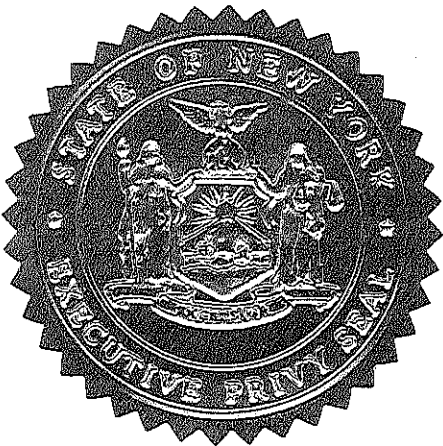
No. 147.26

EXECUTIVE ORDER

In view of the request of Attorney General Letitia James, my order and requirement, embodied in Executive Order Number one hundred and forty-seven, dated July 8, 2015, is hereby amended to include an additional paragraph to the penultimate paragraph as amended by Executive Order Numbers 147.1 - 147.25 to read as follows:

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

(z) of any and all unlawful acts or omissions or alleged unlawful acts or omissions by any law enforcement officer, as listed in subdivision 34 of section 1.20 of the Criminal Procedure Law, arising out of, relating to or in any way connected with the death of Ferdy Jacinto-Martinez on July 25, 2019, in Rockland County.



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

BY THE GOVERNOR


Secretary to the Governor



EXHIBIT 2

GROSS FINDINGS:

- I. History of unexplained (see police investigation), sudden collapse following physical restraint with hypertensive episode (180/100) while in police custody, with subsequent hospitalization at the Nyack Hospital in Rockland, New York and Englewood Hospital in New Jersey.
- II. Back and front of neck with multiple muscular hemorrhages, thyroid cartilage fracture, and slight hemorrhage of eyes.
- III. Blunt trauma of torso and shoulders including front of the chest (history of attempted resuscitation) and back (more on the right side).
- IV. Blunt injuries of four extremities.
- V. See Toxicology Report: no evidence of acute intoxication by drugs, prescription medication or alcohol.
- VI. See Histopathology Report (attached).
- VII. See medical records from both Nyack Hospital and Englewood Hospital.
- VIII. See Police Investigative Report (from Rockland County, New York).

CAUSE OF DEATH:


Pending further studies. Amended on August 22, 2019 to: Hypoxic-ischemic encephalopathy due to neck compression during physical restraint for agitated behavior.

CONTRIBUTING CONDITION:

Amended on August 22, 2019: Chronic alcoholism with cardiac hypertrophy and liver steatosis.

MANNER OF DEATH:

Pending investigation. Amended on August 22, 2019 to: Homicide.


8/22/2019
Zhongyue Hua, MD, Ph.D.
Interim Acting Medical Examiner

ZH/rmc

DATE DICTATED: 07/26/2019

DATE TRANSCRIBED: 07/30/2019

DATE FINALIZED: 08/22/2019

EXHIBIT 3

James Gill, M.D.
Forensic Pathology Consultation



March 21, 2020

Re: Ferdy Jacinto-Martinez

Dear Deputy Chief Wun,

I have been engaged by Special Investigations and Prosecutions Unit of the State of New York, Office of the Attorney General to provide my opinions in connection with the death of Ferdy Jacinto-Martinez. I am a licensed physician and board certified in anatomic and forensic pathology. I have experience in autopsy pathology and in determining the cause and manner of death. My opinions below are all given to a reasonable degree of medical certainty. I have received the following in reference to this matter:

1. EMS/Paramedic (Prehospital Care Report) record
2. Englewood Hospital (7/23/19) and Medical Center and Montefiore Nyack Hospital Records (4/22/19 and 7/23/19)
3. Jacinto-Martinez Autopsy Report and Images
4. Rockland County Correctional Health records
5. Video from Rockland County Correctional facility (July 23, 2019, 3.5 hrs.)
6. A sample spit-mask.

Brief synopsis of clinical history:

Mr. Jacinto Martinez was a 32-year-old man with a history of alcohol abuse (“heavy drinker” per interview with brother) who was arrested on 7/22/19 and was being held in Rockland County Correctional facility. During his incarceration he was described as “very anxious” and had an elevated blood pressure (182/106, 183/128) and a rapid heartbeat (up to 165 bpm). He was given high blood pressure medications. There are three episodes involving physical altercation with restraint by the correctional staff over a period of approximately three hours starting just after midnight on July 23, 2019. These episodes were captured on videotape which included the third event with loss of consciousness followed by attempted resuscitation.

The first episode of physical contact/restraint occurred while he was standing with several guards in the jail hallway (00:16:50 video). He made a sudden movement toward a door and was immediately taken down to the floor. During the ensuing struggle he was restrained and then hand cuffed. During this time, it is conceivable that he sustained injury to the neck causing the fracture. His head and neck are obscured in some of the altercation. Since he remained conscious and was walked to the “court holding” room, he did not suffer any prolonged neck compression at this time that would have resulted in brain damage or loss of consciousness hours later. During the time in the holding cell, he

was routinely monitored by guards and medical staff who checked his vital signs. At 00:25, due to his continued elevated blood pressure and agitation, he was given amlodipine (Norvasc 5mg, a medicine to treat high blood pressure) and hydroxyzine (Vistaril 50 mg, an antihistamine with sedative action). Following this, his blood pressures were 150/81 and 164/107.

At 02:24, staff attempted to release him from restraint chair, and he was forcefully maintained in the restraint chair because he was “very agitated.” At this time, the medical staff reported him with “more confusion, restless, sweating, and agitation.” Following this episode, he remained conscious with voluntary movements.

At 03:16:18 he was transferred from the restraint chair to a stretcher that was in a “chair” configuration (not flat). He was walked over to stretcher and put on it and held down by 6-7 guards. During this struggling, he was held down and the view of much of his body was obscured by guards. At 3:17:41, the guards started to move away from him. At this point, he appeared unconscious with no voluntary movements. At 3:18:05, his feet started twitching and then his head and torso started bucking. This may represent seizure activity or him regaining consciousness. A guard then held down his head and left neck/shoulder area and the movement eventually stopped (3:18:40). He never moved again and when he was examined by the EMT/Paramedics (3:19:39) he was unresponsive (GCS = 3) with agonal respirations (RR=3) and a weak pulse. By 3:23:18 he had clearly lost his pulse as evidenced by the start of chest compressions.

Resuscitation was started and he regained, lost, and then regained pulses. He was transferred to Montefiore Nyack Hospital. Testing for alcohol and drugs of abuse were negative. His liver tests were slightly elevated (AST = 289 U/L). EKG changes showed heart injury and he was transferred to Englewood Hospital for a cardiac catheterization which showed normal coronary arteries with an ejection fraction of 45% (mild global hypokinesia). A CT scan of the head demonstrated hypoxic-ischemic changes with no traumatic bleed. His repeated liver tests (AST > 7,500 U/L) were markedly elevated. He remained unconscious and hypotensive (low blood pressure). He was pronounced dead on July 25, 2019 and a forensic autopsy was conducted on July 26, 2019.

Brief synopsis of findings at autopsy and photographs:

At autopsy, he was a 67”, 194 lb. man. There were scattered superficial contusions of the torso and extremities. There were no internal injuries of the head or trunk. There was injury of the neck and petechiae of the eyes.

Neck: The upper posterior right neck (near midline) had a 2-1/2” x 2” acute superficial contusion and the upper posterior left neck (close to midline) had a 1-1/2” x 1” superficial contusion. There were contusions (1-1/2” x 1”) of the deep muscles of the upper posterior left neck. The undersurface of the anterior left strap muscle had slight superficial congestion/hemorrhage (3/4 x 1/4”). The right thyroid cartilage (close to midline), had a 3/4” acute, vertical fracture with associated hemorrhage.

The brain was swollen with hypoxic-ischemic changes. There was no skull fracture or intracranial hemorrhage. The heart had ventricular dilatation and hypertrophy. There was no flow-limiting coronary artery atherosclerosis. Microscopic sections reported to show early bronchopneumonia, marked hepatic steatosis, and muscle

hemorrhage (contusion) of the left anterior neck, deep and deep posterior left neck, and superficial posterior right neck.

Opinions:

The following are my opinions:

1. His clinical signs and symptoms are consistent with an agitated delirium due to his chronic alcohol abuse (withdrawal syndrome). An agitated delirium and a hypertensive crisis in combination, or alone, may cause death.
2. Asphyxia is defined as the unnatural interference with the body's oxygen/carbon dioxide cycle. It may be caused by neck compression, a compromised body position that interferes with breathing (positional asphyxia), compression of the chest, or external blockage of the nose/mouth (smothering).
3. The temporal relationship of the physical restraint following transfer to the stretcher (~3:16) with his subsequent loss of consciousness, in conjunction with the autopsy findings (fractured larynx, neck hemorrhage, petechiae), are concerning for an asphyxial injury. At autopsy, there was injury of the neck that was forceful enough to fracture the thyroid cartilage of the larynx (voice box). Petechial (pinpoint hemorrhages) of the eyes were observed at autopsy. Petechiae may be a sign of neck compression, however, they also may be seen with vigorous attempts at resuscitation. The thyroid fracture by itself does not signify for how long the force was applied; it only shows that enough force was applied to cause the fracture. A sudden forceful blow/pressure, without a prolonged (asphyxial) compression, also may cause such an injury. The length of time needed to cause brain injury by strangulation is an important factor to consider and the video does provide information about this issue.
4. Although the video does not demonstrate or exclude actual neck compression, it does give a well-established timeframe for how long potential compression could have lasted. It generally takes longer than 100 seconds of constant neck compression to cause irreversible brain injury and/or death. A sudden stoppage (arrhythmia) of the heart will result in loss of consciousness in several seconds with irreversible brain injury occurring within minutes. Based on the length of the obscured view (under 90 seconds), it is unlikely that there was enough time for neck compression, even if it were constantly applied, to have caused lethal brain injury.
5. At 3:17:41, the guards started to move away from him. At this point, he appeared unconscious with no voluntary movements. At 3:18:05, his feet started twitching and then his head and torso started bucking. This may represent seizure activity or him regaining consciousness. If this is indeed him regaining consciousness, it would further exclude neck compression as the cause of the lethal brain injury.

6. Given that the video demonstrated insufficient time for fatal neck compression, the uncertainty of whether he had regained consciousness at ~3:18:05, and his current cardiovascular disease with decompensation (hypertension, tachycardia, cardiac hypertrophy/dilation), and his chronic alcohol abuse with withdrawal, it is reasonable that the stress of the restraint along with his heart disease and agitated delirium caused his death without any “asphyxial” neck compression component.

7. The subsequent brain injury and EKG and liver changes were all secondary processes, caused by the cardiac arrest at the jail with the subsequent resuscitation. The entire period of the lack of oxygen (hypoxia) lasted over 4 minutes which would have been enough to cause irreversible brain injury. Because the heart is more resistant to hypoxia than the brain, the EMT/Paramedics ultimately were able to get the heart restarted. By this time, the brain, however, had already suffered enough lack of oxygen to result in the irreversible hypoxic-ischemic encephalopathy. Standard attempts at resuscitation would not explain a fractured thyroid cartilage.

All my opinions are based on a reasonable degree of medical certainty. I reserve the right to revise my opinions based upon the receipt of new and/or additional information.

Sincerely,

James Gill, M.D.

Addendum 1: Video timeline and events of 7/23/19

Time	Event
3:00	Secured in restraint chair, wearing spit mask, and moving head
3:03:34	Guard and two Paramedics enter room
3:04	Vitals check (130/100 BP, 148 Pulse, 28 RR, GCS 15 at "3:11" on PCR)
3:10:25	Stretcher brought in, more guards in room
3:11:16	Ankles cuffed
3:12:09	Struggle, head grabbed from behind
3:12:52	Hands on sides of jaw, head extended posteriorly
3:14	Tipped forward, still with posture, sitting up, moving head
3:15	Has posture, moving head
3:16:12	Conscious, moved over to stretcher, wearing spit mask
3:16:18	Put on stretcher and held down, 7 guards around stretcher
3:16:45	Head and body held down, much of body obscured by guards
3:17:03	Position re-adjusted: moved up on stretcher
3:17:41	Guards getting off him, he is not struggling
3:17:51	Guard drops spit mask on bench
3:17:54	Guards off him, his head/neck bent to right, no spit mask on
3:18:05	Feet twitching
3:18:07	Head and torso moving/bucking
3:18:09	Guard with hands on head and left neck/shoulder area
3:18:40	No movement
3:19:07	Spit mask put on, feet not moving
3:19:25	Guards off him, no movement
3:19:39	No movement, neck pulses checked by EMT, paramedic returns ("3:20" on PCR: pulse 100 "thread"; 3 RR, GCS 3)
3:20:10	EMS folded back cot
3:21:49	Restraint straps removed
3:22:44	Oxygen started
3:23:18	Chest compressions started

PCR = Prehospital Care Report by EMS/Paramedic

RR = Respiratory Rate per minute

GCS = Glasgow Coma Scale (15=Fully conscious → 3= unconscious/unresponsive)