New York State Office of the Attorney General

Special Investigations and Prosecutions Unit

Report on the Investigation into The Death of Andrew Kearse

Barbara D. Underwood
NYS Attorney General

EXECUTIVE SUMMARY

On July 8, 2015, Governor Andrew Cuomo signed Executive Order No. 147 (the "Executive Order"), appointing the Attorney General as a special prosecutor "to investigate, and if warranted, prosecute certain matters involving the death of an unarmed civilian . . . caused by a law enforcement officer." On June 15, 2017, Governor Cuomo issued Executive Order No. 147.11, which expressly conferred jurisdiction upon the Attorney General to investigate any potential unlawful acts or omissions relating to the death of Andrew Kearse, a civilian who died in the custody of the Schenectady Police Department ("SPD") on May 11, 2017.

Nearly all the interaction between the SPD and Mr. Kearse on May 11, 2017, was captured by SPD forward and rear-facing dashboard and stationhouse cameras. The Office of the Attorney General ("OAG") synchronized a video from these cameras into one chronological video. The synchronized video, which is referred in this report to as "the Video," can be viewed here: ag.ny.gov/KearseVideo. What follows is an overview of the interaction between Mr. Kearse and the SPD; unless otherwise noted, these events are captured on the Video.

- On Thursday, May 11, 2017, Andrew Kearse was driving in Schenectady. SPD Sergeant Dean DeMartino attempted to stop Mr. Kearse for speeding and running a red light. Mr. Kearse did not stop his vehicle, and instead led Sergeant DeMartino on a high-speed chase for approximately .6 miles until Mr. Kearse pulled into the driveway of his friend's home (the "Home").

- According to Sergeant DeMartino, he saw Mr. Kearse run around the corner of the Home, Sergeant DeMartino followed him and then saw a person Sergeant DeMartino believed to be Mr. Kearse, but Mr. Kearse claimed that the driver of the car had fled.[1] According to Sergeant DeMartino, he directed Mr. Kearse to sit by the front door of the Home, Mr. Kearse complied, and Sergeant DeMartino told Mr. Kearse that Sergeant DeMartino was going to check his dashboard camera video to determine if the person he had been pursuing was Mr. Kearse; Mr. Kearse then ran into the Home and out the back door of the Home into the yard.[2] PO Kietlinksi and Coppola arrived moments later, and Sergeant DeMartino informed them that Mr. Kearse had run out of the back door of the Home. Sergeant DeMartino stayed back while several SPD officers, including PO Kietlinksi, PO Coppola, and PO Weekes, chased Mr. Kearse on foot.

- After approximately one to two minutes, according to PO Brandon Kietlinski, he located Mr. Kearse crouching down near the corner of a house in an adjacent backyard, approximately 50 yards from the rear of the Home, and placed Mr. Kearse in handcuffs after some resistance from Mr. Kearse. PO Weekes and PO Coppola arrived to assist Kietlinski. Mr. Kearse told the officers that he could not walk and needed to catch his

[1] The Video captures a discussion between Mr. Kearse and Sergeant DeMartino, but this portion of the Video does not have audio.

[2] There is no audio at this point in the Video. Nevertheless, the Video confirms that: (1) Mr. Kearse gets out of the vehicle and runs around the corner of the Home; (2) Sergeant DeMartino follows Mr. Kearse around the Home; (3) Mr. Kearse sits on the steps; and (4) Mr. Kearse abruptly stands up and runs into the Home.

breath. PO Weekes, PO Coppola, and PO Kietlinksi then carried Mr. Kearse to PO Weekes' patrol car.[3]

- PO Weekes drove his patrol car back to the Home. No other officer was in PO Weekes' patrol car with him. During the approximately one-minute drive back to the Home, Mr. Kearse informed PO Weekes that he could not breathe and called out to PO Weekes several times. PO Weekes parked near the Home and spoke with other officers there, during which time Mr. Kearse again informed PO Weekes that he could not breathe and called out to him seeking assistance over twenty times. For much of this period, PO Weekes was outside of the patrol car talking to other officers.

- After approximately seven minutes at the Home, PO Weekes started to drive to the stationhouse with Mr. Kearse in the back seat. No other officer was in PO Weekes' patrol car with him. The drive to the stationhouse took approximately nine minutes. PO Weekes drove directly to the stationhouse, but at a normal rate of speed and without activating the car's lights or sirens. During the drive, Mr. Kearse called out to PO Weekes twenty-nine times and complained that he could not breathe, felt nauseous and dizzy, and was going numb, and asked to roll the windows down. Mr. Kearse writhed around in the back seat. After approximately eight minutes of the nine-minute ride back to the stationhouse (and after being in the patrol vehicle for a total of approximately 16 minutes), Mr. Kearse fell onto his side in the back seat and did not speak again.

- PO Weekes' patrol car arrived at the SPD stationhouse forty seconds after Mr. Kearse had fallen onto his side. The total amount of time — from the moment that Mr. Kearse was placed in the police vehicle until the vehicle arrived at the stationhouse — was 17 minutes.

- Upon arrival at the stationhouse, officers removed Mr. Kearse from the patrol car and placed him on the sidewalk. Approximately six minutes after arriving at the stationhouse, PO Weekes began to perform chest compressions on Mr. Kearse.

- Shortly before starting to do chest compressions, PO Weekes called for assistance from Emergency Medical Services ("EMS").[4] EMS arrived at the stationhouse approximately four minutes after EMS received the dispatch call. No call for medical assistance had been made prior to this point.

- PO Weekes continued compressions until EMS arrived. Emergency Medical Technicians ("EMTs") continued resuscitation efforts on the scene and then took Mr. Kearse by

[3] The duration of the foot search is based upon SPD radio records. Mr. Kearse's location when found by officers and his interactions with the officers there are based upon SPD officer statements. The Video recorded Mr. Kearse's voice telling officers that he could not walk, and that he needed to breathe.

[4] A call to EMS is captured on an SPD audio recording. In a statement that PO Weekes provided to the New York State Police ("NYSP"), PO Weekes said that he called EMS for assistance. PO Weekes declined to speak with the OAG, as he was entitled to do under the Fifth Amendment.

ambulance to a nearby hospital, Ellis Hospital, where after further efforts at resuscitation, he was pronounced dead.[5]

Police officers have a duty to ensure reasonable and adequate medical care without undue delay for persons in their custody.[6] In his statement to the NYSP, PO Weekes stated that, after Mr. Kearse was put into PO Weekes' vehicle, PO Weekes turned on a live-feed monitor of the back seat so that he could monitor Mr. Kearse. In the statement to the NYPS, PO Weekes gave several reasons why he did not call for medical services prior to arrival at the stationhouse:

- PO Weekes declined Mr. Kearse's request to roll down any windows in PO Weekes' vehicle for security reasons (i.e., an arrestee could reach outside the car and open the door, or flee through the open window) and, given Mr. Kearse's multiple attempts to flee that day, PO Weekes regarded Mr. Kearse's request for the windows to be lowered as a possible ruse to escape custody;

- PO Weekes had been trained in the police academy and the military (and otherwise learned through his professional experience) that if someone can speak, he or she can breathe;[7]

- Mr. Kearse did not expressly complain of any pain and did not expressly ask for medical assistance; and

- Mr. Kearse was able to "upright" his body on his own when the car made turns.

Following an autopsy, the Medical Examiner concluded that Mr. Kearse's death was caused by heart rhythm problems (i.e., a cardiac arrhythmia) due to an enlarged heart and thickening of the heart's walls. Mr. Kearse's prior medical records note his history of high blood pressure, which is consistent with the Medical Examiner's conclusions.

The OAG retained an expert cardiologist to review and further elaborate on the Medical Examiner's work. The expert cardiologist's conclusions about cause of death are consistent with those of the Medical Examiner. According to the expert cardiologist, Mr. Kearse had pre-existing left ventricular hypertrophy, or thickening of the heart walls, due to high blood pressure. This condition leads to an increased risk of malignant arrhythmias (essentially, extra heartbeats), which in turn can cause a cardiac arrest. Due to his underlying health conditions, combined with the

[5] The Video ends when the EMTs remove Mr. Kearse from the stationhouse.

[6] See People v. Liang, No. 99882014, 2016 WL 3949829 (N.Y. Sup. Ct. 2016) ("[P]rompt emergency medical assistance from a person trained in first aid . . . is clearly inherent in the nature of [a police officer]'s job."); see generally SPD General Order 0-07, July 1, 2006 (attached hereto as Exhibit 1) (SPD policy requiring that, after any level of force is used against an arrestee, an officer must immediately summon medical assistance if an arrestee "complains of pain, or demonstrates any type of medical distress"; here, the physical interaction that was required to handcuff Mr. Kearse and carry him to PO Weekes' vehicle qualifies as a "use of force" under the SPD policy, as reflected by the fact that use of force documentation was completed for this incident).

[7] The OAG sought SPD training records concerning this issue. We received training records on medical treatment, but did not receive anything directly providing that if a person can speak, he or she can breathe. Other SPD officers whom the OAG interviewed stated that they too had been trained or otherwise learned through professional experiences that if a person can speak, he or she can breathe. No officer pointed the OAG to any particular training.

mental and physical stress from fleeing the police, Mr. Kearse developed an arrhythmia after being placed in the back seat of PO Weekes' car, which progressed over time to a heart attack.[8] The expert cardiologist further concluded that the arrhythmia would explain why Mr. Kearse felt like he could not breathe. When the heart fails to pump properly, blood backs up into the blood vessels of the lungs, impeding their functioning; moreover, a malfunctioning heart does not adequately circulate oxygenated blood. Both consequences of an arrhythmia event can create a sensation that one cannot breathe, even though the airway is not blocked and air is entering the lungs normally. The expert cardiologist also noted that because an arrhythmia does not cause the chest pain typically associated with a heart attack, and because the symptoms expressed by Mr. Kearse can also be consistent with other non-life-threatening events like a panic attack, it would be very difficult to identify his symptoms as originating from a cardiac event without additional sophisticated medical testing, such as an electrocardiogram. Finally, the expert cardiologist concluded that Mr. Kearse's physical condition deteriorated rapidly after the onset of the malignant arrhythmia, with a limited window of time in which appropriate medical intervention could have saved his life and quite possibly even prevented any serious physical injury, such as brain damage, a stroke, or permanent shutdown of the kidneys.[9]

After conducting an independent investigation and undertaking comprehensive, non-grand jury investigative steps,[10] the OAG decided to present this matter to a grand jury, because the OAG concluded that the evidence was sufficient for a properly instructed grand jury to find probable cause for a criminal charge. This decision was made with full recognition that the probable cause determination would depend on the grand jury's assessment of several difficult factual questions, including PO Weekes' state of mind while Mr. Kearse was in his custody, and whether PO Weekes' failure to secure medical attention for Mr. Kearse prior to their arrival at the stationhouse was a cause (under the relevant legal standards) of Mr. Kearse's death. As discussed further below, these factual questions—particularly the assessment of PO Weekes' intent and state of mind—are matters especially suited to be resolved by juries, rather than lawyers or judges, relying as they do in this case on assessments of how a "reasonable person" would behave and what the standards of the community are regarding what one person owes to another person who is dependent upon him—in this case a police officer with an arrestee in custody—for care.[11]

---

[8] The Medical Examiner found no physical trauma suggesting any form of physical abuse by the SPD.

[9] The expert cardiologist could not reach a definitive conclusion regarding when medical intervention would have saved Mr. Kearse's life or spared him other serious physical injury, because the video evidence was not sufficient to determine precisely when Mr. Kearse stopped breathing or when arrhythmia started.

[10] In addition to compiling the Video and retaining the expert cardiologist, the OAG's pre-grand jury investigation included (a) review of historical medical records of Mr. Kearse, SPD training records, and SPD policies; and (b) interviews of responding officers, EMTs, the treating doctor at the hospital, and Mr. Kearse's friend who was at the Home during Mr. Kearse's interactions with the SPD officers.

[11] See generally People v. Flack, 125 N.Y. 324,334 (1891) ("[T] he question of intent can never be ruled as a question of law, but must always be submitted to the jury."); Policano v. Herbert, 7 N.Y.3d 588 (2006), (the question of a defendant's state of mind is a matter for the jury); People v Gallagher, 69 N.Y.2d 525 (1987), (it is the jury's function to determine whether a defendant acted intentionally or recklessly at the time of a crime).

After hearing the evidence and receiving instruction on the applicable law, the grand jury in this case determined that no criminal charges should be brought. That determination is final. Because this matter was submitted to a grand jury, the OAG is constrained by law from discussing what actually occurred in the grand jury, either with respect to the evidence presented or the charges considered by the grand jury.[12] However, because much of the evidence, including the Video, is publicly available, this report seeks to provide the public with an understanding of the difficulties posed in this case by the evidence and the law, and to provide context to our policy recommendations.

Nearly any potential criminal charge[13] in this case would have required at least two key factual determinations: (1) that PO Weekes' conduct[14] caused a particular harm to Mr. Kearse (whether death or serious physical injury),[15] and, if it did, (2) that PO Weekes had the requisite mental state, such as knowing that such a result was likely. These two issues are interrelated. For example, for a charge that requires causing a substantial risk of serious physical injury, a jury would have to find that PO Weekes not only caused such a risk but also had actual knowledge that he was doing so,[16] and that he had that knowledge at a point in time when calling for medical intervention could have saved Mr. Kearse's life or avoided serious physical injury.

All discussion of the legal standards and issues in this report are illustrative examples, and all of the factual information is drawn from evidence gathered outside the grand jury. We do not and cannot lawfully discuss what specific evidence and potential criminal charges were submitted to the grand jury.

* * *

[12] "Grand jury proceedings are secret" and a prosecutor may not "disclose the nature or substance of any grand jury testimony, evidence, or any decision, result or other matter attending a grand jury proceeding. C.P.L. §190.25(4).

[13] A few potentially applicable charges, such as official misconduct, would not require causation as an element. The OAG considered the merits of such charges as well.

[14] See generally Penal Law §§ 15.00 (3), (4) (criminal conduct may be "an act or omission" and an "omission" may be "a failure to perform an act as to which a duty of performance is imposed by law").

[15] In other words, if earlier provision of medical care would have saved Mr. Kearse's life, then PO Weekes' failure to procure that care could be deemed a "cause" of Mr. Kearse's death under the law. At the other end of the spectrum, if Mr Kearse would have died even if appropriate medical care had been provided from the moment he was placed in PO Weekes' car, then PO Weekes could not have "caused" Mr. Kearse's death, regardless of PO Weekes' state of mind or a fact-finder's view of whether his failure to procure medical attention was appropriate.

[16] For example, a person acts recklessly with regard to a result when he is aware of and consciously disregards a substantial and unjustifiable risk that the result will occur. The disregard of the risk must constitute a "gross deviation" from the way a reasonable person would behave. N.Y. Penal Law § 15.05(3). Other culpable criminal mental states include acts that are intentional, knowing, or criminally negligent.

Executive Orders No. 147 and 147.11 also provide that the OAG may offer "any recommendations for systemic reform arising from the investigation. The OAG recommends that:

- In order to avoid any more tragic deaths like Mr. Kearse's, the New York State Legislature pass legislation requiring the New York State Division of Criminal Justice Services ("DCJS") to establish a uniform statewide policy for police departments in New York (a) requiring that police officers treat indications of breathing difficulties by arrestees (whether reported by the arrestee or observed by the officer) as medical emergencies and (b) conduct training concerning the policy that makes clear that a complaint about breathing difficulties should not be dismissed because the arrestee is able to talk;

- The SPD revise its policies concerning medical treatment of arrestees to make clear that arrestees should receive emergency medical services whenever they are in need of such services, even if the need for such services does not arise from the use of force against the arrestee; and

- The SPD should take steps to become a New York State-accredited law enforcement agency. The New York State Division of Criminal Justice Services ("DCJS") offers an accreditation process that requires police agencies to achieve and maintain various standards that constitute best practices in the field of law enforcement.

STATEMENT OF FACTS[17]

A. The Videotaped Evidence Showing Mr. Kearse's Arrest and Transport to the Schenectady Police Station

1. The Pursuit and Arrest of Mr. Kearse

At 4:32 pm, Sergeant DeMartino began to pursue Mr. Kearse after seeing Mr. Kearse's car drive through a red light at the intersection of State Street and Fehr Avenue in Schenectady. Police camera footage shows Sergeant DeMartino's SPD car, marked number 22, following Mr. Kearse's white SUV (Video). Sergeant DeMartino drove down New York Route 5, turned left onto Consaul Road, then kept right onto Ivy Avenue, and finally turned right onto Ward Avenue (Video at counter 0:27[18]). Sergeant DeMartino's dashboard camera shows that Mr. Kearse then parked in the driveway of the Home on Ward Avenue, got out of the white vehicle, and ran around to the side of the Home. (Video at counter 0:33). Sergeant DeMartino parked behind the white vehicle in the driveway of the Home.

Mr. Kearse's friend (referred to hereafter as Civilian Witness or "CW"), after hearing the screeching of tires in her driveway, emerged from the front door of the Home and approached Sergeant DeMartino's car. Sergeant DeMartino got out of his car and ran around to the left of the

[17] None of the information referenced in this report was obtained through the use of grand jury subpoenas.

[18] The "counter" referenced in the Video citations reflects the elapsed time. Counter times are approximate.

Home; CW followed Sergeant DeMartino around to a chain-link fence in her yard. Sergeant DeMartino first encountered Mr. Kearse on the other side of this chain-link fence. According to Sergeant DeMartino, Mr. Kearse gestured towards the yard and claimed that the driver of the white SUV had fled through the back yard. Still speaking with Mr. Kearse, Sergeant DeMartino returned to the front of the Home with Mr. Kearse and CW behind him. Sergeant DeMartino directed Mr. Kearse to sit by the front door of the Home, Mr. Kearse complied, and Sergeant DeMartino told Mr. Kearse that Sergeant DeMartino was going to check his dashboard camera video to determine if the person he had been pursuing was Mr. Kearse. Mr. Kearse then ran into the Home and out the back door into the yard. (Video at counter 3:02).

The Video captured the arrival of PO Kietlinski, PO Coppola, and PO Weekes at the Home moments later. (Video at counter 3:06). Sergeant DeMartino communicated to them that Mr. Kearse had run out of the back door of the Home. Several officers, including PO Kietlinski, PO Coppola, and PO Weekes, then pursued Mr. Kearse from the backyard of the Home through the yards of several properties between Ward Avenue and Donald Avenue. (Video at counter 3:15-5:39). The route taken by Mr. Kearse would have required him to scale at least one stockade-type backyard fence.

According to PO Kietlinski, PO Kietlinski apprehended Mr. Kearse huddled in the corner of a neighboring yard on Donald Avenue. PO Kietlinski attempted to handcuff Mr. Kearse; Mr. Kearse resisted the handcuffing by tensing one of his arms and refusing to put the arm behind his back, but PO Kietlinski was able to handcuff Mr. Kearse without assistance from any other officers. Shortly thereafter, PO Coppola and PO Weekes joined PO Kietlinski in the yard where Mr. Kearse was handcuffed. As the officers attempted to get Mr. Kearse to stand and walk to PO Weekes' car, Mr. Kearse told the officers that his legs would not support him, that he could not walk, and that he needed to breathe. (Video at counter 5:45-6:39). POs Kietlinski, Coppola and Weekes then physically carried Mr. Kearse from the yard to PO Weekes' nearby police car on Donald Avenue.

The rear-facing dashboard camera in PO Weekes' car (which records audio) captured Mr. Kearse entering the car with his hands cuffed and his breathing sounding labored (Video at counter 7:48). This same camera recorded PO Weekes telling Mr. Kearse, "You can't out-run the police, man. We're too fast for you". (Video at counter 7:50). Mr. Kearse remained handcuffed in the vehicle for the duration of the ride to the stationhouse.

2. **The Drive from the Point of Arrest Back to the Home**

PO Weekes drove back up Donald Avenue and onto Ward Avenue to join the officers remaining at the Home. During the brief drive back to Ward Avenue, Mr. Kearse stated that he could not breathe and asked PO Weekes to open a window. (Video at counter 8:16). Mr. Kearse repeated "please sir" multiple times over the next minute. PO Weekes did not respond. PO Weekes then pulled up to the Home and got out of the car to speak with other officers. Mr. Kearse remained in the back seat of PO Weekes' car. (Video at counter 8:51).

3. **The Time Spent Stopped at the Home**

PO Weekes spent approximately seven minutes speaking to other officers outside the Home.[19] (Video at counter 8:49-15:33). According to other officers who were part of this group at the Home, the assembled officers were discussing various police matters, such as ascertaining the whereabouts of a minor child whom CW had said was present at the Home, and determining whether Mr. Kearse should be taken to the stationhouse for arrest processing. During this time, Mr. Kearse called out to PO Weekes and the other officers a total of seventeen times. (Video at counter 8:49-15:33).

First, Mr. Kearse shouted, "I can't breathe." (Video at counter 9:06-9:10). Mr. Kearse called out two more times, saying "Excuse me sir, excuse me sir. Please . . . Please roll down the window. Please." (Video at counter 10:30). PO Weekes did not respond for over a minute,[20] eventually opened the driver's door and asked, "What?"[21] Mr. Kearse then asked PO Weekes to open a window. PO Weekes did not respond and closed the door. (Video at counter 10:32-10:35). Mr. Kearse called out seven more times over the next two minutes, stating "Please, please. Officer, officer, officer, officer." PO Weekes did not respond until two minutes later, when he opened the door and asked, "What's wrong?" Mr. Kearse then said, "I need [unintelligible]." PO Weekes responded: "Is it hot? Probably shouldn't run next time." (Video at counter 10:37-12:43). PO Weekes then returned to his conversation with the other officers.

Mr. Kearse then called out twice more. PO Weekes again returned to the car and asked, "Yeah what . . . what do you want?" (Video at counter 12:52-13:00). Mr. Kearse replied, "I really can't breathe, Officer please." (Video at counter 13:07). PO Weekes told Mr. Kearse: "Slow down your breathing. Take deep breaths. You'll be fine." PO Weekes again closed the door. Mr. Kearse called out "Officer" five more times and received no response from PO Weekes. (Video at counter 13:50-15:25). Approximately two minutes after closing the door the last time, PO Weekes returned to the car and began to drive to the stationhouse.[22] (Video at counter 15:34).

4. **The Drive from the Home to the Stationhouse**

The rear-facing camera in PO Weekes' car recorded Mr. Kearse throughout the drive back to the stationhouse, which took approximately nine minutes. (Video at counter 15:34-24:34). As PO Weekes' statement to the NYSP states, PO Weekes (who was the only officer in the car), was monitoring Mr. Kearse through the live-feed monitor of the back seat that PO Weekes had turned

[19] These conversations are difficult to hear on the Video. The OAG tried to enhance the audio for this part of the Video, but the enhancement was insufficient to render the exterior conversations audible.

[20] It is impossible to tell from the Video which of Mr. Kearse's statements were audible to the officers outside the vehicle.

[21] In this and the next paragraph, we attribute several statements to PO Weekes. It is possible that another officer made some of these comments, but it appears to the OAG that many, if not all, were made by PO Weekes.

[22] According to a statement provided by Sergeant DeMartino to OAG investigators, Sergeant DeMartino instructed PO Weekes to transport Mr. Kearse to the police station and to call a medic. Based on his statement to the OAG, Sergeant DeMartino did not clearly convey to PO Weekes whether PO Weekes should make the call to a medic only after he reached the station house, or whether he expected Weekes to make the call on the way to the stationhouse.

on. As described in the next paragraphs, during this period, Mr. Kearse called out to PO Weekes twenty-nine times. He variously stated that he could not breathe, that he thought he would vomit, that he felt faint, that he felt dizzy, that he needed fresh air, and that he was going numb.

Mr. Kearse first called out "Officer" four times and PO Weekes responded "What?" (Video at counter 15:34). Mr. Kearse responded, "Goddamn . . . I'm gonna . . .[mumbles unintelligibly]." PO Weekes asked, "You think this might have to do with you running from the police?" Mr. Kearse rolled from his side to his back and said, "Please open a window, please." PO Weekes responded, "I'm not opening the window." Mr. Kearse repeated his request for PO Weekes to open the window and PO Weekes said, "No." (Video at counter 15:50).

Mr. Kearse subsequently said "Officer" and "Officer please" three more times before saying, "I really feel like I'm gonna throw up." (Video at counter 16:10). PO Weekes responded by saying, "Don't throw up in my car." (Video at counter 16:14). Mr. Kearse called out to PO Weekes five more times over the next minute, saying "Officer please . . . please I'm begging you man . . . Officer please . . . Officer." PO Weekes did not respond. (Video at counter 16:14-17:00).

The rear-facing camera footage shows Mr. Kearse rolling back and forth in the rear back seat, leaning on his side and then his back. (Video at counter 17:04). Mr. Kearse then said, "I can't breathe" again. PO Weekes did not respond. Several seconds later, Mr. Kearse repeated, "Officer please . . . I can't breathe" and again received no response. Mr. Kearse then told PO Weekes, "Officer I'm getting dizzy . . . Officer . . . getting dizzy." (Video at counter 17:33-17:39). PO Weekes continued driving to the stationhouse and made no reply.

Mr. Kearse then told PO Weekes again, "Officer, I'm gonna throw up" and made a retching noise as he lurched into the back seat. PO Weekes did not respond. Mr. Kearse repeated three times that he was "getting numb." Several moments later, Mr. Kearse again told PO Weekes, "Officer, I can't breathe." PO Weekes did not respond. (Video at counter 17:50-18:30).

Two minutes later, Mr. Kearse told PO Weekes, "I feel like I'm gonna pass out." (Video at counter 20:08). He called out to PO Weekes three more times before again making a retching sound and crying out, "Ahhhhh." (Video at counter 20:34-20:57). Several seconds later, Mr. Kearse called out "Officer, Officer, Officer . . . I can't breathe Officer." (Video at counter 21:34). Mr. Kearse then slumped into the corner of the seat with his head down and did not speak again. Several minutes later, PO Weekes took a right turn and Mr. Kearse fell prone onto the rear bench seat; his body falling onto the seat is audible on the Video. (Video at counter 23:55). This happened approximately 16 minutes after Mr. Kearse had been placed into PO Weekes' patrol car.[23]

[23] The hospital to which Mr. Kearse ultimately was taken is near the SPD stationhouse. Based upon the rate of speed of the initial vehicle pursuit of Mr. Kearse by Sergeant DeMartino, we estimate that if PO Weekes had put on his lights and sirens and rushed to the hospital when PO Weekes got back into the patrol car after he stopped at the Home, PO Weekes would have arrived at the hospital within 5-6 minutes.

5. **PO Weekes' Arrival at the Stationhouse**

PO Weekes arrived at the rear entrance of the stationhouse near the sally port approximately 40 seconds after Mr. Kearse fell (and remained) prone in the back seat of PO Weekes' patrol car. (Video at counter 24:33). Footage from the stationhouse's exterior security camera shows PO Weekes getting out of his vehicle and going to the back door of the car. PO Weekes requested assistance removing Mr. Kearse from the car from PO Ross Flood, who was passing by at that moment. According to audio recording, one or both officers repeatedly told Mr. Kearse to, "Get up man, come on, get up man, come on." PO Weekes and PO Flood dragged Mr. Kearse from the back of PO Weekes' car, held him up against the side of the car, and then placed him on the adjacent sidewalk. (Video at counter 26:40). A report of an unresponsive man at the precinct came over the radio and was captured on the Video approximately two minutes after PO Weekes arrived at the stationhouse.[24] (Video at counter 26:50).

Several other officers then began to approach PO Weekes, including PO Molly Winch and Lieutenant Ryan Macherone. PO Weekes and PO Flood were keeping Mr. Kearse propped in a sitting position against the wall of the station. PO Flood knelt down to inspect Mr. Kearse and said, "Come on man." (Video at counter 27:21). Two officers approached PO Weekes and PO Weekes said: "The whole way down he was doing that 'I can't breathe, I can't breathe' thing . . . wanted me to open the window. I'm not gonna roll that down . . . now he's unresponsive." (Video at counter 28:40). The male officer speaking to PO Weekes (who appears to be Lieutenant Macherone) asked, "Was he breathing?" PO Weekes' answer is not audible on the Video. Lieutenant Macherone asked if anyone had checked Mr. Kearse for a pulse.

PO Weekes, Lieutenant Macherone, and PO Winch then approached Mr. Kearse; he remained handcuffed and sitting propped up on the sidewalk outside the stationhouse. (Video at counter 29:21). PO Flood checked for a pulse and then he and PO Winch removed Mr. Kearse's handcuffs and laid him on his back on the sidewalk. PO Weekes began CPR approximately six minutes after he arrived at the stationhouse. (Video at counter 31:08). Lieutenant Macherone sent PO Coppola to retrieve the station's AED device[25] and POs Coppola and Winch subsequently attached the AED to Mr. Kearse and attempted to revive him.

With the exception of the time while the AED was in use, PO Weekes continuously performed chest compressions on Mr. Kearse for several minutes until EMS arrived. (Video at counter 31:08-33:16).

EMS received the dispatch call at 5:02 pm, and arrived at the stationhouse at 5:06 pm. (See Exhibit 2). EMS noted the initial complaint as "cardiac arrest." Mr. Kearse's pupils were

---

[24] According to the Video at counter 26:50, it appears that PO Weekes is the person who radios for EMS. This is consistent with PO Weekes' statement that he radioed dispatch to request medical assistance.

[25] "An automated external defibrillator (AED) is a lightweight, portable device that delivers an electric shock through the chest to the heart. The shock can potentially stop an irregular heart beat (arrhythmia) and allow a normal rhythm to resume following sudden cardiac arrest (SCA)". http://www.heart.org/idc/groups/heart-public/@wcm/@hcm/documents/downloadable/ucm_300340.pdf

"pinpoint" and "nonreactive" and EMS officers entered a "3" in the Glasgow Coma Scale.[26] EMS officers attempted to resuscitate Mr. Kearse multiple times by performing CPR, attempting to revive Mr. Kearse's heart by shocking it, and administering epinephrine multiple times. They were unable to revive him at the stationhouse. At 5:20 pm, EMS left the stationhouse to transport Mr. Kearse by ambulance to Ellis Hospital, where they arrived at approximately 5:27 pm. Resuscitation efforts continued at the hospital. (See Exhibit 3 and pages 14-15 below). Ellis Hospital records indicate that Mr. Kearse was admitted with "ventricular tachycardia"[27] and that he arrived in ventricular fibrillation.[28] Although medical professionals were able to detect a pulse and blood pressure at various points, efforts to revive Mr. Kearse were ultimately unsuccessful. The hospital recorded the time of Mr. Kearse's death as 7:47 p.m.

B. Summary of PO Weekes' Statement

PO Weekes provided a sworn statement to the NYSP regarding his involvement in the arrest of Mr. Kearse. (See Exhibit 4). PO Weekes stated that, at the time of arrest, Mr. Kearse did not respond to verbal commands to get up and walk. PO Weekes and PO Coppola helped Mr. Kearse stand up and Mr. Kearse then attempted to stand with support. Mr. Kearse was still out of breath and indicating that he could not walk, and eventually POs Kietlinski, Coppola, and Weekes had to carry him to PO Weekes' car. The officers told Mr. Kearse to get into the car and he said that he could not. PO Weekes does not remember exactly how Mr. Kearse was placed into the car, but officers did have to guide his feet into the car to place him onto the backseat.

Once Mr. Kearse was in the car (in a seated position), PO Weekes rotated his dashboard camera to show the back seat so that he could monitor Mr. Kearse. PO Weekes then drove back to the Home on Ward Avenue, during which time PO Weekes remembered Mr. Kearse saying that he could not breathe. PO Weekes did not remember Mr. Kearse making any other complaint at this time. PO Weekes looked in the monitor and saw that Mr. Kearse was still upright in the seat. He believed that if someone can speak, then he or she can breathe.

PO Weekes parked on Ward Avenue near the Home. PO Weekes left the car's climate control on and the driver's window open; the partition between the front and back of the car was closed and both rear windows were closed. PO Weekes stood with other officers in the front yard of the Home. PO Weekes heard Mr. Kearse yelling from inside the car and heard him scream that he could not breathe. PO Weekes determined that Sergeant DeMartino did not need Mr. Kearse to remain on scene and decided, due to Mr. Kearse's yelling, to begin the drive to the stationhouse.

---

[26] A "3" on the scale means no verbal, eye or motor response. https://www.brainline.org/article/what-glasgow-coma-scale

[27] Ventricular tachycardia is a heart rhythm disorder (arrhythmia) caused by abnormal electrical signals in the lower chambers of the heart (ventricles). https://www.mayoclinic.org/diseases-conditions/ventricular-tachycardia/symptoms-causes/syc-20355138

[28] Ventricular fibrillation is a heart rhythm problem that occurs when the heart beats with rapid, erratic electrical impulses. This causes pumping chambers in the heart (the ventricles) to quiver uselessly, instead of pumping blood. Sometimes triggered by a heart attack, ventricular fibrillation causes blood pressure to plummet, cutting off blood supply to vital organs. https://www.mayoclinic.org/diseases-conditions/ventricular-fibrillation/symptoms-causes/syc-20364523

When PO Weekes returned to the car, Mr. Kearse told PO Weekes that he could not breathe. Mr. Kearse then asked PO Weekes to open a window, but PO Weekes refused; PO Weekes was concerned that this request might be a ruse to escape custody. Because Mr. Kearse had fled from Sergeant DeMartino earlier and, because of the risk that Mr. Kearse could open the door if Mr. Kearse was able to reach out of an open window, PO Weekes decided to leave the windows closed. PO Weekes heard Mr. Kearse saying that he could not breathe, that he needed to open a window, and that he was going to throw up. PO Weekes watched through the camera and observed Mr. Kearse shifting with the movement of the car and then righting himself.

PO Weekes noted that, during this time, Mr. Kearse did not explicitly ask for medical assistance nor did he complain of pain. He did, however, hear Mr. Kearse make a regurgitation sound at one point; he also noticed Mr. Kearse falling back onto the seat when PO Weekes took a right turn near the stationhouse.

PO Weekes entered the stationhouse at the closer entrance in order to transport Mr. Kearse more quickly after hearing him fall over onto the seat. PO Weekes also noted that this entrance has a security camera, and he wanted to record his interactions with Mr. Kearse because he now suspected Mr. Kearse had a medical issue.

C. SPD Policies Relating to Medical Care

Two SPD policies address medical treatment of arrestees. (See Exhibits 1 and 5).

First, SPD General Order O-07 requires that medical assistance be summoned immediately when force has been used and the arrestee exhibits any sign of medical distress:

> When safe to do so after any level of force is used, the subject will be verbally and visually checked to ascertain whether they are in need of medical care. If a subject is physically injured in any way, complains of pain, or demonstrates any type of medical distress, medical assistance shall be immediately summoned.

General Order O-07 defines "physical force" as "physical contact or action exerted against a subject, beyond un-resisted handcuffing, utilized for any legitimate law enforcement objective." PO Kietlinski completed a Use of Force Report indicating that "Resistant Handcuffing" and "Supported Feet on Carry to Police Car" were used during Mr. Kearse's arrest.

Second, SPD Interim Order 92-4, which is entitled "Medical Treatment [of] Ill or Injured Persons or Prisoner," states:

> Whenever[,] a person is brought to the station and appears to have an injury or illness, no matter how minor, or; whenever a person in the custody of this department complains of an illness or injury, it is the responsibility of the Desk Officer to [among other things] [e]nsure that the Schenectady Fire Department Paramedics are notified to respond to examine the person, whether or not the

injured/ill person requests medical attention.[29]

By its plain language, SPD Interim Order 92-4 only applies to an arrestee who has arrived at the stationhouse.

D. Summary of Medical Examiner Findings and Prior Medical Treatment Records

1. Medical Examiner

On May 12, 2017, Dr. Michael Sikirica performed a comprehensive autopsy of Mr. Kearse's body at the Albany Medical Center.[30] (See Exhibit 6). The death certificate lists the immediate cause of death as an "arrhythmia"[31] (with the approximate time between onset of the arrhythmia and death as "minutes") due to cardiomegaly (an enlarged heart, which may result in congestive heart failure)[32] and left ventricular hypertrophy[33] (with the approximate time between onset of the hypertrophy and Mr. Kearse's death as "years" prior). Similar to the death certificate, the autopsy lists the cause of death as "Cardiac arrhythmia due to cardiomegaly and left ventricular hypertrophy." It lists the manner of death as "Natural."

The Medical Examiner noted that Mr. Kearse was 6'4" and weighed 246 pounds. He noted that Mr. Kearse's body appeared to be "well-nourished" and of "good health." During the external examination of the eyes, the Medical Examiner noted no conjunctival petechiae,[34]

---

[29] Mr. Kearse clearly demonstrated medical distress and it appears that the force used to handcuff Mr. Kearse and the assistance rendered to get him to and into PO Weekes' car qualify as physical force under General Order O-07. Violation of police policy is not dispositive of whether a police officer committed a criminal act, but knowledge of the underlying policy and failure to follow the policy may be factors that are probative of an officer's mental state. Cf. generally Wilson v. Meeks, 52 F.3d 1547, 1554 (10th Cir. 1995) (holding that "violation of a police department regulation is insufficient for liability under section 1983"); Cole v. Bone, 993 F.2d 1328, 1334 (8th Cir. 1993) (when determining whether an officer's use of deadly force was reasonable, the issue is whether the officer "violated the Constitution or federal law, not whether he violated the policies of a state agency"); Edwards v. Baer, 863 F.2d 606, 608 (8th Cir. 1988) ("Police department guidelines do not create a constitutional right.").

[30] The Medical Examiner reviewed emergency room records from Ellis Hospital; Schenectady New York Fire Department EMS Service records; sworn statements from the responding officers; camera footage and radio transmissions of Mr. Kearse in PO Weekes' vehicle; images of Mr. Kearse at the stationhouse and from another vehicle as he was apprehended by the police; and portions of Mr. Kearse's prior medical records.

[31] An arrhythmia is any change from the normal sequence of electrical impulses, causing the heart to beat too fast, too slowly, or erratically, which can cause the heart not to pump blood effectively, such that the lungs, brain and all other organs cannot work properly and may shut down or be damaged. http://www.heart.org/HEARTORG/Conditions/Arrhythmia/Arrhythmia_UCM_002013_SubHomePage.jsp

[32] http://www.webmd.com/heart-disease/guide/enlarged-heart-causes-symptoms-types#1

[33] Left ventricular hypertrophy is enlargement and thickening of the heart's main pumping chamber, the left ventricle, which causes the left ventricle to work harder and eventually may cause a failure to pump with as much force as needed. http://www.mayoclinic.org/diseases-conditions/left-ventricular-hypertrophy/basics/definition/con-20026690

[34] These are indications of bleeding from the small capillaries in the eyes. They are "most frequently observed in those who have died natural deaths (particularly due to cardiovascular disease), followed by those who have died

no unusual marks or injuries on the body, and no evidence of drug use.

On external examination, the Medical Examiner noted recent medical therapy (from the emergency medical care at the stationhouse and hospital), including an endotracheal tube, a defibrillator pad and EKG and monitor pads, an IV and catheters. External injuries included a bruise and several small red abrasions, consistent with resuscitation attempts. Other minor injuries included: two small scratches on the right upper arm; two thin scratch-type marks; several small abrasions on the right elbow; a small red abrasion along the upper right flank; a patch of red abrasion on the left wrist; a slight scraping type injury to the knuckle of the left index finger; a superficial laceration on the left palm; a "somewhat circular burn type mark or healing abrasion" on the right thumb; a small red abrasion along the upper portion of the left knee; a thin scratch type mark on the right thigh just above the knee; a red abrasion along the front portion of the right knee; an abrasion and a scratch type mark on the right knee; a slight red abrasion on the left ankle; and two scrapes on the left instep.

On internal examination, the Medical Examiner noted rib fractures consistent with resuscitation attempts, and "severe vascular congestion"[35] in Mr. Kearse's lungs. In Mr. Kearse's cardiovascular system, the Medical Examiner noted a "significantly enlarged" 560 gram heart,[36] and a left ventricular chamber which was "reduced in size due to concentric left ventricular hypertrophy."[37] The Medical Examiner noted a patchy subendocardial purple infarction[38] along the upper portion of the left ventricle. Mr. Kearse had an enlarged liver but no evidence of liver diseases. The other bodily systems were largely "unremarkable."

Microscopic examination of the tissues taken from major internal organs revealed hemorrhages in Mr. Kearse's tongue. The autopsy noted a small amount of lung disease, evidence of heart disease in the left ventricle, heart congestion and focal infarction.

The toxicology reports revealed the presence of atropine (used in attempted resuscitations); nicotine; an ingredient of marijuana; and a metabolite of nicotine.

---

from asphyxia, head injury, and central nervous system disorders." https://www.ncbi.nlm.nih.gov/pubmed/3354519

[35] This is distention of the blood vessels in the lungs, which can be as a result of an infection, high blood pressure, or cardiac insufficiencies (i.e., inability of the heart to function adequately). https://www.britannica.com/science/lung-congestion

[36] The average weight of the normal heart in an adult male is about 300 grams. http://www.onlinejacc.org/content/33/2/291

[37] Left ventricular hypertrophy is enlargement and thickening (hypertrophy) of the walls of the heart's main pumping chamber (left ventricle). Left ventricular hypertrophy can develop in response to some factor, such as high blood pressure or a heart condition, that causes the left ventricle to work harder. http://www.mayoclinic.org/diseases-conditions/left-ventricular-hypertrophy/basics/definition/con-20026690

[38] A patchy subendocardial purple infarction reflects the death of a heart muscle or a heart attack. http://www.webmd.com/heart-disease/understanding-heart-attack-basics#1

E. Summary of Expert Cardiologist's Report

OAG retained Dr. Stuart Zarich to render a professional opinion, to as high a degree of medical certainty as possible, whether at any time after Mr. Kearse was taken into custody, Mr. Kearse's death or other serious physical injury could have been prevented with appropriate medical intervention. (See Exhibit 7). "Serious physical injury" was defined for Dr. Zarich as "impairment of a person's physical condition which creates a substantial risk of death, which causes death or serious and protracted disfigurement, protracted impairment of health, or protracted loss or impairment of the function of any bodily organ, or severe and prolonged physical pain."

Dr. Zarich is currently the Chief of Cardiovascular Medicine at Bridgeport Hospital and an Associate Clinical Professor of Medicine at Yale University School of Medicine. He is active in clinical cardiology and has several decades of experience as a medical expert in the field of cardiology. Dr. Zarich reviewed various medical records of Mr. Kearse from 2011 through 2017, video footage relating to Mr. Kearse's death, the autopsy report, and the death certificate.

Dr. Zarich concluded that Mr. Kearse had previously developed a condition known as left ventricular hypertrophy, which is excessive thickening of the heart due to high blood pressure. This condition leads to an increased risk of extra heartbeats (malignant arrhythmias) and can cause cardiac arrest. Due to both the excess mental stress and physical stress from fleeing the police, Dr. Zarich believes Mr. Kearse developed an arrhythmia after being placed in the back of the patrol car, which progressed over time to a cardiac arrest. A crucial factor that weighed heavily on Dr. Zarich's conclusion is that Mr. Kearse never complained about chest discomfort, which would normally indicate a heart attack. According to Dr. Zarich, arrhythmia would explain why Mr. Kearse complained about having trouble breathing. Arrhythmia typically does not cause chest pain; instead, it creates a sensation of an inability to breathe because blood backs up into the blood vessels of the lungs and fluids leak into the lungs themselves.

Dr. Zarich could not reach a definitive conclusion regarding when medical intervention would have saved Mr. Kearse's life or spared him other serious physical injury because the video evidence was not sufficient to determine precisely when Mr. Kearse stopped breathing or when arrhythmia started. However, Dr. Zarich stated, with a reasonable degree of medical certainty, that Mr. Kearse would have survived had he received medical treatment prior to falling prone onto the car seat and becoming unconscious. Had Mr. Kearse survived, he would have had a 70% - 80% chance of doing so without any residual brain damage, although the risk of brain damage or other serious physical injury (such as stroke or a shutdown of the kidneys) would have begun to emerge from the time Mr. Kearse fell silent in the rear of the car.

According to Dr. Zarich, in the absence of medical therapy or electrical shock to correct the arrhythmia, Mr. Kearse would almost certainly have died, as occurred here. In order to address his medical condition, several interventions would have been required. First, Mr. Kearse would have needed to have been assessed as soon as possible by EMS personnel possessing electrocardiogram equipment. A brief history and physical exam would have been performed and an ECG would have been obtained. The ECG, with a high degree of medical certainty, would have showed a malignant arrhythmia that would have been treated with either medical therapy or electrical shock. As the electrical shocks that he received at the stationhouse were ineffective, Dr. Zarich concluded that Mr. Kearse would have needed that treatment earlier (prior to when he slumped over in the car and became unconscious), in order for the treatment to prevent his death.

Given that Mr. Kearse did not complain of having chest pain, nor did the autopsy reveal evidence of a coronary blockage, Dr. Zarich concluded that this was a very unusual case of sudden cardiac death in the setting of excess thickening of the heart from high blood pressure. Dr. Zarich stated that as a trained cardiologist, absent medical assessment tools available in an ambulance or hospital such as an ECG machine, even he would not have recognized from observation alone that Mr. Kearse required advanced cardiac life support measures.[39] Mr. Kearse was a relatively young man who had demonstrated earlier that day that he was physically capable of running and jumping fences; only specifically complained of shortness of breath; did not complain of chest pains; and was not exhibiting other typical signs of a heart attack.

LEGAL BACKGROUND

The OAG decided to present this matter to a grand jury, because the OAG concluded that the evidence was sufficient for a properly instructed grand jury to find probable cause for a criminal charge. In accordance with state law, we do not and cannot discuss what specific evidence and charges were submitted to the grand jury. As noted in the Executive Summary, however, the law applicable to the events at issue here requires determination of two difficult factual issues: (1) whether PO Weekes' conduct actually caused either death or a substantial risk of death or serious physical injury, and (2) if so, whether PO Weekes knew he was creating such a risk at the time when his act or omission caused the harm, i.e., at the time when he could have taken action to avoid the harm.

First, causation: In order to prove that a person caused death, the prosecution must prove that the defendant's conduct "forged a link in the chain of causes which actually brought about the death." People v. Stewart, 40 N.Y.2d 692, 697 (1976). Furthermore, that conduct "must be a sufficiently direct cause of the ensuing death." Id. "[A]n 'obscure or merely probable connection between an assault and death will . . . require acquittal of the charge of any degree of homicide.'" Id. Similarly, in order to prove that person caused serious physical injury, or created a substantial risk of serious physical injury, the prosecution must prove that the defendant's conduct was a direct cause of the injury or the risk of injury.

When the conduct at issue is not an assault but rather the *failure* to act, the question is more complex. A defendant may cause a death by failing to provide medical attention while the victim was in his care. People v. Knapp, 113 A.D.2d 154 (3rd Dept. 1985). But the failure to provide care causes death only if the victim had a chance to survive with appropriate medical attention, and the defendant's failure to act deprived the victim of that chance. Id. at 164. Similarly, failure to provide medical attention may cause serious physical injury, or create a risk of serious physical injury, if the defendant's failure to procure prompt, adequate medical care deprived the victim of the chance to avoid serious physical injury. See People v. Montesa, 211 A.D.2d 648 (2d Dep't 1995).

Second, state of mind and intent: In order to prove a crime of causing death or serious physical injury or the risk of such injury, the prosecution must establish that the defendant had a specific state of mind at the time he caused the harm. And when the conduct consists of failure

[39] Advance Cardiac Life Support refers to a set of clinical interventions for urgent treatment of cardiac arrest, stroke, and other life-threatening medical emergencies, as well as the knowledge and skills to deploy those interventions.

to provide medical care, that means the defendant must have had the necessary state of mind at the time when taking action could have saved the victim's life or avoided the harm or risk of harm.

The questions of what was in a person's mind and what he intended when he performed relevant actions are common and persistent in the criminal law. As we noted above, these questions are both very difficult (particularly in the absence of direct evidence) and also uniquely appropriate for resolution by a jury, which can bring to bear the collective experience of numerous individuals and can draw upon their collective sense of what their community deems to be reasonable inferences about a person's mental state given the evidence about that person's actions.[40] Direct or dispositive evidence of a person's state of mind is rare. In reaching a conclusion about state of mind or intent, the jury is permitted to consider the evidence about the defendant's actions or failures to act, the evidence about the surrounding circumstances and other facts known to the defendant, statements made by the defendant (including contemporaneous statements, later statements that might bear on what a defendant believed at a prior time, and the defendant's own testimony to the jury, if any), and whatever inferences the jury chooses to draw from that evidence, so long as those inferences are supported by reason and common sense and are not wholly speculative.[41] The jury is not required to accept a defendant's own statements about his or her intent as true, but rather should consider those statements, if any, and assign to them whatever weight and value they deem appropriate.[42]

As noted, many of these questions intersect. For example, under a recklessness standard, a fact finder would have to decide if there was a time when PO Weekes was aware of and disregarded a substantial risk of death or serious physical injury and the failure to call for medical help at that time, or after it, caused that result, giving consideration to how relatively short the entire incident was.[43] Courts have consistently recognized that the amount of time a person has to

---

[40] For example, New York Penal Law Section 15.05 defines a "reckless" mental state as: "A person acts recklessly with respect to a result or to a circumstance . . . when he is aware of and consciously disregards a substantial and unjustifiable risk that such result will occur or that such circumstance exists. The risk must be of such nature and degree that disregard thereof constitutes a gross deviation from the standard of conduct that a reasonable person would observe in the situation."

[41] See Criminal Jury Instructions on Intent (CJI2d [NY] Culpable Mental States—Intent); Criminal Jury Instructions on Evidentiary Inferences (CJI2d [NY] Evidentiary Inferences); "Section 15.00 of the Penal Law and defined in section 15.05 (intentionally, knowingly, recklessly, with criminal negligence) are not capable of direct proof. They are, instead, to be inferred from the facts and circumstances proved and involve 'fine gradations along but a single spectrum of culpability.'" People v. Green, 56 NY2d 427, 432 (1982) citing People v. Stanfield, 36 NY2d 467, 473 (1975); See also Policano v. Herbert, 7 N.Y.3d 588 (2006); People v Gallagher, 69 N.Y.2d 525 (1987).

[42] People v. Ward, 282 A.D.2d 819, 820 (3rd Dept. 2001) ("It is the jury's function to resolve issues of credibility and to accept or reject all or part of the testimony.").

[43] See generally People v. Raymond, 56 A.D.3d 1306 (4th Dept. 2008) (Defendant indicted for second-degree manslaughter for leaving victim in defendant's vehicle after an accident without seeking medical or emergency assistance before the victim was found dead four hours later. Court dismissed charge as the evidence was legally insufficient to prove causation. The medical examiner testified that the victim's death occurred more than two to three minutes, but less than one hour, after the accident and that the victim might have survived had he received appropriate medical intervention. According to the Court, if the victim's death occurred near the beginning of the established time frame, medical intervention could not have changed the outcome even if defendant had

perceive a risk can and should bear on the determination of whether the defendant actually perceived the risk, and also on whether failing to perceive it or disregarding it is criminally culpable, as a gross deviation from the way a reasonable person would behave under those circumstances.[44] Other relevant evidentiary considerations could include, among other things, Mr. Kearse's persistent complaints and physical presentation of distress, weighed against Dr. Zarich's expert opinions concerning the difficulty of perceiving the risk of death, initially due to the fact that Mr. Kearse had been running and jumping, and subsequently because Mr. Kearse's symptoms may not, for some time, have presented as necessarily life-threatening even to a medical professional.[45]

RECOMMENDATIONS

Executive Orders No. 147 and 147.11 provide that the OAG may offer "any recommendations for systemic reform arising from the investigation." The OAG recommends that:

- The Legislature pass legislation requiring DCJS to establish a uniform statewide policy for police departments in New York (a) requiring that police officers treat indications of breathing difficulties by arrestees (whether reported by the arrestee or observed by the officer) as medical emergencies and (b) conduct training concerning the policy that makes clear that a complaint about breathing difficulties should not be dismissed because the arrestee is able to talk;

- The SPD revise its policies concerning medical treatment of arrestees to make clear that arrestees should receive emergency medical services whenever they are in need of such services, even if the need for such services does not arise from the use of force against the arrestee; and

- The SPD apply for accreditation from the New York State Division of Criminal Justice Services ("DCJS").

---

immediately reported the accident.).

[44] See, e.g., Einaugler v. Supreme Court, 109 F.3d 836 (2d Cir. 1997) (the defendant, a medical doctor, failed to immediately hospitalize the patient resulting in a ten-hour delay in hospitalizing the patient, despite express instructions from other physicians to do so, indicating that the defendant consciously deviated from what he knew to be the appropriate standard of care); People v. Sanford, 24 A.D.3d 572 (2d Dep't 2005) (defendant, a geriatric nurse, was involved in mother's fall, knew of her age, ill health, and the seriousness of the fall, and failed to render or summon aid for approximately five hours).

[45] As a general rule, the admissibility and limits of expert testimony lie primarily in the sound discretion of the trial court. It is for the trial court in the first instance to determine when jurors are able to draw conclusions from the evidence based on their day-to-day experience, their common observation and their knowledge, and when they would benefit from the specialized knowledge of an expert witness. In rendering this determination, courts should be wary not to exclude such testimony merely because, to some degree, it invades the jury's province. Expert opinion testimony is used in partial substitution for the jury's otherwise exclusive province which is to draw "conclusions from the facts." It is an "authorized encroachment" in that respect. People v. Lee, 96 N.Y.2d 157, 162 (2001) (quoting People v. Jones, 73 N.Y.2d, 430-431 (1989)).

A. Police Departments Should Treat Any Indications of Breathing Difficulties By Arrestees As Medical Emergencies

In order to avoid any more tragic deaths like Mr. Kearse's, the Legislature should pass legislation requiring DCJS to establish a uniform statewide policy for police departments in New York requiring that indications of breathing difficulties by an arrestee must be treated as medical emergencies. This uniform state policy should apply regardless of whether an officer has used force on the arrestee. Mandatory training about the policy should make clear that a person who is able to speak about difficulty breathing may nonetheless require emergency medical attention.

A policy such as the one we are recommending, if followed, would have increased the likelihood that Mr. Kearse's life would have been saved by medical intervention. According to PO Weekes' statement to the NYSP, PO Weekes did not treat the situation as a medical emergency, in part because PO Weekes said that he had been trained that if a person can talk, as Mr. Kearse was doing, the person can breathe.[46] Dr. Zarich concluded that Mr. Kearse developed an arrhythmia that progressed to a cardiac arrest. According to Dr. Zarich, developing an arrhythmia would explain why Mr. Kearse complained about having trouble breathing. Arrhythmia creates a sensation of an inability to breathe because blood backs up into the blood vessels of the lungs and fluids leak into the lungs themselves; in addition, a malfunctioning heart is not adequately circulating oxygenated blood. But, as Mr. Kearse's repeated statements to PO Weekes make clear, one can talk while developing an arrhythmia. Under the type of policy that we recommend that all police departments in New York State adopt, PO Weekes undoubtedly would have been required to call for emergency medical services long before PO Weekes did so in this case.

The NYPD, the Minneapolis Police Department, and the Metropolitan Police Department in Washington, D.C. each have policies that expressly treat breathing difficulties by arrestees as medical emergencies. (See Exhibits 8, 9, and 10).

The NYPD use of force policy states:

> After an individual has been controlled and placed under custodial restraint using handcuffs and other authorized methods, the person should be positioned so as to promote free breathing. The subject should not be maintained or transported in a face down position. <u>If a person appears to be having difficulty breathing or is otherwise demonstrating life-threatening symptoms, medical assistance will be requested immediately</u>.

NYPD Patrol Guide 203-11 – Use of Force (emphasis added). Likewise, the NYPD policy on prisoners requiring medical treatment states: "In all life threatening situations, apparent heart attack, <u>breathing difficulties</u>, serious fractures, severe hemorrhaging, epilepsy, extreme emotional disturbance, etc., <u>a prisoner will be removed to the nearest hospital</u>." NYPD Patrol Guide 210-04 – Prisoners Requiring Medical and Psychiatric Treatment (emphasis added).

[46] As noted above, the OAG sought SPD training records concerning this issue. We received training records on medical treatment, but did not receive anything directly providing that if a person can speak, he or she can breathe.

The Minneapolis Police Department policy provides as follows:

> G. Once the subject is secured, an officer shall watch for any of the following signs: Significant change in behavior or level consciousness; Shortness of breath or irregular breathing; Seizures or convulsions; Complaints of serious pain or injury; and/or any other serious medical problem.
>
> H. If officers observe any serious medical issue, they shall immediately contact EMS or transport directly to a local hospital. Officers shall also notify a supervisor.

Police 9-110 - Prisoner Control, Safety, and Transportation (emphasis added).

The policy of the Metropolitan Police Department in Washington, D.C. states:

> 1. In order to avoid asphyxiation, members shall: . . .
>
> > b. Position the individual in a manner to allow free breathing once the subject has been controlled and placed under custodial restraint using handcuffs or other authorized methods.
> >
> > c. Seek medical assistance immediately if a person appears to be having difficulty breathing or is otherwise demonstrating life threatening symptoms. An official shall direct that alternative means to maintain custody be utilized, if appropriate.

General Order 901.07 - Use of Force. [47]

We strongly recommend that the Legislature pass legislation requiring DCJS to establish a uniform statewide policy containing language similar to the ones adopted by NYPD, the Minneapolis Police Department, and the Metropolitan Police Department in Washington, D.C. and require mandatory training for such policies, so that all police officers in the State will be trained to respond to indications of breathing difficulties by arrestees as medical emergencies. The policy and the training should make clear that police officers should treat indications of breathing difficulties as medical emergencies even if no force was used against the arrestee.

B. Revise SPD Policies Concerning Medical Care

The SPD should revise its policies to make clear that arresting officers should arrange for emergency medical services after an arrest, whenever such services are needed and notwithstanding whether force was used in effecting the arrest.

[47] The Washington DC Use of Force Policy 901.07 contains a provision that states, "Admission to the hospital must be directly associated with the use of force." Nevertheless, this policy makes clear that emergency services should be provided for breathing difficulties. The OAG recommends that the SPD adopt a policy that clearly states that all necessary life-saving services should be provided for indications of breathing difficulties, notwithstanding whether there was a use of force.

SPD General Order 0-07, Use of Force Policy, states in relevant part:

> When safe to do so after any level of force is used, the subject will be verbally and visually checked to ascertain whether they are in need of medical care. If a subject is physically injured in any way, complains of pain, or demonstrates any type of medical distress, medical assistance shall be immediately summoned.

"Physical force" is defined in the General Order as "[p]hysical contact or action exerted against a subject, beyond unresisted handcuffing, utilized for any legitimate law enforcement objective." Id. This policy imposes no obligation on an arresting officer to call for emergency medical assistance unless physical force has been used.[48] The policy, therefore, overlooks circumstances where an arrestee needs emergency medical assistance, but no force was used. The SPD should expressly provide that officers should secure prompt emergency services whenever they are required, regardless of whether force was used.

C. The SPD Should Seek State Accreditation

We strongly encourage the SPD to become a New York State-accredited law enforcement agency. DCJS offers an accreditation process that provides a "progressive and contemporary way of helping police agencies evaluate and improve their overall performance."[49] The accreditation process requires police agencies to achieve and maintain various standards of excellence that constitute best practices in the field of law enforcement. The process of becoming accredited is time and labor intensive, but accredited agencies are recognized as having policies that are "conceptually sound and operationally effective."[50]

Approximately 150 law enforcement agencies throughout New York State have committed the time and resources to become accredited. According to the most recent US Census Bureau data, Schenectady is the 8th largest metropolitan area in the State outside of New York City.[51] Moreover, more than 139 law enforcement agencies that have fewer officers than SPD have been accredited by DCJS. But, while scores of police departments and sheriff's offices throughout the State are accredited, the SPD is not one of them. We recommend that the SPD undertake the accreditation process.

---

[48] Interim Order 92-4, Medical Treatment [of] Ill or Injured Persons or Prisoner, requires the Desk Officer to notify paramedics "[w]henever[,] a person is brought to the station and appears to have an injury or illness, no matter how minor, or; whenever a person in the custody of this department complains of an illness or injury." It is not limited to when force has been used; but, by its plain language, it only applies after a person has been taken to the stationhouse.

[49] http://www.criminaljustice.ny.gov/ops/accred/

[50] Id.

[51] https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=PEP_2015_PEPANNCHG.ST05&prodType=table

According to DCJS, the accreditation program has four goals, quoted here:

1. Increased effectiveness and efficiency of law enforcement agencies utilizing existing personnel, equipment and facilities to the extent possible;

2. Promotion of increased cooperation and coordination among law enforcement agencies and other agencies of the criminal justice services;

3. Ensure appropriate training of law enforcement personnel; and

4. Promotion of public confidence in law enforcement agencies.[52]

The training and protocols required by the accreditation process would benefit the SPD.

CONCLUSION

This case raises a number of complicated legal and factual issues. In particular, it was necessary to determine PO Weekes' state of mind while Mr. Kearse was in his custody, and whether PO Weekes' failure to secure medical attention for Mr. Kearse prior to their arrival at the stationhouse was a cause (under the relevant legal standards) of Mr. Kearse's death. The OAG decided to present this matter to a grand jury, because the OAG concluded that the evidence was such that a properly instructed grand jury could find probable cause for a criminal charge. After hearing the evidence and receiving instruction on the applicable law, the grand jury determined that no criminal charges should be brought. The grand jury's determination is final. We respect the determination made by the grand jury and issue this report to assist the public in understanding the difficulties posed in this case by the evidence and the law, and to provide context to our policy recommendations.

[52] See https://www.criminaljustice.ny.gov/ops/accred/.

EXHIBIT 1

SCHENECTADY POLICE DEPARTMENT

GENERAL ORDER	ORDER #: O-07	ISSUE DATE: July 1 , 2006
SUBJECT: Use of Force Policy	ISSUING AUTHORITY:	Page 1 of 16
DISTRIBUTION: All Sworn Members		
REVISES ORDER #: N/A	SUPERSEDES ORDER #: GO 2002-02, IO 1998-12	ACCREDITATION REFERENCE STANDARD: NYS 20.1, 20.4, 20.6, 20.7, 21.1, 21.2
ATTACHMENT(S): (1) *Use of Force Report* (SPD126); (2) *Supervisory Report of Discharge of Firearm* (SPD32)		

I. Purpose:

The purpose of this Order is to establish a policy for the use of force by Department members that is within the limits established by Article 35 of the New York State Penal Law and consistent with training provided by the Department.

II. Policy:

Members will exhaust every reasonable means to effectively bring an incident or person under control before using force. If force is necessary, members shall use only the amount of force reasonably necessary to overcome resistance to effectively and safely bring an incident or person under control, while protecting themselves or others.

Ideally, the use of effective communication skills during officer-citizen encounters will induce compliance. Poor communication skills (e.g., rudeness/discourtesy) arouse resentment, which may in turn, precipitate physical resistance. Clear & firm directions, with which a subject complies, are the most desirable method of controlling a situation. Control may be achieved through direction, persuasion, and warnings before resorting to actual physical force. This does not mean that officers should ever become complacent and lose control of a situation, thus endangering their personal safety or the safety of others.

Since no policy can realistically predict every possible situation an officer might encounter in the field, it is recognized that each officer is entrusted with well-reasoned discretion in determining the appropriate use of force in each incident. While it is the ultimate objective of every law enforcement encounter to minimize injury to everyone involved, nothing in this policy requires an officer to actually sustain or unreasonably risk physical injury before applying reasonable force to accomplish a legitimate law enforcement objective, and/or prevent injury to a member of the public or the officer.

An officer may be present during an incident involving the use of force, but not directly involved in the use of force. However, this does not relieve any officer present of the obligation to insure that the requirements of the law and Department regulations and policy are complied with. Members of this department are required to maintain control or intervene if the use of force against a subject becomes excessive. Failure to do so may result in department disciplinary action, criminal prosecution, and civil liability.

III. Definitions:

A. *Use of Force Continuum:* A training model/philosophy that supports the progressive and reasonable escalation and de-escalation of officer-applied force in proportional response to the actions and level of resistance offered by a subject. The level of response is based upon the situation encountered and the actions of the subject in response to an officer's commands. Such response may progress from the officer's actual physical presence to the use of deadly physical force.

B. *Reasonable Cause to Believe That A Person Has Committed An Offense:* As defined in section 70.10 (2) of the New York State Criminal Procedure Law, "exists when evidence or information which appears reliable discloses facts or circumstances which are collectively of such weight and persuasiveness as to convince a person of ordinary intelligence, judgment and experience that it is reasonably likely that such offense was committed and that such person committed it."

C. *Positional Asphyxia:* Death that occurs from respiratory muscle failure as a result of body position that interferes with a person's ability to breathe. Positional asphyxia occurs most often following a violent struggle ["Positional Asphyxia–Sudden Death," *National Law Enforcement Technology Center Bulletin*, June 1995].

D. *Physical Contact:* Physical Contact involves routine or procedural contact with a subject, less than resistant handcuffing, necessary to effectively accomplish a legitimate law enforcement objective (e.g., guiding a subject into/out of a police vehicle, handcuffing a subject, and/or maneuvering or securing a subject for a frisk).

E. *Physical Force:* Physical contact or action exerted against a subject, beyond un-resisted handcuffing, utilized for any legitimate law enforcement objective.

F. *Physical Injury:* Impairment of physical condition or substantial pain.

G. *Serious Physical Injury:* Physical injury which creates a substantial risk of death, or which causes death or serious and protracted disfigurement, protracted impairment of health, or protracted loss or impairment of the function of any bodily organ.

H. *Excessive Force:* Occurs when it is apparent that the type or degree of force used was more than was reasonably necessary to overcome resistance.

I. *Deadly Physical Force:* Physical force which, under the circumstances in which it is used, is readily capable of causing death or serious physical injury.

IV. Use of Physical Force:

A. Officers shall use only the force reasonably necessary to overcome resistance.

B. Officers are authorized to use Physical Force in the following situations:

1. To make a lawful arrest
2. To protect themselves or another person from physical harm
3. To restrain or subdue an uncooperative or resistant person
4. To safely and effectively control an unlawful or hazardous situation
5. To prevent the escape of a person in custody
6. To effect other lawful objectives.

C. Officers shall use force as outlined in this order. Excessive Force is prohibited and may be subject to disciplinary action, criminal prosecution and civil liability.

D. The use or threatened use of a weapon or instrument by an officer against a person is a use of force. While on-duty, officers shall carry only the following weapons/instruments:

1. Department-issued sidearm and ammunition
2. Department-issued shotgun and ammunition
3. Department-issued oleoresin capsicum (OC) spray
4. Department-issued baton or expandable baton

* Additionally, a personally owned utility knife (a folding knife or fixed blade knife with a blade or blades up to five inches (5") in length) and a flashlight are authorized to be carried. Carrying cases shall match the duty belt.

E. Special Operations Squad (SOS): In addition to the weapons listed above, SOS members are authorized to use approved specialized weapons.

F. The use of force, or the use of a weapon or instrument, shall be done in accordance with training techniques and instruction provided or approved by the Department.

G. Subjects who engage in violent struggles with officers may be more vulnerable to positional asphyxia. To help minimize the risk of positional asphyxia, officers shall adhere to the following procedures:

1. As soon as possible (under the circumstances), after the subject is handcuffed get the subject off of their stomach. Turn them on their side or place them in a seated position.

2. If they continue to struggle after being handcuffed, do not sit on the subject's back. Hold their legs down or utilize leg shackles.

3. Never tie the handcuffs to a leg or ankle restraint.

4. If needed, get the subject immediate medical attention.

5. Do not lay the subject on their stomach during transport. Instead, place them in a seated position.

V. Use of Force Continuum:

A number of factors are taken into consideration when an officer selects force options and when evaluating whether the officer used reasonable force. Officers must be able to articulate the facts and circumstances surrounding the force used in a particular situation. An officer's use of force will be judged by reasonableness and necessity under the circumstances.

A. Factors that affect an officer's force selection include, but are not limited to:
   1. Officer/Subject factors
      a. age
      b. size
      c. strength
      d. skill level
      e. exhaustion
      f. injury
      g. officer/subject ratio

2. Seriousness of the offense/incident
3. Apparent influence of drugs/alcohol
4. Subject's emotional condition/mental instability
5. Physical condition/disability
6. Proximity to weapons
7. Pre-attack postures, gestures, and/or statements.
8. Apparent willingness to sustain injury
9. Other exigent circumstances
10. Availability of other options
11. Level of threat or resistance presented by the subject
12. Level of threat to the community

B. Action of Subject(s) & Officer Response Options:

A subject's demeanor and actions are instrumental factors in an officer's decision as to what level of force is appropriate to take control of a particular situation. If at all possible, situations should be resolved by effective communication skills. Often, the mere presence of the officer, coupled with effective communications skills, will be sufficient to persuade an individual to follow the officer's directions. Effective communication skills may prevent physical confrontations from occurring or escalating to higher levels.

Avoiding the use of force is preferable; however, if officer presence and/or communications skills fail to overcome an individual's resistance, the officer must be prepared to escalate the use of force.

Subject behaviors and officer response options are classified into the following categories (see Diagram 1):

1. *Cooperative Subject:* Cooperative and complies with verbal commands and directions.

   Response Option: Restraining, firm grip, application of restraining devices.

2. *Uncooperative/Passively Resistant Subject:* Uncooperative when taken into custody, fails to respond/comply with verbal commands and directions, or passively resists an officer's authority and direction (e.g., body intentionally made limp - not resistive tension).

Response Option: Low-level force – Physical direction, Defensive tactics (e.g., pain compliance techniques). *Note: If possible, officers should avoid using pepper gas (Oleoresin Capsicum) on passively resisting subjects.

3. *Actively Resistant Subject:* Attempting to interfere with the officer's actions by physically resisting or indicating an intention to do so.

   Response Option: Intermediate-level force. Officers may use pepper-spray (Oleoresin Capsicum), defensive tactics (e.g., pain compliance techniques, joint-manipulation, arm-bars, take-downs), and/or personal weapon strikes (e.g., hands/fists, knees, elbows, and feet) in which training has been given to control or arrest an actively resistant subject.

   a. Impact Weapons: In the event that the officer reasonably believes that the situation cannot be resolved with the effective use of any aforementioned force options, then, officers are authorized to utilize the departmentally approved impact weapon – the baton/expandable baton, or a police K-9 (see below).

      Intentional baton strikes to a subject's head, neck or throat are prohibited unless the officer reasonably believes there is an imminent threat of death or serious physical injury to themselves or another person, and the officer has no other reasonable alternative for defending themselves or another person.

      Officers will make every effort to use their primary Department-issued or approved impact weapon. In the event that the officer's primary impact weapon has been lost as a result of that confrontation, broken or taken away, the officer may be justified in using an alternative impact weapon (flashlight, radio, or any other impact weapon not issued or approved specifically as a defensive weapon as a means of force). An alternative impact weapon may be used only when no other reasonable alternative is present. If an alternative impact weapon is used, it will be used in a manner consistent with the training given for Department-issued or approved impact weapons.

b. Police Canine: A police canine may be deployed to apprehend or control an individual when other less injurious techniques have been insufficient. Accordingly, the Schenectady Police Department's *K-9 Standard Operating Procedure* (GO 02-08), states: "Handlers will only use their canine as a force instrument to : 1) Apprehend or render safe a fleeing or hiding subject who has committed a felony, or misdemeanor involving force/violence or sex offense; and 2) Protect citizens or officers from an immediate threat of injury" (pg.3).

In instances where a canine apprehends a suspect by biting, the handler will call the dog off at the first moment the canine can be safely released, taking into account that the average person may continue to move, regardless of an officer's directions to the contrary, if seized or confronted by a canine. Specifically, officer(s) must be able to differentiate between a suspect's movement that constitutes active resistance and poses an immediate threat of harm to the officer(s) or others versus movement caused by the pain of a dog bite and/or fear of the police canine. The latter type of movement compels the officer to terminate the police canine's attack.

Off-leash canine deployments are limited in searches and other instances where there is otherwise a significant risk of a canine bite to a suspect. One of three situations must apply: 1) Searches of commercial buildings; 2) Suspect is wanted for an offense of violence or sex offense; or 3) Suspect is believed to have a weapon.

4. *Subject Using Deadly Physical Force:* Commits an attack using his/her personal weapons (hands, elbows, knees, feet etc.), an object or a weapon wherein the officer reasonably believes that the assault will result in death or serious physical injury.

Response Option: The use of a firearm or any other available weapon or means that has a reasonable likelihood of causing death or serious physical injury (see VII: Use of Deadly Physical Force).

It is important to note that an officer need not attempt to gain control over an individual by use of the lowest level of force on the continuum when reason and circumstances dictate, and the officer can articulate that a higher level of force used is

reasonable. Escalation to a higher level of force may be appropriate given the resistance encountered.

VI. Use of Less-Lethal Weapons:

1. OC spray, police baton, and police canine are alternative uses of force in situations where there is a potential for injury to an officer, suspect or another person.

2. The use of OC spray will be limited to the degree of force which is reasonably necessary to provide protection to the officer or another person, to prevent an escape of a person from custody or to make a legal arrest. Prior to using OC spray, a standard verbal warning will be given ordering the subject to cease action or a OC spray will be released, unless such a warning would present a danger to the officer or others. When possible, the officer will allow the intended target a reasonable amount of time to comply with the warning before utilizing the OC spray.

3. The use of police batons may be used as an alternative force in situations where the potential for injury to an officer or another person exists, but where the use of deadly physical force is not appropriate. The use of police batons will be limited to that degree of force that is reasonably necessary to provide protection to the officer or another person in preventing an escape of a person in custody or to make a legal arrest.

4. The use of police canine may be used as an alternative force in situations where the potential for injury to an officer or another person exists, but where the use of deadly physical force may not be appropriate. Prior to deploying a police canine, a standard verbal warning will be given ordering the subject to cease action or a police canine will be released. The warning will be issued in a loud and clear manner, unless such a warning would present a danger to the officer or others. When possible, the officer will allow the intended target a reasonable amount of time to comply with the warning before utilizing a police canine.

VII. Use of Deadly Physical Force:

A. Deadly physical force is to be used only after all other reasonable means of attaining control have been considered as outlined in V (Use of Force Continuum).

B. A police officer may use deadly physical force under the following circumstances:

1. The officer reasonably believes that another person is using or is about to use deadly physical force, and that it is necessary for the officer to use deadly physical force to defend himself or another person; or

2. To make an arrest or prevent an escape of a suspect whose freedom is reasonably believed to represent an imminent threat of death or serious physical injury to the officer or another person (e.g., Suspect is fleeing the scene of a robbery or felony assault and armed with a visible deadly weapon).

C. When feasible, officers shall identify themselves as police officers and issue an initial standard verbal warning to the intended target before using deadly physical force. The initial standard warning is "**POLICE, DON'T MOVE.**" Identification is not required if it places the officer or another person in greater risk. Officers may supplement the aforementioned standard warning with additional directions (e.g., "Show me your hands").

D. Warning shots are not permitted under any circumstances.

E. Officers shall not discharge a firearm from or at a moving vehicle, except in self-defense or in defense of another person, and there is an imminent threat of death or serious physical injury. The moving vehicle itself shall not presumptively constitute a threat that justifies an officer's use of deadly force. An officer threatened by an oncoming vehicle shall attempt to move out of its path before discharging a firearm at it or any of its occupants. Whenever possible, officers shall use tactics that avoid placing themselves in the path of vehicles.

F. Except for general maintenance, storage, or authorized training, officers will not draw, point or exhibit their firearm unless circumstances create reasonable cause to believe that it may be necessary to lawfully use the weapon in conformance with Article 35 of the NYS Penal Law and this Order.

G. The fact that a police officer is justified in using deadly physical force does not allow reckless conduct by the officer.

H. If an officer has discharged his/her firearm, his/her patrol supervisor must fill out *Supervisory Report of Discharge of Firearm* (SPD32).

VIII. Medical Attention:

A. When safe to do so after any level of force is used, the subject will be verbally and visually checked to ascertain whether they are in need of medical care. If a subject is physically injured in any way, complains of pain, or demonstrates any type of medical distress, medical assistance shall be immediately summoned.

B. Following the use of OC spray on a subject, officers will:

1. Assure the subject that the effects of the OC spray are temporary.

2. If the subject displays serious respiratory/medical problems, direct Communications to dispatch paramedics to the scene of the incident or a safer location.

3. Subjects who are obese, suffer from respiratory ailments (e.g., asthma, emphysema, bronchitis), or wear contact lenses shall be decontaminated by EMS personnel. Additionally, EMS should decontaminate any person whose health condition gives the officer cause for concern.

4. Upon transporting the subject to Police Headquarters for arrest processing, officers will direct the suspect to decontaminate themselves by rinsing the affected area with water.

IX. Reporting & Documenting Use of Force:

A. Any time an officer uses *physical force* on a person or points a firearm at a person, the officer shall notify a patrol supervisor and complete a Department *Use of Force Report* (SPD126) (Attachment 1) before the end of the officer's tour.

B. If more than one officer is involved in the pointing of a firearm at a subject (e.g., felony traffic stop, building clearing, etc.), a supervisor or his/her designee shall

complete one SPD126. In such a case, one officer's information will be filled in the appropriate spaces. Additionally, all other officers who pointed their weapons must be identified in the narrative of the SPD126, or on an attached SIR Supplemental Form, as well as all subjects who had officer weapons pointed at them.

C. There may be exigent circumstances that require supervisory discretion in regards to completion of the SPD126. Examples:

1. In a crowd control situation in which there are multiple officers and direct force against multiple unidentified subjects, then the supervisor or his designee will complete one SPD126, listing all officers involved, the type of force used by each officer, and the fact that subjects involved were not identified.

2. If two or more officers approached a group of subjects which led to force being used, and each officer used different types of force and/or sustained different injuries but the subjects fled on foot and were not identified, then the supervisor or his designee will advise each officer to complete one SPD126 listing the force he/she used and/or injuries he/she sustained, and noting 'UNK' under subject information.

D. If the involved officer is incapable of completing the report, a supervisor will complete the report based on the officer's reporting and/or other available information.

E. *Use of Force Report* (SPD126)

1. All areas on the SPD126 must be completed.

2. If a particular question does not apply, indicate such with an 'N/A' or if the requested information is unknown, indicate such with 'UNK'.

F. During arrest processing, all visible injuries to a subject shall be photographed utilizing the RICI System, Polaroid camera or Evidence Technician. The officer responsible for photographing arrestees shall complete the "Photos" information area on the front of the SPD126. If photographs were not taken, that officer shall indicate why photographs were not taken.

G. Special Circumstances: SOS/Vice Squad Raids

Reporting and documenting use of force becomes more difficult during raids conducted by the Special Operations Squad (SOS), Vice Squad, etc. To ensure adherence to the spirit of this order, the supervising personnel conducting raid operations will report and document use of force as follows:

1. Whenever department personnel involved in raid operations use advanced tactical standard operating procedures (e.g., flash-bang grenades), and the effected suspects comply with all directions by the officers, said officers will not be required to accomplish an entire SPD126. Rather, a SOS or Vice Squad Supervisor shall:

    a. Fill in the Incident # on SPD126.
    b. Under "Incident Type": Write in the appropriate operational phrase (e.g., Vice Raid, etc.).
    c. In the "Narrative" include a list of officers detailing the relevant procedures performed by each officer (e.g., pointed weapons) and a list of suspects with procedures they were subjected to. For example:

        Officer A inserted a flash-bang grenade into a window of Target structure. Officers B, C, D cleared the Target apartment by pointing their assigned firearms and ordering all occupants to "get on the floor," etc. The suspects who were the targets of this procedure were as follows: Citizen A, B, C. All suspects complied with all directives given by the officers identified above.

2. When suspects involved in such raids do not comply with directives and more force is required to gain compliance than un-resisted handcuffing, effected officers will comply with the procedures of this policy.

X. Use of Force Incident Review:

A. Initial Review

1. The supervisor initially notified of the use of force incident shall review the SPD126 for completeness and fill out the appropriate section; making a determination if the force used was proper. Said determination will be based

upon the information reported to the supervisor by the involved officers and if the supervisor was on the scene, then also his personal observations.

2. Upon reviewing the SPD126 and completing the appropriate section, the supervisor shall make 3 copies of the SPD126 and 4 copies of the SIR/DIR.

   a. The original SPD126 and a copy of the SIR/DIR shall be forwarded to the Office of Professional Standards.

   b. A copy of the SPD126 and SIR/DIR shall be forwarded to the following:

      1) Commander of the Administrative Services Bureau

      2) The involved officer's Bureau Commander

      3) Platoon/Unit Commander assigned to the shift that the use of force incident occurred

B. Supervisory Review of SPD126

   1. Supervisors required to review the SPD126 who determine that the force used was inconsistent with this General Order shall immediately notify his/her superior for further review of the incident and possible commencement of an internal investigation by the Office of Professional Standards,

C. The Commander of the Administrative Services Bureau

   1. Shall review and ensure the safekeeping of all completed *Use of Force Reports* by the Office of Professional Standards.

D. Office of Professional Standards

   1. Shall be responsible for the safekeeping of all completed *Use of Force Reports.*

SCHENECTADY POLICE DEPARTMENT

GENERAL ORDER	ORDER #: O-07	ISSUE DATE: July 1 , 2006
SUBJECT: Use of Force Policy	ISSUING AUTHORITY:	Page 14 of 16
DISTRIBUTION: All Sworn Members		
REVISES ORDER #: N/A	SUPERSEDES ORDER #: GO 2002-02, IO 1998-12	ACCREDITATION REFERENCE STANDARD: NYS 20.1, 20.4, 20.6, 20.7, 21.1, 21.2
ATTACHMENT(S): (1) *Use of Force Report* (SPD126); (2) *Supervisory Report of Discharge of Firearm* (SPD32)		

XI. Use of Firearms Incident Review:

A. Initial Review

1. The supervisor initially notified of the discharge of a firearm shall complete a *Supervisory Report of Discharge of Firearm* (SPD32) (Attachment 2).

   a. If the discharge of a firearm involved a person, a *Use of Force Report* (SPD126) shall be completed in the manner described in IX and the patrol supervisor will attach a completed SPD32 to the *Use of Force Report* once he/she has completed his/her review and filled in the appropriate section. The supervisor will then distribute the SPD126 and attached SPD32 in the manner described in X.A.2.

   b. If the discharge of a firearm did not involve a person (e.g., accidental, against an animal, etc.), the patrol supervisor shall forward:

      1) The original SPD32 and a copy of the SIR/DIR to the Office of Professional Standards.

      2) A copy of the SPD32 and SIR/DIR to:

         a) Commander of the Administrative Services Bureau
         b) The involved officer's Bureau Commander
         c) Platoon/Unit Commander assigned to the shift that the use of force incident occurred

B. Supervisory Review of SPD32

1. Supervisors required to review the SPD32 who determine that the discharge of a firearm was not consistent with this General Order shall immediately contact his/her superior for further review of the incident and possible commencement of an internal review by the Office of Professional Standards.

C. The Commander of the Administrative Services Bureau

1. Shall review and ensure the safekeeping of all completed *Supervisory Reports of Discharge of Firearm* by the Office of Professional Standards.

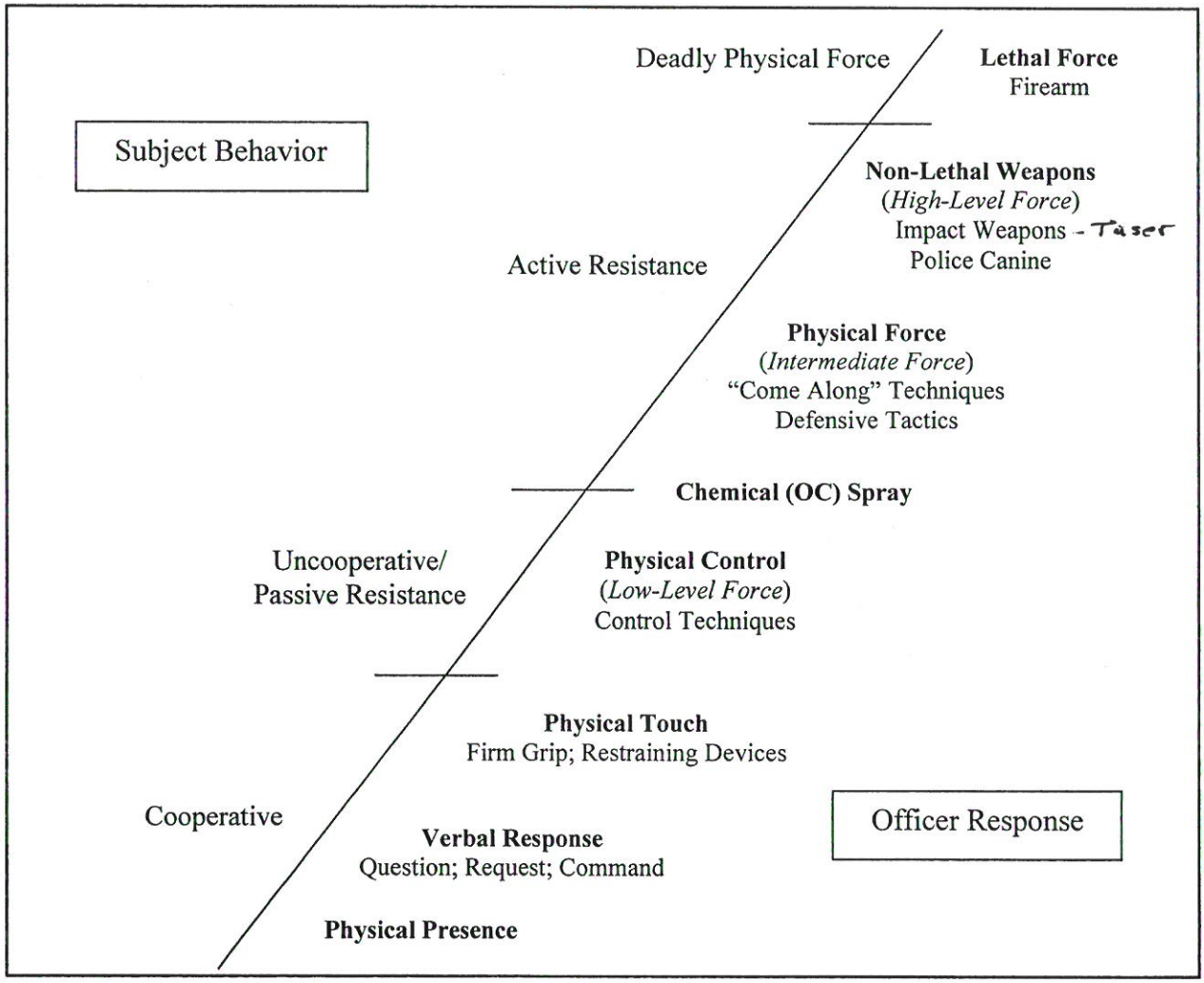
D. Office of Professional Standards

1. Shall be responsible for the safekeeping of all completed *Supervisory Reports of Discharge of Firearm.*

SCHENECTADY POLICE DEPARTMENT

GENERAL ORDER	ORDER #: O-07	ISSUE DATE: July 1 , 2006
SUBJECT: Use of Force Policy	ISSUING AUTHORITY:	Page 16 of 16
DISTRIBUTION: All Sworn Members		
REVISES ORDER #: N/A	SUPERSEDES ORDER #: GO 2002-02, IO 1998-12	ACCREDITATION REFERENCE STANDARD: NYS 20.1, 20.4, 20.6, 20.7, 21.1, 21.2
ATTACHMENT(S): (1) *Use of Force Report* (SPD126); (2) *Supervisory Report of Discharge of Firearm* (SPD32)		

Diagram 1. Use of Force Continuum.



Schenectady Police Department

Use of Force Report

CLEARLY PRINT ALL INFORMATION

INCIDENT #: **INCIDENT TYPE:**	**SUBJECT NAME:** (L) (F) (MI)
INCIDENT LOCATION:	**ADDRESS:**
INCIDENT DATE: / / **TIME:** a.m. / p.m.	**DOB:** / / **SEX:** M F **RACE:** Wh Blk Hisp Other-
OFFICER APPLYING FORCE: (L) (F) (Rank)	**PHONE:** (Home) (Work) (Other)
CHARGES:	

[1] Nature of Contact
(Circle all that apply)

A. Arrest
B. Field Interview
C. Attempt to Control
D. Traffic Stop
E. Transport
F. EDP
G. Other: _____

[2] Force Used By Officer
(Circle all that apply)

A. Resistant Handcuffing
B. Leg Restraints
C. Defensive Tactics (*list all techniques used*: e.g., Kumara, bent-wrist lock, Bar-Hammer, etc.)
_____
D. O.C. Spray
E. Strikes (*indicate type below, and point of impact on suspect's body*)
   i. Elbow to _____
   ii. Fist to _____
   iii. Hand to _____
   iv. Knee to _____
   v. Kick to _____
F. Impact Weapon (*indicate type below, and point of impact on suspect's body*)
   i. Expandable Baton to _____
   ii. Other: _____ to _____
G. Police K-9 (*indicate type below, and point of impact on suspect's body*)
   i. Not bitten
   ii. Bitten on _____
H. Firearm pointed @ subject (*indicate type below*)
   i. Pistol
   ii. Shotgun
I. Firearm fired @ subject (*indicate type below, and point (if any) of impact on suspect's body*)
   i. Pistol shot to _____ (or missed ___)
   ii. Shotgun shot to _____ (or missed ___)
J. Other: _____
K. Threatened use of force (indicate letters):_____

[3] Reason Force Used:
(Circle all that apply)

A. Subject attacked another person
B. Subject attacked officer
C. To effect an arrest
D. To prevent an escape from custody
E. To prevent a crime
F. To restrain for subject's safety
G. Refused to comply w/ verbal commands
H. Other: _____

[4] Subject's Resistance
(Circle all that apply)

A. Passive Resistance
(uncooperative, refuses to comply w/ commands)
B. Active Resistance/Combative
(physically interferes/resists, verbally/physically indicates intent to assault, attempts to injure)
C. Used/Threatened Deadly Physical Force

[5] Subject Impairment
(Circle all that apply)

A. None
B. Alcohol
C. Drugs
D. Psychological
E. Other: _____
F. Unknown (*explain*): _____

[6] Effects of Force on Subject
(Circle all that apply)

A. No visible injury
B. Minor Visible Injury (redness, swelling, abrasion)
C. Serious Visible Injury (gunshot, laceration, fracture)
D. Unconscious
E. No complaint of injury
F. Complaint of injury
G. Injury w/ hospital treatment
H. Injury w/ hospital admission
I. Fatality
J. Other: _____

[7] Officer's Observations of Subject's Condition
(Circle all that apply & indicate location on body)

A. No injuries or medical conditions observed
B. Difficulty Breathing
C. Abrasions: _____
D. Bruising: _____
E. Laceration: Minor / Severe
_____
F. Bleeding: Minor / Moderate / Heavy
_____
G. Stab wound: Minor / Severe
_____
H. Gunshot wound: _____
I. Incoherent
J. Fracture: Internal / Compound
_____
K. Other: _____
L. Pre-existing injuries of above (indicate letters): _____
_____

[8] Complaints Made By Subject
(Circle all that apply)

A. None
B. Pain (Location: _____)
C. Injury (Location: _____)
D. Burning (Location: _____)
E. Difficulty breathing
F. Dizziness
G. Nausea
H. Numbness (Location: _____)
I. Other: _____

[9] Subject Medical Treatment:
(Circle all that apply)

A. None necessary
B. Refused treatment
C. Treated @ scene
SFD / MAS / Other: _____
D. Treated @ hospital and released
Ellis / St. Clare's / Other: _____
E. Admitted to hospital
Ellis / St. Clare's / Other: _____
F. O.C. spray decontamination

[10] Photo(s) of subject *(attach to form)*

1. Taken by: _____
2. Taken of (Location(s): _____
_____)

[11] Force Used By Subject *(Circle all that apply)*

A. None
B. Hands
C. Fist
D. Elbow
E. Knee
F. Kick
G. Weapon (Type: _____)
H. Other: _____

[12] Officer's Condition *(Circle all that apply & indicate location on body)*

A. No injuries or medical conditions observed
B. Difficulty Breathing
C. Abrasions: _____
D. Bruising: _____
E. Laceration: Minor / Severe
_____
F. Bleeding: Minor / Moderate / Heavy
_____
G. Stab wound: Minor / Severe
_____
H. Gunshot wound: _____
I. Incoherent
J. Fracture: Internal / Compound
_____
K. Other: _____
L. Pre-existing injuries of above (indicate letters): _____
_____

[13] Other Officers Present _____ Yes _____ No

1. _____ _____, _____
Rank Last name First Name
2. _____ _____, _____
3. _____ _____, _____
4. _____ _____, _____
(If additional officers present, note in narrative or on SIR Supplement form)

[14] Civilian Witnesses _____ Yes _____ No

1. _____
Last Name First Name Address Phone #
2. _____
3. _____
4. _____
(If additional witnesses present, note in narrative or on SIR Supplement form)

Narrative:

_____
_____
_____
_____
_____

Officer's Signature:	Date:	Reviewing Supervisor's Signature:	Force Used:	Date:
Print Name:	/ /	Print Name:	☐ Proper ☐ Improper	/ /

Schenectady Police Department

Supervisory Report of Discharge of Firearm

Officer Name (print): _____ ID#: _____ Rank: _____

Date: _____ Time: _____ On ☐ / Off ☐ Duty If on duty, assignment: _____

Location of Incident: _____

Lighting: _____ Weather: _____

Weapon: _____ Serial #: _____ # of Shots: _____

Result of Shot(s) (e.g., object struck): _____ Direction Fired: _____

Reason for Discharge: _____

Description of Target: _____

- If person: Name, Address, DOB (*if unknown, physical description*)

_____

Extent of Wounds/Damage: _____

Target Action (e.g., moving, lunging, etc.): _____

Officer Action/Position: _____

Officers Present at Incident: _____

Officers Responding After Incident: _____

Name and Address of Witness(es): _____

_____

Officer's Statement: Yes ☐ No ☐ If no, reason: _____

Weapon Turned Over To: _____ ID#: _____ Rank: _____

Signature of Supervisor: _____ ID#: _____ Date: _____

Signature of Bureau Commander: _____ Date: _____

EXHIBIT 2

FINAL — Patient Care Report

MOHAWK AMBULANCE SERVICE
793 State Street, Schenectady, NY 12307
Phone # 518-374-5190 Fax # 518-374-8368
EMS Agency Code: 4611

Patient Name: Andrew Kearse [redacted]

DOS: 05/11/2017 **Run#:** 27530 **Veh#:** 04
REMO#: **MD#:** **AEMT#:**

RESPONSE INFO

Nature Of Call:	Unconscious
Response Priority:	1 - Emergency Priority 1
Location Code:	Sch'dy Co. - Schenectady - 4801
Care in Progress:	Schdy FD Schdy PD
PickUp Location:	Schenectady City Police Dept. 531 LIBERTY ST SCHENECTADY, NY 12305
Scene Delay:	

DISPOSITION

Outcome:	Treated & Xported to Hospital
Transport Priority:	1 - Emergency Priority 1
Level of care:	FD ALS
Transport Mileage:	1.20
Waiting Time:	
Pt. Transported:	Head Elevated - Stretcher
Destination:	Ellis Hospital Dept: ER 1101 NOTT ST SCHENECTADY, NY 12308-2425
Barriers to Care:	Unconscious

TIMES

Recvd:	17:01 05-11-17
Dispatch:	17:02 05-11-17
En route:	17:04 05-11-17
At scene:	17:06 05-11-17
At patient:	17:09 05-11-17
Transport:	17:21 05-11-17
At dest.:	17:24 05-11-17
In service:	18:00 05-11-17
Xport Agency	Mohawk Ambulance
Arrival:	
Departure:	

PATIENT INFORMATION

Name: Andrew Kearse [redacted]
[redacted]
Sex: Male
Weight:
Doctor:
Invisible Bracelet ID :
Personal Effects:
DNR Status: Not Known

NEXT OF KIN

Name: Relation:
Home DOB:
Address: SSN:
(H) Phone: (C) Phone:

INSURANCE

no insurance information entered

CHIEF COMPLAINT

Chief Complaint
Cardiac Arrest
Note: PT went unresponsive, in cardiac arrest.

MEDICAL HISTORY

Allergies
Unknown Medication Allergies Unknown Environmental Allergies Unknown Drug Allergies

Medications
Unknown Medications (Rx / OTC) -

Past Medical History
Unknown Past Medical Hx

ASSESSMENTS

05/11/2017 17:09:00 By: Connect Review Comments

Body Area	Assessment and Comments	Body Area	Assessment and Comments	Body Area	Assessment and Comments
Airway	Patent	Breathing	Absent	Circulation	Absent
Mental Status	Unresponsive				

05/11/2017 17:09:00 By: Connect Review Comments

Body Area	Assessment and Comments	Body Area	Assessment and Comments	Body Area	Assessment and Comments
Airway	Patent	Breathing	Absent	Circulation	Absent
Mental Status	Unresponsive				

TRAUMA

no trauma entered

5/12/2017 5:29 PM FROM: 518-374-8368 MAS Mohawk Ambulance TO: +1(518) 612-2184 PAGE: 003 OF 004

FINAL Patient Care Report

MOHAWK AMBULANCE SERVICE
793 State Street, Schenectady, NY 12307
Phone # 518-374-5190 Fax # 518-374-8368
EMS Agency Code: 4611

Patient Name: Andrew Kearse
DOB: [redacted] [redacted]

DOS: 05/11/2017 **Run#:** 27530 **Veh#:** 04
REMO#: **MD#:** **AEMT#:**

VITAL SIGNS

05/11/2017 17:20:00 By: Fire Dept Personnel Comments:

BP	Pulse	Resp	SPO2	ETCO2	Cardiac Monitor Interpretation	BG	LOC	GCS	Pain Scale
0/0 Automated Cuff	0, Absent, <None>	0 Absent, <None>	0%, Source: Room Air				Unresponsive	E1 + V1 + M1 = 3	

Skin: Temp=Cool / Color=Pale / Moisure=Moist/Clammy / Pupils:

05/11/2017 17:30:00 By: Fire Dept Personnel Comments:

BP	Pulse	Resp	SPO2	ETCO2	Cardiac Monitor Interpretation	BG	LOC	GCS	Pain Scale
0/0 Automated Cuff	0, Absent, <None>	0 Absent, <None>	0%, Source: Room Air				Unresponsive	E1 + V1 + M1 = 3	

Skin: Temp=Cool / Color=Pale / Moisure=Moist/Clammy / Pupils:

IMPRESSIONS

Primary Impression: Cardiac Arrest
Secondary Impressions: Unresponsive

TREATMENT SUMMARY

CPR - Compressions & Ventilation — Authorized by: Protocol (Standing Orders)
05/11/2017 17:02:00 By: Fire Dept Personnel Comments:

Downtime to CPR=10 | # of Attempts=1 | Successful=No | Response=Unchanged

FD ALS - IV/IO Attempted/Estab... — Authorized by: Protocol (Standing Orders)
05/11/2017 17:09:00 By: Fire Dept Personnel Comments:

FD BLS - OPA/NPA Attempted/Pla... — Authorized by: Protocol (Standing Orders)
05/11/2017 17:09:00 By: Fire Dept Personnel... Comments:

FD BLS - Artificial Ventilatio... — Authorized by: Protocol (Standing Orders)
05/11/2017 17:09:00 By: Corrado, Kayleigh Comments:

Oxygen — Authorized by: Protocol (Standing Orders)
05/11/2017 17:09:00 By: Corrado, Kayleigh Comments:

Response=Unchanged | Dosage=25 | Delivery device=BVM | Dosage Units=LPM
Route=Inhalation | Successful=Yes | # of Attempts=1

FD ALS - Medications Administe... — Authorized by: Protocol (Standing Orders)
05/11/2017 17:11:00 By: Fire Dept Personnel Comments:

FD ALS - Defibrillation/Cardio... — Authorized by: Protocol (Standing Orders)
05/11/2017 17:12:00 By: Fire Dept Personnel Comments:

FD ALS - Medications Administe... — Authorized by: Protocol (Standing Orders)
05/11/2017 17:13:00 By: Fire Dept Personnel Comments:

FD ALS - Medications Administe... — Authorized by: Protocol (Standing Orders)
05/11/2017 17:16:00 By: Fire Dept Personnel Comments:

NARRATIVE

MAS called to the SFD police station for a thirty-six yr. old male in cardiac arrest. Upon arrival, PT was lying supine on the sidewalk, unresponsive and in cardiac arrest. CPR was being performed by SFD, who had already delivered Narcan, to no effect. MAS attached MAS oxygen to BVM and delivered artificial ventilations at 25 L, 2 every 15 compressions until SFD placed an artifical airway, at which point respiration rate was changed to 1 every 5 to 6 seconds as CPR was continued. SFD placed an IV in PT's shin and AC, through which SFD delivered medications. PT was rolled on his side, while ventilations were continued, to be placed on a backboard, where he was secured with straps and lifted onto the stretcher, where he was again secured with straps, rails up x2, and lifted into the ambulance, without incident. Back story on how PT went into cardiac unrest unknown.

During transport, PT remained unresponsive with occasional shockable cardiac rhythms. PT was shocked with the AED roughly 3 times, around which CPR and artifical respirations were continued. All PT care was supervised and maintained by SFD.

At Ellis, PT was brought to room 39, where he was transferred to the bed via back board lift, without incident. PT was transferred to 25 L BVM facility oxygen, and ventilations and CPR were taken over by facility staff. SFD gave report to MD and RN, and RN signature obtained.

PT unable to sign due to being in cardiac arrest.

Ellis KEARSE, ANDREW Enc #3041070586 IPT ICU 5/11/2017 5/11/2017 ED0080 EMS Ambulance Form 5/15/2017 3 pg

FINAL — **Patient Care Report**

MOHAWK AMBULANCE SERVICE
793 State Street, Schenectady, NY 12307
Phone # 518-374-5190 Fax # 518-374-8368
EMS Agency Code: 4611

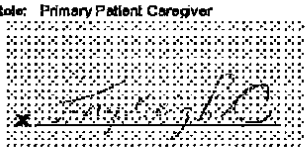
Patient Name: Andrew Kearse [redacted]

DOS: 05/11/2017 **Run#:** 27530 **Veh#:** 04
REMO#: **MD#:** **AEMT#:**

CREW INFORMATION

Documented By: Corrado, Kayleigh

Crew #: 1288	**Crew #:** 1211	**Crew #:**
Name: Corrado, Kayleigh	**Name:** Mash, Natalie	**Name:**
License: 432803 // EMT-B	**License:** 427528 // EMT-B	**License:**
Crew Role: Primary Patient Caregiver	**Crew Role:** Driver	**Crew Role:**



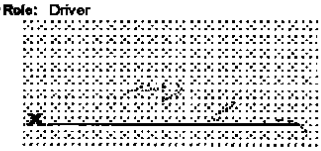


EXHIBIT 3

INPATIENT Admission Form

Encounter #	MR#	Enc Start Date Time	Pt Location
244448726	1715034	05/11/2017 19:48	39-A-1

ECD#	LOC	Clin Svc	EPT	Enc Type
3041070586	Acute	ICU	IP	IP

Adm Dx Code	Desc	PAT	Adm Type
		N	X
		Gdr	MS
		M	U

Encounter Reason	Race	Soc Sec #
VENTRICULAR TACHYCARDIA	U	
Referring Facility: None		

Age	Birth Date	Religion	Adm Clerk
36Y	[redacted]	Unknown	

Patient Name Address, Phone	Employer Name, Address, Phone	Emplm Sts
Kearse, Andrew [redacted] Home: Day: Cell:		

Guarantor Name, Pt Rel, Address, Phone	Guarantor Empr, Address, Phone	Emplm Sts
Kearse, Andrew Self SS#: Phone:		

Emergency Contact 1	Emergency Contact 2
Phone 1: Phone 2:	Phone 1: Phone 2:

Insurance 1 Name, Address, Phone	Policy Number	Group Number	Subscriber
[redacted]	01		Andrew Kearse
	Referral/Authorization #		Subscriber Employer
	Eff. Date	Pre-Cert. Phone	

Insurance 2 Name, Address, Phone	Policy Number	Group Number	Subscriber
	Referral/Authorization #		Subscriber Employer
Verified?	Eff. Date	Pre-Cert. Phone	

Insurance 3 Name, Address, Phone	Policy Number	Group Number	Subscriber
	Referral/Authorization #		Subscriber Employer
Verified?	Eff. Date	Pre-Cert. Phone	

Primary Physician	Adm Source	Confidential Reason	Infectious Disease
Doctor, Emergency, MD	EO		

Admitting Physician, ID	Last Enc Date	Visitor Restriction	Release of Info	Benefits Assigned
Parkes, Robert J, MD 210047			Y	Y

Attending Physician, ID	Health Care Proxy Sts	Behavioral Hlth	Maiden Name
Parkes, Robert J, MD 210047			

Mothers Name	Mothers MRN	Mothers ECD #	Mothers Enc#

Comment: ER TO CATH TO ICU

Ambulance Squad:

Incident Date	Incident Type	Inc St/Prov	Incident Description / Location
05/11/17	Onset		

Generated from 05/11/2017 00:00 to END

Order Type: Cardiology

Order Sub Type: Cardiovascular Services

Str / End DTime	Order as Written	Ord Status	Signed-By / Co-Signed By	Ord No
05/11/17 17:57	ECG Stat Reason: CARDIAC ARREST	Discontinue	ROSEANNA ROCISSANO	32145121
05/11/17 17:57				

Order Type: COM

Order Sub Type: NRSCOM

Str / End DTime	Order as Written	Ord Status	Signed-By / Co-Signed By	Ord No
05/11/17 17:57	Nrs Communication Routine; The provider entering this	Discontinue	ROSEANNA ROCISSANO	32145113
05/11/17 17:57				

Instructions: The provider entering this Lactate order is authorizing a repeat auto-generated Lactate order within 4 hours of the first Lactate order if the Lactate result is greater than 2.0

05/11/17 19:05	Nrs Communication Routine; The provider entering this	Discontinue	DEBORAH M. HUGHES	32146354
05/11/17 19:05				

Instructions: The provider entering this Lactate order is authorizing a repeat auto-generated Lactate order within 4 hours of the first Lactate order if the Lactate result is greater than 2.0

Order Type: Laboratory

Order Sub Type: ABG Blood Gases

Str / End DTime	Order as Written	Ord Status	Signed-By / Co-Signed By	Ord No
05/11/17 19:43	Blood Gases (1074) Critical Venous	Discontinue	DEBORAH M. HUGHES	32145687
05/11/17 19:43				
05/11/17 19:18	Blood Gases (1074) Critical Venous	Complete	DEBORAH M. HUGHES	32146378
05/11/17 19:18				

Order Type: Laboratory

Order Sub Type: Chemistry

Str / End DTime	Order as Written	Ord Status	Signed-By / Co-Signed By	Ord No

Order Type: Laboratory

Order Sub Type: Chemistry

Str / End DTime	Order as Written	Ord Status	Signed-By / Co-Signed By	Ord No
05/11/17 17:57 05/11/17 17:57	Comprehensive Metabolic Panel (4212); Stat	Complete	ROSEANNA ROCISSANO	32144934
05/11/17 17:57 05/11/17 17:57	Drug Screen, urn ER (4601); Stat	Discontinue	ROSEANNA ROCISSANO	32144935
05/11/17 17:57 05/11/17 17:57	Magnesium (4111); Stat	Complete	ROSEANNA ROCISSANO	32144936
05/11/17 17:58 05/11/17 17:58	Troponin-I (4947); Stat	Complete	ROSEANNA ROCISSANO	32145041
05/11/17 17:57 05/11/17 17:57	Lactic Acid, Plasma, Venous (511); Stat	Cancel	ROSEANNA ROCISSANO	32145112
05/11/17 17:57 05/11/17 17:57	Acetaminophen (4883); Stat	Complete	ROSEANNA ROCISSANO	32145114
05/11/17 17:57 05/11/17 17:57	Salicylate (4087); Stat	Complete	ROSEANNA ROCISSANO	32145115
05/11/17 17:57 05/11/17 17:57	Ethanol (4003); Stat	Complete	ROSEANNA ROCISSANO	32145116

Order Type: Laboratory

Order Sub Type: Chemistry

Str / End DTime	Order as Written	Ord Status	Signed-By / Co-Signed By	Ord No
05/11/17 19:30 05/11/17 19:30	Laboratory Misc (4000); Stat; RSMISC drug screen	Discontinue	DEBORAH M. HUGHES	32145611
Comments: RSMISC drug screen				
05/11/17 23:06 05/11/17 23:06	Lactic Acid, Plasma, Venous (511); Timed; WFE order	Discontinue		32145674
Comments: WFE order				
05/11/17 19:06 05/11/17 19:06	Lactic Acid, Plasma, Venous (511); Stat	Complete	DEBORAH M. HUGHES	32146353

Order Type: Laboratory

Order Sub Type: Hematology

Str / End DTime	Order as Written	Ord Status	Signed-By / Co-Signed By	Ord No
05/11/17 17:57 05/11/17 17:57	CBC, Plt, Diff (5061); Stat	Complete	ROSEANNA ROCISSANO	32144933
05/11/17 17:58 05/11/17 17:58	Protime/INR (5023); Stat	Complete	ROSEANNA ROCISSANO	32145040

Order Type: Laboratory

Order Sub Type: Microbiology

Str / End DTime	Order as Written	Ord Status	Signed-By / Co-Signed By	Ord No
05/11/17 17:57 05/11/17 17:57	Culture, Urine (1014) Clean Catch Urine; Today	Discontinue	ROSEANNA ROCISSANO	32145118

Order Type: Laboratory
Order Sub Type: Microbiology

Str / End DTime	Order as Written	Ord Status	Signed-By / Co-Signed By	Ord No
05/11/17 17:57 05/11/17 17:57	Culture, Blood (1005) Venous; Today	Discontinue	ROSEANNA ROCISSANO	32145119
05/11/17 17:57 05/11/17 17:57	Culture, Blood (1005) Venous; Today	Discontinue	ROSEANNA ROCISSANO	32145120

Order Type: Laboratory
Order Sub Type: Urinalysis

Str / End DTime	Order as Written	Ord Status	Signed-By / Co-Signed By	Ord No
05/11/17 17:57 05/11/17 17:57	Urinalysis w/Micro (9029) Clean Catch Urine; Stat	Discontinue	ROSEANNA ROCISSANO	32145117

Order Type: Medication/IV
Order Sub Type:

Str / End DTime	Order as Written	Ord Status	Signed-By / Co-Signed By	Ord No
05/11/17 18:08 05/11/17 18:08	DEXTROSE 5%-WATER (250 ML bag) PHENYLEPHF	Discontinue		32145131
05/11/17 18:22	DEXTROSE 5%-WATER (250 ML bag) PHENYLEPHF	Discontinue		32145284

Order Type: Radiology
Order Sub Type: CT Scan

Str / End DTime	Order as Written	Ord Status	Signed-By / Co-Signed By	Ord No
05/11/17 18:28 05/11/17 18:28	CT Head without IV Contrast (1000) Stat	Cancel	ROSEANNA ROCISSANO	32145222

Generated from 05/11/2017 00:00 to END

Order Type: Radiology

Order Sub Type: Dx Radiology

Str / End DTime	Order as Written	Ord Status	Signed-By / Co-Signed By	Ord No
05/11/17 17:47	Portable Chest Xray Stat Reason : TUBE PLACEMENT	Complete	ROSEANNA ROCISSANO	32145005
05/11/17 17:47				

Pt Name:	Kearse, Andrew	**MRN:**	[redacted]
Pt ID:	[redacted]	**Acct No:**	
DOB:		**Age/Sex:**	
Adm DTime:	5/11/2017 7:48:00PM	**Atn Dr:**	Parkes, Robert MD
Dx:			
Alrg:	No Known Drug Allergies		

ED Triage Assessment

Assessment Status	Complete	**Collected D Time**	05/11/2017 20:00
Collected By	Baker, RN Lisa		

ED Triage Assessment

Triage Date / Time	05/11/2017 17:29	ED Triage Level	1
ED Triage Comment	Arrived buy ambulance. In police custody. IN the back of the car, pt complained of SOB and CP. Became unresponsibe. By EMS Had total of 4 epi, 300mg of amidorane, 2 narcan. shocked 3x.	Chief Complaint	VENTRICULAR TACHYCARDIA
Preferred Language	English	Source of Info	Other
Mode/Arrival	Ambulance	Height	0/0
Weight	86.183	NYS Mandatory HIV Testing & Consent offered if 13 - 64 yrs old.	Unable, Life threatening condition
Date of HIV test consent request	05/11/2017 00:00		

Pt Name:	Kearse, Andrew	**MRN:**	[redacted]
Pt ID:	[redacted]	**Acct No:**	
DOB:		**Age/Sex:**	36Y/M
Adm DTime:	05/11/2017	**Atn Dr:**	Parkes, Robert MD
Dx:			
Alrg:	No Known Drug Allergies		

ED Nurse Assessment

Assessment Status	Complete	**Collected D Time**	05/11/2017 20:08
Collected By	Baker, RN Lisa		

ED Nurse Assessment

Eye Opening	No Response	Verbal Response	No Response
Motor Response	No Response	Glasgow Coma Scale	3
CDT called Date:	05/11/2017 00:00	Referral Number	10763706
Comment :	Cardiac arrest	Comment :	Intubated
Patient being evaluated for possible stroke	No	Non-Surgical wound present on admission	Yes
Comment	Abrasion	Neurological System WDL	No
Cardiovascular System WDL	No	Respiratory System WDL	No
Gastrointestinal System WDL	No	Genitourinary System WDL	No
Musculoskeletal System WDL	No	Skin Integumentary WDL	No

ED Fall Risk Chapter

Recent Fall History (immediate or within 3 months)?	No	Is patient 85 years old or more ?	No

Pt Name: Kearse, Andrew

[redacted]

Adm DTime: 05/11/2017

Dx:

Alrg: No Known Drug Allergies

[redacted]

Age/Sex: 36Y/M

Atn Dr: Parkes, Robert MD

ED Nurse Assessment

Assessment Status	Complete
Collected By	Baker, RN Lisa
Collected D Time	05/11/2017 20:08

ED Nurse Assessment

Comment :	Cardiac arrest	Comment :	Intubated
Patient being evaluated for possible stroke	No	Non-Surgical wound present on admission	Yes
Comment	Abrasion	Neurological System WDL	No
Cardiovascular System WDL	No	Respiratory System WDL	No
Gastrointestinal System WDL	No	Genitourinary System WDL	No
Musculoskeletal System WDL	No	Skin Integumentary WDL	No

ED Fall Risk Chapter

Recent Fall History (immediate or within 3 months)?	No	Is patient 85 years old or more ?	No

eHIM Assessment Report

Pt Name: Kearse, Andrew

[redacted]

[redacted]

Age/Sex: 36Y/M

Adm DTime: 05/11/2017

Atn Dr: Parkes, Robert MD

Dx:

Alrg: No Known Drug Allergies

ED Medical History

Assessment Status	Complete	**Collected D Time**	05/11/2017 20:08
Collected By	Baker, RN Lisa		

ED Medical History

Comment	unkown	Tobacco Use?	Unknown if ever smoked
Domestic violence, abuse	Not able to assess at this time - See note	medical Hx Comment	Unkown

Ellis Hospital - Emergency Department

STATUS: FINAL

PATIENT NAME: Andrew Kearse [redacted] DOS: 05-11-2017 at 17:30

[redacted] PROVIDER: Bryan Kurtz, MD CC: Cardiac arrest

Provider bedside time: (05/11/2017 17:30)

HISTORIAN: Further history obtained from EMS personnel and prehospital care records. Limited history due to patient condition. Critical condition. Additionally, the following were also limited due to the stated condition - Physical exam.

CHIEF COMPLAINT: (Cardiac arrest.)

HISTORY OF PRESENT ILLNESS: (Patient is a 36 year old male presenting to the ED via EMS in cardiac arrest. History obtained from EMS due to critical condition of patient. Per EMS, patient was breaking parole, necessitation police intervention. A chase ensued, and the patient was taken under arrest and hand-cuffed. While in the patrol vehicle, patient began complaining of SOB, followed by syncope. The vehicle was stopped and EMS called. PTA pt given 2 narcans and 4 epinephrines. The narcan was administered within 5 minutes of cardiac arrest. The last epinephrine was administered 2 minutes PTA. Cardiac arrest onset was approximately 20 minutes PTA.

)

REVIEW OF SYSTEMS/ADDITIONAL ASSOCIATED SYMPTOMS: All other systems were reviewed and are negative except as noted.
CARDIOVASCULAR: (Cardiac arrest.)

PAST MEDICAL HISTORY: Unknown.

PAST SURGICAL HISTORY: Unknown.

SOCIAL HISTORY: Unknown.

FAMILY HISTORY: Unknown.

MEDICATIONS: Unknown.

ALLERGIES: Unknown.

CONSTITUTIONAL: (Physical examination deferred given critical nature of patient.)

DIAGNOSTIC DATA: Results reviewed by me and any available results are appended at end of document.
EKG interpreted by me: (Accelerated idioventricular rhythm.) Time performed (1741) Rate - 100 beats/min.
Repeat EKG: (Ventricular escape rhythm.
) Time performed (1930) Rate - 50 beats/min.

RADIOLOGY READING:

Chest XR: 2 views. Images reviewed by me. Radiologist interpretation reviewed by me.

Reading: (No consolidation. Endotracheal tube, distal tip positioned appropriately cephalad to the carina.)

PROCEDURES:

CENTRAL LINE PLACEMENT: Procedure performed by me.
Time (1755)
Consent - Implied secondary to emergency.
Universal protocol -
Indication - Critical care monitoring.
Prep - Sterile prep and drape.
Position - Placed in Trendelenburg position.
Location - Right. Femoral vein.
Catheter - Triple lumen catheter.
Technique - Placed using a modified Seldinger technique.
Comments - No complications. Patient tolerated procedure well.
Post procedure CXR -

CARDIOVERSION: Procedure performed by me.
Time (1730)
Consent - Implied secondary to emergency.
Universal protocol -
Indication - Atrial fibrillation.
Technique -
Attempt 1 - 200 joules. No change in rhythm.
Confirmation -
Post cardioversion EKG: (Accelerated idioventricular rhythm.) Time performed (1741) Rate - 100 beats/min.

INTERVENTIONS:
Crtical care interventions:
Circulation - CPR given. See my central line procedure note.

INTERVENTION:
Time: (1803)
Norepinephrine.

CONSULT: (1821- call
case discussed wtih Dr. Goynkman said call back with cat scan and blood results
) Time (1821)

CONSULT: Time (1902)
DISCUSSED WITH: (Cardiology.)
Plan of care - (Will float at transvenous pacemaker.) Discussed with consultant all pertinent details of the history and physical as well as any pertinent or abnormal lab and/or radiology findings. Will see patient now.

Ellis Hospital - Emergency Department STATUS: FINAL

PATIENT NAME: Andrew Kearse [redacted] DOS: 05-11-2017 at 17:30

[redacted] PROVIDER: Bryan Kurtz, MD CC: Cardiac arrest

[redacted]

MEDICAL DECISION MAKING: (Pt is a 36 year old male presenting in cardiac arrest. He arrived in ventricular fibrillation. ACLS protocol followed with serial defibrillation attempts with epinephrine and vasopressin administration. We finally were able to get a pulse back with initial BP of 101 systolic. The electrocardiogram revealed accelerated ventricular rhythm. CXR shows good tube placement above corina with
no pneumothorax and no infiltrates. At points, pt became bradycardic at 35-45 and BP dipped down to 65-75, systolic. The lungs were auscultated and initially sounds were stronger on the right side and line retracted from 25 to 23, with equal breath sounds afterwards. Right groin area prepped and draped for triple lumen cathedral placement. Good venous blood return obtained and triple lumen placed with good blood return from all ports. Due to bradycardia, 2 mg atropine administered. Norepinephrine started at 1813 at 10 micrograms per kilogram. 2 more mg of narcan administered. Bedside US found good cardiac contractility. Venous pH from central line 6.65. 2 ampules bicarbonate pushed. Pt bradycardic to vent rhythm. Swan-Ganz introducer placed in right femoral location, however, pulses lost. CPR continued and asystole ensued. Code was called at 1947.

)

CRITICAL CARE TIME: The condition of the patient indicated a high probability of imminent or life threatening deterioration and required critical care services. My time excluded minutes spent performing separately billable procedures and time spent treating any other patients simultaneously. Amount of time spent fully attending to the care of the patient was 120 minutes. Critical care management included: History obtained from additional sources other than the patient. Nursing notes including vital signs reviewed. Medications ordered and managed. Labs ordered and reviewed. Xrays ordered and reviewed. Re-evaluations done. Collaboration with consultants. Admit planning.

NOTES:

Note: Time (1838) (Bradychardia returned at a rate of 33, which did not respond to 1 mg atropine. External pacemaker activated. Pt now running at a rate of 68 with capture. There is contractile of the heart on bedside US. Carotid pulse palpated. Unable to get BP at this time.
)

Note: Time (1905) (BP 115/90. External pacemaker is capturing and carotid pulse is correlated with the pacemaker.
)

Note: Time (1920) (Bedside US reveals good cardiac contractility. Venous pH from central line 6.65. 2 ampules bicarbonate pushed. Pt bradycardic to ventricular rhythm. Swan-Ganz introducer placed in right femural location,
however, pt's pulses lost. CPR continued and asystole ensued.)

Note: Time (1947) (Code called.)

CLINICAL IMPRESSION / PROBLEM LIST:
> Cardiac arrest.

DISPOSITION:
Condition: Expired.

Disposition decision time: (05/11/2017 19:47)

LABORATORIES - Reviewed by me

Acetaminophen Status: Final
Collected: 05/11/2017 17:55 Received: 05/11/2017 18:09 Reported: 05/11/2017 18:41

Name		Value	Ref Range
Acetaminophen	L	<2.0	[10-30] mcg/mL
Acetaminophen		Acetaminophen concentrations > 200 ug/ml	
Acetaminophen		at 4 hours after ingestion and 50 ug/mL	
Acetaminophen		at 12 hours after ingestion are often	
Acetaminophen		associated with toxic reactions.	

Comp Metabolic Panel Status: Final
Collected: 05/11/2017 17:55 Received: 05/11/2017 18:09 Reported: 05/11/2017 18:41

Name		Value	Ref Range
Sodium	H	158	[135-145] mEq/L
Potassium	H	5.5	[3.5-5.0] mEq/L
Potassium		This specimen exhibits	
Potassium		a large amount of	
Potassium		hemolysis which may	
Potassium		cause falsely increased	
Potassium		results for:	
Potassium		K+ LDH AST	
Potassium		IRON TIBC AMMONIA	
Potassium		PHOS CPK MG	
Potassium		CREAT	
Chloride	H	113	[97-109] mEq/L
CO2	L	14	[22-30] mEq/L
Elect Bal	H	36.5	[10.0-20.0]
Glucose	H	103	[65-99] mg/dL

BUN		9	[6-22] mg/dL
Creatinine	H	1.75	[0.6-1.3] mg/dL
Calcium		9.7	[8.5-10.5] mg/dL
Total Protein		6.3	[6.0-8.0] g/dL
Albumin		3.2	[3.0-5.0] g/dL
Globulin		3.1	[2.3-3.5] g/dL
Bilirubin,Total		0.50	[0.20-1.00] mg/dL
Alkaline Phos		87	[45-117] Units/L
AST(SGOT)	H	175	[10-41] Units/L
AST(SGOT)		This specimen exhibits	
AST(SGOT)		a large amount of	
AST(SGOT)		hemolysis which may	
AST(SGOT)		cause falsely increased	
AST(SGOT)		results for:	
AST(SGOT)		K+ LDH AST	
AST(SGOT)		IRON TIBC AMMONIA	
AST(SGOT)		PHOS CPK MG	
AST(SGOT)		CREAT	
ALT(SGPT)	H	259	[15-62] Units/L
Glomerular Filt Rate	L	44	[>60] mL/min/1.73m2
GFR Message		NOTE: As reported, the GFR result is for	
GFR Message		a non-African American patient. Values	
GFR Message		for an African-American patient can be	
GFR Message		obtained by multiplying this result by	
GFR Message		1.21.	
GFR Message		a non-African American patient. Values	
GFR Message		for an African-American patient can be	
GFR Message		obtained by multiplying this result by	
GFR Message		1.21.	

Ethanol Status: Final
Collected: 05/11/2017 17:55 Received: 05/11/2017 18:09 Reported: 05/11/2017 18:41

Name	Value	Ref Range
Ethanol	<3.0	[<3.0] mg/dL
Ethanol	This assay is for medical use only.	
Ethanol	Serum concentrations greater than	
Ethanol	400 mg/dL can be fatal.	

Magnesium Status: Final

Ellis Hospital - Emergency Department

STATUS: FINAL

PATIENT NAME: Andrew Kearse [redacted] DOS: 05-11-2017 at 17:30

[redacted] PROVIDER: Bryan Kurtz, MD CC: Cardiac arrest

Collected: 05/11/2017 17:55 Received: 05/11/2017 18:09 Reported: 05/11/2017 18:41

Name		Value	Ref Range
Magnesium	H	2.9	[1.6-2.6] mg/dL

Troponin-I Status: Final

Collected: 05/11/2017 17:55 Received: 05/11/2017 18:09 Reported: 05/11/2017 18:41

Name		Value	Ref Range
Troponin-I	H	0.245	[0.000-0.090] ng/mL
Troponin Interp		Troponin-I Reference Range:	
Troponin Interp		[0.00-0.09] - Normal	
Troponin Interp		[0.10-0.60] - Possible indication of	
Troponin Interp		myocardial damage,	
Troponin Interp		unstable angina,	
Troponin Interp		congestive heart failure,	
Troponin Interp		myocarditis, cardiac	
Troponin Interp		surgery or invasive	
Troponin Interp		testing. Clinical	
Troponin Interp		correlation is required.	
Troponin Interp		[> 0.60] - May indicate significant	
Troponin Interp		myocardial injury.	
Troponin Interp		Clinical correlation is	
Troponin Interp		required.	
Troponin Interp		[0.00-0.09] - Normal	
Troponin Interp		[0.10-0.60] - Possible indication of	
Troponin Interp		myocardial damage,	
Troponin Interp		unstable angina,	
Troponin Interp		congestive heart failure,	
Troponin Interp		myocarditis, cardiac	
Troponin Interp		surgery or invasive	
Troponin Interp		testing. Clinical	
Troponin Interp		correlation is required.	
Troponin Interp		[> 0.60] - May indicate significant	
Troponin Interp		myocardial injury.	
Troponin Interp		Clinical correlation is	
Troponin Interp		required.	

Salicylate Status: Final

Ellis Hospital - Emergency Department

STATUS: FINAL

PATIENT NAME: Andrew Kearse [redacted] DOS: 05-11-2017 at 17:30

[redacted] PROVIDER: Bryan Kurtz, MD CC: Cardiac arrest

[redacted]

Collected: 05/11/2017 17:55 Received: 05/11/2017 18:10 Reported: 05/11/2017 18:48

Name	Value	Ref Range
Salicylate	3.5	[0.5-20.0] mg/dL

Protime Status: Final

Collected: 05/11/2017 17:55 Received: 05/11/2017 18:09 Reported: 05/11/2017 18:58

Name		Value	Ref Range
PROTIME	H	21.9	[10.2-11.9] seconds
INR	H	2.1	[0.9-1.2] RATIO
INR INTERP		The following are recommended therapeutic	
INR INTERP		ranges in INR values based on condition:	
INR INTERP		CONDITIONS INR RANGE TARGET INR	
INR INTERP		Primary and secondary	
INR INTERP		prevention of	
INR INTERP		venous thrombosis: 2 - 3 2.5	
INR INTERP		Prevention of recurrent	
INR INTERP		venous thrombosis	
INR INTERP		(2 or more episodes): 2.5-4.0 3.0	
INR INTERP		Prevention of arterial	
INR INTERP		thrombo-embolism: 3.0-4.5 3.5	

Blood Gas Status: Final

Collected: 05/11/2017 19:43 Received: 05/11/2017 19:47 Reported: 05/11/2017 19:47

Name		Value	Ref Range
SOURCE		Arterial	
SOURCE		CORRECTED ON 05/11 AT 1947: PREVIOUSLY REPORTED AS Venous	
pH	L	6.892	[7.350-7.450]
pH		CALLED TO AND READ BACK BY	
pH		DEBBIE H. EDD1 1950	
pCO2	H	107.0	[35.0-45.0] mmHg
pO2	L	64.7	[80-100] mmHg
HCO3	L	20.2	[22-26] mmol/L
BASE DEFICIT	H	12.8	[0-3] mmol/L
% HbO2 SAT	L	70.4	[90-100] %
O2 CONTENT (TOTAL)	L	8.6	[15.0-23.0] mL/dL

Ellis Hospital - Emergency Department STATUS: FINAL

PATIENT NAME: Andrew Kearse [redacted] DOS: 05-11-2017 at 17:30

[redacted] PROVIDER: Bryan Kurtz, MD CC: Cardiac arrest

O2 SATURATION	L	71.3	[90-100] %
TEMP		98	
O2 DEVICE		bagged	

CBC Status: Final

Collected: 05/11/2017 17:55 Received: 05/11/2017 18:09 Reported: 05/11/2017 19:03

Name		Value	Ref Range
WBC		8.5	[3.9-10.6] thous/mcL
RBC	L	3.46	[4.7-6.1] mill/mcL
Hemoglobin	L	10.5	[13.5-17.0] g/dL
Hematocrit	L	34.1	[41.0-53.0] %
MCV	H	98.5	[80.0-95.0] fL
MCH		30.2	[26.0-34.0] pg
MCHC	L	30.7	[31.0-37.0] g/dL
PLT	L	71	[130-400] thous/mcL
RDW		13.6	[11.5-14.5] %
MPV	L	8.4	[9.0-13.0] fl

Lactic Acid, Plasma Status: Final

Collected: 05/11/2017 19:11 Received: 05/11/2017 19:18 Reported: 05/11/2017 20:02

Name		Value	Ref Range
Lactic Acid, Plasma	H	27.7	[0.4-2.0] mmol/L
Lactic Acid, Plasma		CALLED TO AND READ BACK BY	
Lactic Acid, Plasma		DEBBIE H ER 2002	

Differential Status: Final

Collected: 05/11/2017 17:55 Received: 05/11/2017 18:09 Reported: 05/11/2017 20:45

Name		Value	Ref Range
NEUT		TNP	[45.0-80.0] %
NEUTROPHIL	L	21	[50-75] %
LYMPHOCYTE	H	63	[15-40] %
MONOCYTE		7	[0-10] %

Ellis Hospital - Emergency Department

STATUS: FINAL

PATIENT NAME: Andrew Kearse [redacted] DOS: 05-11-2017 at 17:30

[redacted] PROVIDER: Bryan Kurtz, MD CC: Cardiac arrest

[redacted]

EOSINOPHIL		2	[0-3] %
BAND NEUTROPHIL		5	[0-6] %
METAMYELOCYTE	H	1	[0] %
ATYPICAL LYMPHS	H	1	[0] %
RBC MORPHOLOGY		ANISOCYTES	
RBC MORPHOLOGY		1+	
RBC MORPHOLOGY		HYPOCHROMIA	
RBC MORPHOLOGY		1+	
PLATELET EVALUATION		DECREASED	
DIFF TYPE		Manual Differential Performed	

This note is prepared by Olivia Beltrani acting as a Scribe for Bryan Kurtz, MD on 05-11-2017 at 22:47.

The scribe documentation has been prepared under my direction and personally reviewed by me in its entirety, and I confirm that it is accurate and complete. Electronically signed by Bryan Kurtz, MD on 05-11-2017 at 22:47

Ellis MEDICINE

Emergency Department Addendum to the Medical Record

A. Critical Values

Chemistry

Test	Result	Critical Value
Ammonia	_____	≥ 50 umol/L
CO2	_____	≤ 10 mEq/L
Calcium	_____	≤ 6 mg/dl or ≥ 13 mg/dl
Glucose	_____	< 50mg/dl or > 500mg/dl (Neonate <30mg/dl or > 300mg/dl)
Magnesium	_____	<1.0mg/dL or >6.1mg/dl
Sodium	_____	<120mEq/l or >160mEq/l
Potassium	_____	< 3.0 mEq/l or >5.0mEq/l
Troponin	_____	≥ 0.6ng/ml

Hematology

Test	Result	Critical Value
WBC	_____	<1000 or > 40,000
Differential	_____	+ blasts/leukemic cells
Hemoglobin	_____	< 7 gm/dl ***OR*** > 2gm drop from 12.0 mg/dL
Hematocrit	_____	< 21%
Platelets	_____	< 50,000 or > 1 million
INR	_____	> 4.0
PTT	_____	> 85

Drug Levels

Digoxin	_____	≥ 2.0 ng/ml
Phenytoin	_____	≥ 30mcg/ml
Phenobarbital	_____	≥ 50mcg/ml
Carbamazepine	_____	≥ 15mcg/ml
Valproic acid	_____	> 200mcg/ml
Lithium	_____	> 2.0mEq/l

Toxicology

Acetaminophen	_____	≥ 200mcg/ml
Salicylate	_____	≥ 30mg/dl

Sepsis

Lactate _____ ≥ 4mmol/L
* must repeat within 4 hours

ABG/VBG

pH 6699 pCO2 _____ pO2 _____ (≤60mm/Hg)

B. Medical Imaging/EKG

Radiology Procedure:

Result:

C. Microbiology

Source:

Result:

D. Receiving Call

Received by: D Hughes

Read back and verification performed: X Y __ N

Report given to (Name of provider) Kurtz

Date and Time: 1926 5-11-17

E. Actions Taken:

___ See Medical Record
___ See HIM addendum

Provider Signature: _____ Date and Time: _____

ED0055

Top copy (to provider, then Medical Records)
Back copy (to ED QA file)

Form 678-21 Rev 4/16

Patient I

Kearse, Andrew M 36Y 39-A-1

K [redacted]

Ellis MEDICINE

Emergency Department
Addendum to the Medical Record

A. Critical Values

Chemistry

Test	Result	Critical Value
Ammonia		≥ 50 umol/L
CO2		≤ 10 mEq/L
Calcium		≤ 6 mg/dl or ≥ 13 mg/dl
Glucose		< 50mg/dl or > 500mg/dl (Neonate <30mg/dl or > 300mg/dl)
Magnesium		<1.0mg/dL or >6.1mg/dl
Sodium		<120mEq/l or >160mEq/l
Potassium		< 3.0 mEq/l or >5.0mEq/l
Troponin		≥ 0.6ng/ml

Hematology

Test	Result	Critical Value
WBC		<1000 or > 40,000
Differential		+ blasts/leukemic cells
Hemoglobin		< 7 gm/dl ***OR*** > 2gm drop from 12.0 mg/dL
Hematocrit		< 21%
Platelets		< 50,000 or > 1 million
INR		> 4.0
PTT		> 85

Toxicology

Test	Result	Critical Value
Acetaminophen		≥ 200mcg/ml
Salicylate		≥ 30mg/dl

Drug Levels

Test	Result	Critical Value
Digoxin		≥ 2.0 ng/ml
Phenytoin		≥ 30mcg/ml
Phenobarbital		≥ 50mcg/ml
Carbamazepine		≥ 15mcg/ml
Valproic acid		> 200mcg/ml
Lithium		> 2.0mEq/l

Sepsis

Lactate ______ ≥ 4mmol/L

* must repeat within 4 hours

ABG/VBG

pH 6.892 pCO2 ______ pO2 ______ (≤60mm/Hg)

B. Medical Imaging/EKG

Radiology Procedure:

Result:

C. Microbiology

Source:

Result:

D. Receiving Call

Received by: D Hughes

Read back and verification performed: X Y __ N

Report given to (Name of provider) Kurtz

Date and Time: 1953 5-11-17

E. Actions Taken:

__ See Medical Record

__ See HIM addendum

Provider Signature: [signature]

Date and Time: ______

ED0055

Patient Label Ke

Kearse, Andrew M 36Y

[redacted]

Top copy (to provider, then Medical Records)
Back copy (to ED QA file) *Form 678-21 Rev 4/16*

Ellis MEDICINE

Emergency Department
Addendum to the Medical Record

A. Critical Values

Chemistry

Test	Result	Critical Value
Ammonia		≥ 50 umol/L
CO2		≤ 10 mEq/L
Calcium		≤ 6 mg/dl or ≥ 13 mg/dl
Glucose		< 50mg/dl or > 500mg/dl (Neonate <30mg/dl or > 300mg/dl)
Magnesium		<1.0mg/dL or >6.1mg/dl
Sodium		<120mEq/l or >160mEq/l
Potassium		< 3.0 mEq/l or >5.0mEq/l
Troponin		≥ 0.6ng/ml

Hematology

Test	Result	Critical Value
WBC		<1000 or > 40,000
Differential		+ blasts/leukemic cells
Hemoglobin		< 7 gm/dl ***OR*** > 2gm drop from 12.0 mg/dL
Hematocrit		< 21%
Platelets		< 50,000 or > 1 million
INR		> 4.0
PTT		> 85

Toxicology

Test	Result	Critical Value
Acetaminophen		≥ 200mcg/ml
Salicylate		≥ 30mg/dl

Drug Levels

Test	Result	Critical Value
Digoxin		≥ 2.0 ng/ml
Phenytoin		≥ 30mcg/ml
Phenobarbital		≥ 50mcg/ml
Carbamazepine		≥ 15mcg/ml
Valproic acid		> 200mcg/ml
Lithium		> 2.0mEq/l

Sepsis

Lactate ________ ≥ 4mmol/L
* must repeat within 4 hours

ABG/VBG

pH 6.699 pCO2 ______ pO2 ______ (≤60mm/Hg)

B. Medical Imaging/EKG

Radiology Procedure:

Result:

C. Microbiology

Source:

Result:

D. Receiving Call

Received by: D Hughes

Read back and verification performed: X Y __ N

Report given to (Name of provider) Kurtz

Date and Time: 1926 5-11-17

E. Actions Taken:

__ See Medical Record
__ See HIM addendum

Provider Signature: ______________________ Date and Time: ______________________

ED0055

Top copy (to provider, then Medical Records)
Back copy (to ED QA file) *Form 678-21 Rev 4/16*

Patient I Kearse, Andrew M 36Y
Ke [redacted]

Ellis MEDICINE

Emergency Department
Addendum to the Medical Record

A. Critical Values

Chemistry

Test	Result	Critical Value
Ammonia		≥ 50 umol/L
CO2		≤ 10 mEq/L
Calcium		≤ 6 mg/dl or ≥ 13 mg/dl
Glucose		< 50mg/dl or > 500mg/dl (Neonate <30mg/dl or > 300mg/dl)
Magnesium		<1.0mg/dL or >6.1mg/dl
Sodium		<120mEq/l or >160mEq/l
Potassium		< 3.0 mEq/l or >5.0mEq/l
Troponin		≥ 0.6ng/ml

Hematology

Test	Result	Critical Value
WBC		<1000 or > 40,000
Differential		+ blasts/leukemic cells
Hemoglobin		< 7 gm/dl ***OR*** > 2gm drop from 12.0 mg/dL
Hematocrit		< 21%
Platelets		< 50,000 or > 1 million
INR		> 4.0
PTT		> 85

Drug Levels

Test	Result	Critical Value
Digoxin		≥ 2.0 ng/ml
Phenytoin		≥ 30mcg/ml
Phenobarbital		≥ 50mcg/ml
Carbamazepine		≥ 15mcg/ml
Valproic acid		> 200mcg/ml
Lithium		> 2.0mEq/l

Toxicology

Test	Result	Critical Value
Acetaminophen		≥ 200mcg/ml
Salicylate		≥ 30mg/dl

Sepsis

Test	Result	Critical Value
Lactate		≥ 4mmol/L

* must repeat within 4 hours

ABG/VBG

pH 6.892 pCO2 ______ pO2 ______ (≤60mm/Hg)

B. Medical Imaging/EKG

Radiology Procedure:

Result:

C. Microbiology

Source:

Result:

D. Receiving Call

Received by: D Hughes

Read back and verification performed ✓ Y __ N

Report given to (Name of provider) Kurtz

Date and Time: 1953 5-11-17

E. Actions Taken:

__ See Medical Record
__ See HIM addendum

Provider Signature: [signature]

Date and Time: ______________

Patient Label: Kearse, Andrew M 36Y 39-A-1

Ke [redacted]

ED0055

Top copy (to provider, then Medical Records)
Back copy (to ED QA file)

Form 678-21 Rev 4/16

Circle and Charge if Applicable

Charge Code	Description
1060	Alcosensor
1282	Aerosol
1063	BGM
1281	Oxygen
1030	Venipuncture

RN Signature: [signature] Date:__________ Time:__________

Employee Entering Charges: [signature]
Signature

(See Sorian Financial for charge entry details)

[redacted]
Kearse, Andrew
[redacted]
Attending: Doctor, Emer[redacted]

Gender: M 36Y
[redacted]
DOS: 05/11/2017

Time seen by Provider:

ED INITIAL PHYSICIAN ORDERS

Physician Initiated — **INITIAL ORDERS** — **Time Ordered:**

- ☐ Chest Pain
- ☐ Pediatric Fever
- ☐ Extremity Injury
- ☐ Stroke
- ☐ Suspected Pneumonia
- ☐ Hyperglycemia
- ☐ Abdominal Pain
- ☐ Shortness of Breath
- ☐ Hypoglycemia
- ☐ Sepsis/Shock
- ☐ Pain
- ☐ Vaginal Bleed
- ☐ Rapid HIV screen
- ☐ Needlestick Protocol (see policy #7894)

(See Reverse for Protocol Details)

LABORATORY TESTING

- ☑ CBC
- ☑ CMP
- ☐ LIPASE
- ☐ PT/INR
- ☐ TROPONIN
- ☐ ABG on _____ L / _____ %
- ☐ BMP
- ☐ MAGNESIUM
- ☑ Lactate
- ☐ aPTT
- ☐ B-NP
- ☐ serum B-HCG (qualitative)
- ☐ serum B-HCG (quantitative)
- ☐ URINE TOX SCREEN
- ☐ ETOH
- ☐ ASA
- ☐ ACETAMINOPHEN
- ☐ U/A w/Micro – uncomplicated UTI/screen, *no C&S*
- ☐ U/A w/ Micro – complicated UTI, *with C&S*
- ☑ Blood Culture X 2
- ☐ Red Blood Culture X1
- ☐ Rapid Flu
- ☐ Rapid HIV
- ☐ Rapid Strep (no backup)
- ☐ GC Swab
- ☐ Chlamydia Swab
- ☐ Trichomonas
- ☐ OTHER: _____
- ☐ POC U/A
- ☐ POC urine pregnancy
- ☐ Urine Pregnancy (lab)
- ☐ RSV swab
- ☐ Wet Prep

EKG/ RADIOLOGY TESTING

- ☐ EKG ☑ CXR (Reason) Portable ☑ Portable ☐ PA/Lat
- ☐ X-RAYS (Reason): _____
- ☐ CT SCAN: _____ ☐ No Contrast ☐ IV Only ☐ Oral Only ☐ IV AND Oral
  Reason: _____ *No IV Contrast if creat >1.5 or GFR <50*
- ☐ OTHER: _____

INITIAL FLUIDS AND MEDICATIONS

☐ OBTAIN IV ACCESS ☐ CARDIAC MONITOR ☐ OXYGEN: Liters via ☐ NC ☐ Face Mask ☐ NRB

IV FLUIDS - Pick One	RN Initials	Time Started	Time Completed
☐ NS _____ mL bolus IV ☐ for hydration			
☐ NS _____ mL/hr IV ☐ for hydration			
☐ NS 30 mL/kg IV bolus over 30 min for sepsis			
☐ Other _____ @rate _____ ml/hr			

MEDICATIONS	RN Initials	Time Started
☐ ALBUTEROL 2.5 mg Nebulized and ☐ Ipratropium 500 MCG Nebulized		
☐ dT or ☐ Tdap		

PROVIDER SIGNATURE: *TIME OF ORDER:*

TIME ORDERED	ADDITIONAL ORDERS – *all medication orders are one time only*	PROVIDER SIGNATURE	RN Initials	Time Started
1805	Nscpt 5th STAT to ER			
	☐ Medically cleared for Crisis ☐ Crisis Screen (or) ☐ Crisis Full Evaluation ☐ Regular diet			
	☐ Stable for transfer to _____			

☐ Admit for IN-PATIENT care *(anticipate > 2 midnights)* ☐ Admit for OBSERVATION *(anticipate < 2 midnights)*

☐ Holding orders written ☐ Dictation completed #_____

☐ Telemetry ☐ ICU ☐ Neuro ICU ☐ OR ☐ Pediatrics DATE: _____ TIME: _____

DIAGNOSIS. | ADMITTING PHYSICIAN

☐ See continued orders on back of form.

[redacted] Gender: M 36Y

[redacted]

ED0110

Chest Pain Consistent with ischemia	STROKE	SEPSIS: BP systolic <90mm with end-organ dysfunction	PAIN
Continuous monitoring O2 via NC, keep O2 sat > 95% Obtain IV access Obtain STAT EKG, Obtain previous EKG Order Portable CXR **Labs:** CBC, CMP, troponin, Add INR if on warfarin ASA 324 mg po chewed (if no allergy to ASA)	• Continuous monitoring • O2 via NC, Keep O2 sat > 95% • Insert 2 peripheral IV's, • Start NS at 60ml/hr • Obtain STAT EKG • STAT non-contrast Head CT *include deficit on order • **Labs:** CBC, CMP, troponin, PT/PTT • Accu-check on arrival • Follow Acute Stroke Algorithm • **If tPA candidate:Activate Stroke 911** • Place Head of bed 0 - 30 degrees	Continuous monitoring O2 via NC, keep O2 sat > 95% Insert 2 IV's, prefer large-bore Start NS bolus - 30ml/kg over 30min Obtain EKG, Portable CXR **Labs:** CBC, CMP, troponin, PT/PTT, BC x2, lactate, UA,urine C&S Monitor I & O's [Broad spectrum antibiotics to be started within 3 hours of recognition] [If lactate > 4, repeat within 4 hours]	1) Offer Tylenol 15mg/kg maximum = 1000mg 2) Offer Ibuprofen 10mg/kg maximum = 800mg *Do not offer NSAID if-- -allergic or pregnant -on warfarin - Hx of GI Bleed, CHF or renal failure 3) Offer non-pharmacological interventions: ice, compress, splint, elevation
PEDIATRIC FEVER Fever > 100.4° F	**SUSPECTED PNEUMONIA** age > than 50, Temp > than 38.1, Cough, SOB	**DYSPNEA WITH WHEEZING**	**ABDOMINAL PAIN**
Rectal Temperature, if possible If > 4 hours from last dose: Give acetaminophen 15mg/kg If > 6 hours from last dose: Give ibuprofen 10mg/kg	Continuous monitoring 02 via NC, keep O2 sat > 95% Obtain IV access, Obtain EKG Order Chest x-ray: *portable if unstable OR PA/lat if stable Labs: CBC, CMP, BC x 2, Lactate	1) Continuous monitoring 2) 02 via NC, keep O2 sat > 95% 3) Provide DuoNeb (albuterol 2.5 mg + ipatropium 0.5mg)	Obtain IV access Labs: CBC, CMP, lipase, U/A Women of child-bearing age: *add urine or serum HCG* If unstable - notify physician
EXTREMITY INJURY	**HYPERGLYCEMIA - glucose >400g/dl**	**HYPOGLYCEMIA**	**VAGINAL BLEEDING**
Determine mechanism of injury and exact location of pain. Evaluate joint above and joint below for tenderness **Order appropriate x-ray** Right / Left (circle) Immobilize / elevate injured extremity Apply cold compress if injury less than 48 hours	Insert IV - start NS at 500ml/hr (adult) Labs: 1) not altered MS or ill, send U/A 2) if altered Mental status or ill send UA, CBC, CMP, acetone *If insulin SQ given in ED, must check fingerstick prior to discharge **If Insulin IV given in ED, must check fingerstick and K+ prior to discharge	If altered mental status - immediately perform Accucheck, if < 70mg/dl Insert IV - give 1 amp D50W If IV access unavailable: give glucagon 1mg IM *when sensorium clear, encourage po *recheck Accucheck prior to discharge	Place on pelvic stretcher Immediate vitals: if BP systolic <90 or HR> 100 start IV access, NS 20ml/kg Labs: CBC *if child-bearing age: add serum bHCG ** if pregnant, add Type and Screen

Community Acquired Pneumonia (CAP) ED ORDERS: (Give 1st dose AS SOON AS POSSIBLE)

1A. NON-ICU ADMISSION for CAP Ceftriaxone (Rocephin®) 1gm IV **PLUS** Azithromycin (Zithromax®) 500 mg IV **OR** Levofloxacin (Levaquin®) monotherapy 750 mg (IV or PO) Please Circle Route Note. for patient with multiple allergies, use Tigecycline monotherapy	**2A. ICU ADMISSION for CAP (Needs 2 antibiotics)** Ceftriaxone (Rocephin®) 1gm IV **PLUS** Azithromycin (Zithromax®) 500 mg IV **OR** Ceftriaxone (Rocephin®) 1gm IV **PLUS** Levofloxacin (Levaquin®) 750 mg IV
1B. NON-ICU ADMISSION **for Healthcare Associated Pneumonia (HCAP)** (e.g., Nursing Home and Rehab Facilities, Dialysis, Wound, Trach or Vent care) **and Hospital Acquired Pneumonia (HAP)** **NEED TWO ANTIBIOTICS** A. Cefepime (Maxipime®) 500mg - 2gm IV **OR** B. Piperacillin/Tazobactam (Zosyn®) 3.375 gm IV **PLUS** A. Ciprofloxacin (Cipro®) 200 - 400mg IV **OR** B. Gentamicin _____mg IV Please document. -if you suspect Aspiration or Post-Obstructive Pneumonia -you are covering for Pseudomonas or Atypical Pneumonia -the patient is immunocompromised	**2B. ICU Admissions** **for Healthcare Associated Pneumonia (HCAP)** (e.g., Nursing Home and Rehab Facilities, Dialysis, Wound, Trach or Vent care) **and Hospital Acquired Pneumonia (HAP)** **NEED TWO ANTIBIOTICS** A. Cefepime (Maxipime®) 500mg - 2gm IV **OR** B. Meropenem (Merrem®) 500mg - 1gm IV **OR** C. Piperacillin / Tazo (Zosyn®) 3.375 gm IV **PLUS** A. Ciprofloxacin (Cipro®) 200 - 400mg IV **OR** B. Gentamicin _____mg IV **OR** C. Tobramycin _____mg IV
1C. NON-ICU ADMISSION for CAP, HCAP or HAP **Add Vancomycin if MRSA is suspected:** Vancomycin (Vancocin®) (10-15 mg/kg) _____mg IV	**2C. ICU ADMISSION for CAP, HCAP, HAP** **Add Vancomycin if MRSA is suspected:** Vancomyon (Vancocin®) (10-15 mg/kg) _____mg IV

TIME	ADDITIONAL ORDERS	PROVIDER SIGNATURE	TIME	RN Initials

ELLIS HOSPITAL Schenectady, NY
ED Initial Physician Orders
Form #E0411 (10/14, 2/15, 12/15, 2/16, 4/16, 8/16) Page 2 of 2

ED0110

[redacted] Gender: M 36Y [redacted]
Kearse, Andrew [redacted]

DOS: 05/11/2017

Time seen by Provider:

ED INITIAL PHYSICIAN ORDERS

INITIAL ORDERS — ☐ Physician Initiated — Time Ordered:

☐ Chest Pain ☐ Pediatric Fever ☐ Extremity Injury
☐ Stroke ☐ Suspected Pneumonia ☐ Hyperglycemia
☐ Abdominal Pain ☐ Shortness of Breath ☐ Hypoglycemia
☐ Sepsis/Shock ☐ Pain ☐ Vaginal Bleed
☐ Rapid HIV screen ☐ Needlestick Protocol (see policy #7894)

(See Reverse for Protocol Details)

LABORATORY TESTING

☑ CBC ☑ CMP ☑ LIPASE ☑ PT/INR ☑ TROPONIN ☐ ABG on ____ L / ____ %
☑ BMP ☑ MAGNESIUM ☑ Lactate ☐ aPTT ☐ B-NP
☐ serum B-HCG (qualitative) ☐ serum B-HCG (quantitative) ☑ URINE TOX SCREEN ☑ ETOH ☑ ASA ☑ ACETAMINOPHEN
☐ U/A w/Micro – uncomplicated UTI/screen, *no C&S* ☑ U/A w/ Micro – complicated UTI, *with C&S*
☑ Blood Culture X 2 ☐ Rapid Flu ☐ Rapid HIV
☑ Red Blood Culture X1 ☐ Rapid Strep (no backup) ☐ RSV swab
☐ GC Swab ☐ Chlamydia Swab ☐ Trichomonas ☐ OTHER:
☐ POC U/A ☐ POC urine pregnancy ☐ Urine Pregnancy (lab) ☐ Wet Prep

EKG/ RADIOLOGY TESTING

☐ EKG ☑ CXR (Reason) Portable — ☑ Portable ☐ PA/Lat
☐ X-RAYS (Reason):
☐ CT SCAN: ☐ No Contrast ☐ IV Only ☐ Oral Only ☐ IV AND Oral
No IV Contrast if creat >1.5 or GFR <50
Reason:
☐ OTHER:

INITIAL FLUIDS AND MEDICATIONS

☐ OBTAIN IV ACCESS ☐ CARDIAC MONITOR ☐ OXYGEN: Liters via ☐ N/C ☐ Face Mask ☐ NRB

IV FLUIDS- Pick One	RN Initials	Time Started	Time Completed	MEDICATIONS	RN Initials	Time Started
				☐ ALBUTEROL 2.5 mg Nebulized and ☐ Ipratropium 500 MCG Nebulized		
☐ NS mL bolus IV ☐ for hydration				☐ dT or ☐ Tdap		
☐ NS mL/hr IV ☐ for hydration						
☐ NS 30 mL/kg IV bolus over 30 min for sepsis						
☐ Other						

Signed by KURTZ, BRYAN on 26-May-2017 21:40:42 -0400

PROVIDER SIGNATURE: TIME OF ORDER:

TIME ORDERED	ADDITIONAL ORDERS – *all medication orders are one time only*	PROVIDER SIGNATURE	RN Initials	Time Started
1805	Norepi gtt STAT to ER	[signature]		
	☐ Medically cleared for Crisis ☐ Crisis Screen (or) ☐ Crisis Full Evaluation			
	☐ Regular diet			
	☐ Stable for transfer to			

☐ Admit for IN-PATIENT care *(anticipate > 2 midnights)* ☐ Admit for OBSERVATION *(anticipate < 2 midnights)*
☐ Holding orders written ☐ Dictation completed #
☐ Telemetry ☐ ICU ☐ Neuro ICU ☐ OR ☐ Pediatrics DATE: TIME:
DIAGNOSIS: ADMITTING PHYSICIAN:

☐ See continued orders on back of form.

ELLIS HOSPITAL Schenectady, NY
ED Initial Physician Orders
Form #E0411 (10/14, 2/15, 12/15, 2/16, 4/16, 8/16) Page 1 of 2

ED0110

[redacted]
Kearse, Andrew
[redacted]
Gender: M 36Y
[redacted]
DOS: 05/11/2017

Chest Pain Consistent with Ischemia	STROKE	SEPSIS: BP systolic <80mm with end-organ dysfunction	PAIN
Continuous monitoring O2 via NC, keep O2 sat > 95% Obtain IV access Obtain STAT EKG, Obtain previous EKG Order Portable CXR **Labs:** CBC, CMP, troponin, Add INR if on warfarin ASA 324 mg po chewed (if no allergy to ASA)	• Continuous monitoring • O2 via NC, Keep O2 sat > 95% • Insert 2 peripheral IV's, • Start NS at 60ml/hr • Obtain STAT EKG • STAT non-contrast Head CT *include deficit on order • **Labs:** CBC, CMP, troponin, PT/PTT • Accu-check on arrival • Follow Acute Stroke Algorithm • **If tPA candidate:Activate Stroke 911** • Place Head of bed 0 - 30 degrees	Continuous monitoring 02 via NC, keep O2 sat > 95% Insert 2 IV's, prefer large-bore Start NS bolus - 30ml/kg over 30min Obtain EKG, Portable CXR **Labs:** CBC, CMP, troponin, PT/PTT, BC x2, lactate, UA,urine C&S Monitor I & O's [Broad spectrum antibiotics to be started within 3 hours of recognition.] [If lactate > 4, repeat within 4 hours]	1) Offer Tylenol 15mg/kg maximum = 1000mg 2) Offer Ibuprofen 10mg/kg maximum = 800mg *Do not offer NSAID if– -allergic or pregnant -on warfarin - Hx of GI Bleed, CHF or renal failure 3) Offer non-pharmacological interventions ice, compress, splint, elevation
PEDIATRIC FEVER Fever > 100.4° F	**SUSPECTED PNEUMONIA** Age > than 60, Temp > than 38.1, Cough, SOB	**DYSPNEA WITH WHEEZING**	**ABDOMINAL PAIN**
Rectal Temperature, if possible If > 4 hours from last dose Give acetaminophen 15mg/kg If > 6 hours from last dose, Give ibuprofen 10mg/kg	Continuous monitoring 02 via NC, keep O2 sat > 95% Obtain IV access, Obtain EKG Order Chest x-ray. *portable if unstable OR PA/lat if stable Labs, CBC, CMP, BC x 2, Lactate	1) Continuous monitoring 2) 02 via NC, keep O2 sat > 95% 3) Provide DuoNeb (albuterol 2.5 mg + ipratropium 0.5mg)	Obtain IV access Labs CBC, CMP, lipase, U/A Women of child-bearing age, *add urine or serum HCG* If unstable - notify physician
EXTREMITY INJURY	**HYPERGLYCEMIA - glucose >400g/dl**	**HYPOGLYCEMIA**	**VAGINAL BLEEDING**
Determine mechanism of injury and exact location of pain. Evaluate joint above and joint below for tenderness **Order appropriate x-ray** **Right / Left (circle)** Immobilize / elevate injured extremity Apply cold compress if injury less than 48 hours	Insert IV - start NS at 500ml/hr (adult) Labs 1) not altered MS or ill send U/A 2) if altered Mental status or ill: send UA, CBC, CMP, acetone *If insulin SQ given in ED, must check fingerstick prior to discharge **If insulin IV given in ED, must check fingerstick and K+ prior to discharge	If altered mental status - immediately perform Accucheck If < 70mg/dl Insert IV - give 1 amp D50W If IV access unavailable; give glucagon 1mg IM *when sensorium clear, encourage po *recheck Accucheck prior to discharge	Place on pelvic stretcher Immediate vitals: if BP systolic <90 or HR> 100 start IV access, NS 20ml/kg Labs, CBC *If child-bearing age' add serum bHCG ** If pregnant, add Type and Screen

Community Acquired Pneumonia (CAP) ED ORDERS: (Give 1st dose AS SOON AS POSSIBLE)

1A. NON-ICU ADMISSION for CAP

Ceftriaxone (Rocephin®) 1gm IV

PLUS

Azithromycin (Zithromax®) 500 mg IV

OR

Levofloxacin (Levaquin®) monotherapy 750 mg (IV or PO) Please Circle Route

Note: for patient with multiple allergies, use Tigecycline monotherapy

2A. ICU ADMISSION for CAP (Needs 2 antibiotics)

Ceftriaxone (Rocephin®) 1gm IV

PLUS

Azithromycin (Zithromax®) 500 mg IV

OR

Ceftriaxone (Rocephin®) 1gm IV

PLUS

Levofloxacin (Levaquin®) 750 mg IV

1B. NON-ICU ADMISSION for Healthcare Associated Pneumonia (HCAP)

(e.g., Nursing Home and Rehab Facilities, Dialysis, Wound, Trach or Vent care)

and Hospital Acquired Pneumonia (HAP)

NEED TWO ANTIBIOTICS

A. Cefepime (Maxipime®) 500mg - 2gm IV

OR

B. Piperacillin/Tazobactam (Zosyn®) 3.375 gm IV

PLUS

A. Ciprofloxacin (Cipro®) 200 - 400mg IV

OR

B. Gentamicin _____mg IV

Please document: -if you suspect Aspiration or Post-Obstructive Pneumonia
-you are covering for Pseudomonas or Atypical Pneumonia
-the patient is immunocompromised

2B. ICU Admissions for Healthcare Associated Pneumonia (HCAP)

(e.g., Nursing Home and Rehab Facilities, Dialysis, Wound, Trach or Vent care)

and Hospital Acquired Pneumonia (HAP)

NEED TWO ANTIBIOTICS

A. Cefepime (Maxipime®) 500mg - 2gm IV

OR

B. Meropenem (Merrem®) 500mg - 1gm IV

OR

C. Piperacillin / Tazo (Zosyn®) 3.375 gm IV

PLUS

A. Ciprofloxacin (Cipro®) 200 - 400mg IV

OR

B. Gentamicin _____mg IV

OR

C. Tobramycin _____mg IV

1C. NON-ICU ADMISSION for CAP, HCAP or HAP

Add Vancomycin if MRSA is suspected:

Vancomycin (Vancocin®) (10-15 mg/kg) _____mg IV

2C. ICU ADMISSION for CAP, HCAP, HAP

Add Vancomycin if MRSA is suspected:

Vancomycin (Vancocin®) (10-15 mg/kg) _____mg IV

TIME	ADDITIONAL ORDERS	PROVIDER SIGNATURE	TIME	RN Initials

ELLIS HOSPITAL Schenectady, NY

ED Initial Physician Orders

Form #E0411 (10/14, 2/15, 12/15, 2/16, 4/16, 8/16)

ED0110

[redacted]

Gender: M 36Y

Kearse, Andrew

[redacted]

DOS: 05/11/2017

eHIM Assessment Report

Pt Name: Kearse, Andrew

[redacted]

[redacted]

Age/Sex: 36Y/M

Adm DTime: 05/11/2017

Atn Dr: Parkes, Robert MD

Dx:

Alrg: No Known Drug Allergies

ED Disposition Departure Time

Assessment Status	Complete	**Collected D Time**	05/11/2017 21:20
Collected By	Gould Pamela RN		

ED Disposition Departure Time

ED Disposition	Expired	ED Disposition Comment	PT TAKEN TO AMC FOR FORENSIC AUTOPSY WITH OFFICERS AND CORONER

Note Type: Nursing

Clinical Notes Report

Pt Name:	Kearse, Andrew	[redacted]	
[redacted]		**Age/Sex:**	36Y/M
Adm Date:	05/11/2017	**Atn Dr:**	Parkes, Robert MD
Nurs Sta:	EDD1	**Rm/Bed:**	39-A-1
Dx:			
Alrg:	No Known Drug Allergies		

Collected Date/Time: 05/11/17 21:19 **Status:** Complete

Collected By: Gould Pamela RN

Note: OFFICER AND INVESTIGATORS INQUIRING ABOUT BLOOD SECURED FOR FORENSICS. CALL MADE TO LAB TO CONFIRM. PT BODY PICKED UP BY CORONER AND WILL BE TRANSPORTED WITH OFFICERS TO ALBANY MEDICAL CENTER FOR FURTHER FORENSIC AUTOSPY.

Collected Date/Time: 05/11/17 20:24 **Status:** Complete

Collected By: Baker, RN Lisa

Note: See code sheet

ELLIS HOSPITAL LABORATORY
1101 Nott Street, Schenectady, NY 12308 • 518-243-4055

PATIENT NAME: KEARSE,ANDREW
[redacted]
LOCATION: EDD1 39A-1

Report date/time

H38455 COLL: 05/11/2017 17:55 REC: 05/11/2017 18:09 PHYS: KURTZ,BRYAN E

Acetaminophen	*<2.0	[10-30]	mcg/mL	(EH)05/11/2017,18:41
	Acetaminophen concentrations > 200 ug/ml at 4 hours after ingestion and 50 ug/mL at 12 hours after ingestion are often associated with toxic reactions.			
Comp Metabolic Panel				
Sodium	*158	[135-145]	mEq/L	(EH)05/11/2017,18:41
Potassium	*5.5	[3.5-5.0]	mEq/L	(EH)05/11/2017,18:41
	This specimen exhibits a large amount of hemolysis which may cause falsely increased results for: K+ LDH AST IRON TIBC AMMONIA PHOS CPK MG CREAT			
Chloride	*113	[97-109]	mEq/L	(EH)05/11/2017,18:41
CO2	*14	[22-30]	mEq/L	(EH)05/11/2017,18:41
Elect Bal	*36.5	[10.0-20.0]		(EH)05/11/2017,18:41
Glucose	*103	[65-99]	mg/dL	(EH)05/11/2017,18:41
BUN	9	[6-22]	mg/dL	(EH)05/11/2017,18:41
Creatinine	*1.75	[0.6-1.3]	mg/dL	(EH)05/11/2017,18:41
Calcium	9.7	[8.5-10.5]	mg/dL	(EH)05/11/2017,18:41
Total Protein	6.3	[6.0-8.0]	g/dL	(EH)05/11/2017,18:41
Albumin	3.2	[3.0-5.0]	g/dL	(EH)05/11/2017,18:41
Globulin	3.1	[2.3-3.5]	g/dL	(EH)05/11/2017,18:41
Bilirubin,Total	0.50	[0.20-1.00]	mg/dL	(EH)05/11/2017,18:41
Alkaline Phos	87	[45-117]	Units/L	(EH)05/11/2017,18:41
AST(SGOT)	*175	[10-41]	Units/L	(EH)05/11/2017,18:41
	This specimen exhibits a large amount of hemolysis which may cause falsely increased results for: K+ LDH AST IRON TIBC AMMONIA PHOS CPK MG CREAT			
ALT(SGPT)	*259	[15-62]	Units/L	(EH)05/11/2017,18:41
Glomerular Filt Rate	*44	[>60]	mL/min/1.73m2	(EH)05/11/2017,18:41
GFR Message	NOTE: As reported, the GFR result is for a non-African American patient. Values for an African-American patient can be obtained by multiplying this result by 1.21. a non-African American patient. Values for an African-American patient can be obtained by multiplying this result by 1.21.			(EH)05/11/2017,18:41
Ethanol	<3.0	[<3.0]	mg/dL	(EH)05/11/2017,18:41
	This assay is for medical use only. Serum concentrations greater than 400 mg/dL can be fatal.			
Magnesium	*2.9	[1.6-2.6]	mg/dL	(EH)05/11/2017,18:41
Troponin-I				

CONTINUED

OUTPATIENT DISCHARGE CUMULATIV

Report date/time

H38455 COLL: 05/11/2017 17:55 REC: 05/11/2017 18:09 PHYS: KURTZ,BRYAN E

Troponin-I (CONTINUED)				
Troponin-I	*0.245	[0.000-0.090]	ng/mL	[EH]05/11/2017,18:41
Troponin Interp	Troponin-I Reference Range:			[EH]05/11/2017,18:41
	[0.00-0.09] - Normal			
	[0.10-0.60] - Possible indication of myocardial damage, unstable angina, congestive heart failure, myocarditis, cardiac surgery or invasive testing. Clinical correlation is required.			
	[> 0.60] - May indicate significant myocardial injury. Clinical correlation is required.			
	[0.00-0.09] - Normal			
	[0.10-0.60] - Possible indication of myocardial damage, unstable angina, congestive heart failure, myocarditis, cardiac surgery or invasive testing. Clinical correlation is required.			
	[> 0.60] - May indicate significant myocardial injury. Clinical correlation is required.			
CBC				
WBC	8.5	[3.9-10.6]	thous/mcL	[EH]05/11/2017,19:03
RBC	*3.46	[4.7-6.1]	mil1/mcL	[EH]05/11/2017,19:03
Hemoglobin	*10.5	[13.5-17.0]	g/dL	[EH]05/11/2017,19:03
Hematocrit	*34.1	[41.0-53.0]	%	[EH]05/11/2017,19:03
MCV	*98.5	[80.0-95.0]	fL	[EH]05/11/2017,19:03
MCH	30.2	[26.0-34.0]	pg	[EH]05/11/2017,19:03
MCHC	*30.7	[31.0-37.0]	g/dL	[EH]05/11/2017,19:03
PLT	*71	[130-400]	thous/mcL	[EH]05/11/2017,19:03
RDW	13.6	[11.5-14.5]	%	[EH]05/11/2017,19:03
MPV	*8.4	[9.0-13.0]	fl	[EH]05/11/2017,19:03
Differential				
NEUT	TNP	[45.0-80.0]	%	[EH]05/11/2017,20:45
NEUTROPHIL	*21	[50-75]	%	[EH]05/11/2017,20:45
LYMPHOCYTE	*63	[15-40]	%	[EH]05/11/2017,20:45
MONOCYTE	7	[0-10]	%	[EH]05/11/2017,20:45
EOSINOPHIL	2	[0-3]	%	[EH]05/11/2017,20:45
BAND NEUTROPHIL	5	[0-6]	%	[EH]05/11/2017,20:45
METAMYELOCYTE	*1	[0]	%	[EH]05/11/2017,20:45
ATYPICAL LYMPHS	*1	[0]	%	[EH]05/11/2017,20:45
RBC MORPHOLOGY	ANISOCYTES 1+ HYPOCHROMIA 1+			[EH]05/11/2017,20:45
PLATELET EVALUATION	DECREASED			[EH]05/11/2017,20:45
DIFF TYPE	Manual Differential Performed			[EH]05/11/2017,20:45
Protime				
PROTIME	*21.9	[10.2-11.9]	seconds	[EH]05/11/2017,18:58
INR	*2.1	[0.9-1.2]	RATIO	[EH]05/11/2017,18:58

CONTINUED

OUTPATIENT DISCHARGE CUMULATIV

Report date/time

H38455 COLL: 05/11/2017 17:55 REC: 05/11/2017 18:09 PHYS: KURTZ,BRYAN E

Protime (CONTINUED)
INR INTERP — The following are recommended therapeutic ranges in INR values based on condition: — {EH}05/11/2017,18:58

CONDITIONS	INR RANGE	TARGET INR
Primary and secondary prevention of venous thrombosis:	2 - 3	2.5
Prevention of recurrent venous thrombosis (2 or more episodes):	2.5-4.0	3.0
Prevention of arterial thrombo-embolism:	3.0-4.5	3.5

H38459 COLL: 05/11/2017 17:55 REC: 05/11/2017 18:10 PHYS: KURTZ,BRYAN E

Salicylate 3.5 [0.5-20.0] mg/dL {EH}05/11/2017,18:48

H38458 COLL: 05/11/2017 17:56 REC: 05/11/2017 18:09 PHYS: KURTZ,BRYAN E

Lactic Acid, Plasma — DELETED
Specimen Hemolyzed

H38460 COLL: 05/11/2017 17:56 REC: 05/17/2017 04:31 PHYS: KURTZ,BRYAN E

Urinalysis — DELETED
No specimen received, test cancelled

Urine Microscopic — DELETED
No specimen received, test cancelled

H38461 COLL: 05/11/2017 17:56 REC: 05/14/2017 14:22 PHYS: KURTZ,BRYAN E

Urine Culture — DELETED
Specimen not received in Lab

H38456 COLL: 05/11/2017 17:57 REC: 05/15/2017 04:31 PHYS: KURTZ,BRYAN E

ER Drug Screen — DELETED
No specimen received, test cancelled

H38463 COLL: 05/11/2017 18:22 REC: 05/11/2017 18:56 PHYS: KURTZ,BRYAN E

Blood Culture
SETUP: 05/11/2017 1914
Specimen Description — Right FEMORAL {EH}05/11/2017,18:57

CONTINUED

OUTPATIENT DISCHARGE CUMULATIV

H38463 COLL: 05/11/2017 18:22 REC: 05/11/2017 18:56 PHYS: KURTZ,BRYAN E

Blood Culture (CONTINUED)				
Special Requests	2 Bottles			{EH}05/11/2017,17:58
Culture Result	No growth after 6 days			{EH}05/17/2017,07:13
Report Status	FINAL 05/17/2017			{EH}05/17/2017,07:13

H38462 COLL: 05/11/2017 18:57 REC: 05/11/2017 19:08 PHYS: KURTZ,BRYAN E

Blood Culture				
SETUP: 05/11/2017 1914				
Specimen Description	Right HAND			{EH}05/11/2017,19:09
Special Requests	2 Bottles			{EH}05/11/2017,17:58
Culture Result	No growth after 6 days			{EH}05/17/2017,07:13
Report Status	FINAL 05/17/2017			{EH}05/17/2017,07:13

H38563 COLL: 05/11/2017 19:11 REC: 05/11/2017 19:18 PHYS: KURTZ,BRYAN E

Lactic Acid, Plasma	*27.7	(0.4-2.0)	mmol/L	{EH}05/11/2017,20:02
	CALLED TO AND READ BACK BY DEBBIE H ER 2002			

H38573 COLL: 05/11/2017 19:18 REC: 05/11/2017 19:21 PHYS: KURTZ,BRYAN E

Blood Gas				
SOURCE	Venous			{EH}05/11/2017,19:18
pH	*6.699	[7.350-7.450]		{EH}05/11/2017,19:26
	CALLED TO AND READ BACK BY DEBBIE H. EDD1 1925			
pCO2	*48.5	[35.0-45.0]	mmHg	{EH}05/11/2017,19:26
pO2	98.5	(80-100)	mmHg	{EH}05/11/2017,19:26
HCO3	*5.9	(22-26)	mmol/L	{EH}05/11/2017,19:26
BASE DEFICIT	*29.5	(0-3)	mmol/L	{EH}05/11/2017,19:26
% HbO2 SAT	*86.7	[90-100]	%	{EH}05/11/2017,19:26
O2 CONTENT (TOTAL)	*11.9	[15.0-23.0]	mL/dL	{EH}05/11/2017,19:26
O2 SATURATION	*87.4	(90-100)	%	{EH}05/11/2017,19:26

Venous Blood Gas Reference Range:

pH	[7.31-7.41]
pCO2	[44-48 mmHg]
pO2	[30-40 mmHg]
HCO3	[22-27 mmHg]
O2Sat	[40-85%]

TEMP	98	{EH}05/11/2017,19:18
O2 DEVICE	bagged	{EH}05/11/2017,19:18

H38580 COLL: 05/11/2017 19:30 REC: 05/15/2017 04:31 PHYS: KURTZ,BRYAN E

Misc Ref Test	DELETED	
	No specimen received, test cancelled	

CONTINUED

ELLIS HOSPITAL LABORATORY
1101 Nott Street, Schenectady, NY 12308 * 518-243-4055

PATIENT NAME: KEARSE,ANDREW
[redacted]
LOCATION: EDD1 39A-1

Report date/time

H38585 COLL: 05/11/2017 19:43 REC: 05/11/2017 19:47 PHYS: KURTZ,BRYAN E

Blood Gas

SOURCE	Arterial			{EH}05/11/2017,19:47
	CORRECTED ON 05/11 AT 1947: PREVIOUSLY REPORTED AS Venous			
pH	*6.892	{7.350-7.450}		{EH}05/11/2017,19:51
	CALLED TO AND READ BACK BY			
	DEBBIE H. EDD1 1950			
pCO2	*107.0	[35.0-45.0]	mmHg	{EH}05/11/2017,19:51
pO2	*64.7	[80-100]	mmHg	{EH}05/11/2017,19:51
HCO3	*20.2	[22-26]	mmol/L	{EH}05/11/2017,19:51
BASE DEFICIT	*12.8	[0-3]	mmol/L	{EH}05/11/2017,19:51
% HbO2 SAT	*70.4	[90-100]	%	{EH}05/11/2017,19:51
O2 CONTENT (TOTAL)	*8.6	[15.0-23.0]	mL/dL	{EH}05/11/2017,19:51
O2 SATURATION	*71.3	[90-100]	%	{EH}05/11/2017,19:51
TEMP	98			{EH}05/11/2017,19:43
O2 DEVICE	bagged			{EH}05/11/2017,19:43

H38599 COLL: 05/11/2017 23:06 REC: 05/12/2017 03:01
Req# : CAS1X-198636

Lactic Acid, Plasma DELETED
Cancelled by HIS

{EH} = Performed at Ellis Hospital Laboratory, 1101 Nott Street, Schenectady, NY 12308, Director: Dr. Bernard Ng

END OF REPORT

Ellis
MEDICINE

Ellis Hospital
1101 Nott Street
Schenectady, NY 12308
Phone #: (518) 243-4000

Name: Andrew Kearse
[redacted]
Sex: Male
Pt Status: ERPatients

[redacted]
Exam Date: 5/11/2017
[redacted]
Referrer: Bret Wood
Exam Name: PORTABLE CHEST XRAY | 71010

EXAMINATION: Single View Chest.

INDICATION (as provided on radiology requisition): TUBE PLACEMENT/ CARDIAC ARREST

COMPARISON: None

FINDINGS:
Endotracheal tube, distal tip positioned appropriately cephalad to the carina.
No consolidation.
No pneumothorax.
Cardiomediastinal silhouette is nondisplaced.

IMPRESSION:
No consolidation. Endotracheal tube, distal tip positioned appropriately cephalad to the carina.

This report was electronically signed by: Sara Raymond, MD 5/11/2017 6:33 PM

Kearse, Andrew [redacted] 11-May-2017 19:30:02 Ellis Hospital

[redacted]

Male

Room: 39
Loc: 71

Vent. rate 129 bpm
PR interval * ms
QRS duration 162 ms
QT/QTc 336/492 ms
P-R-T axes * 38 236

*** Poor data quality, interpretation may be adversely affected
Undetermined rhythm
Left bundle branch block
Abnormal ECG

Kearse, Andrew M 36Y
[redacted] 39-A-1 [redacted]
[redacted]
ATND: Doctor, Emergency,

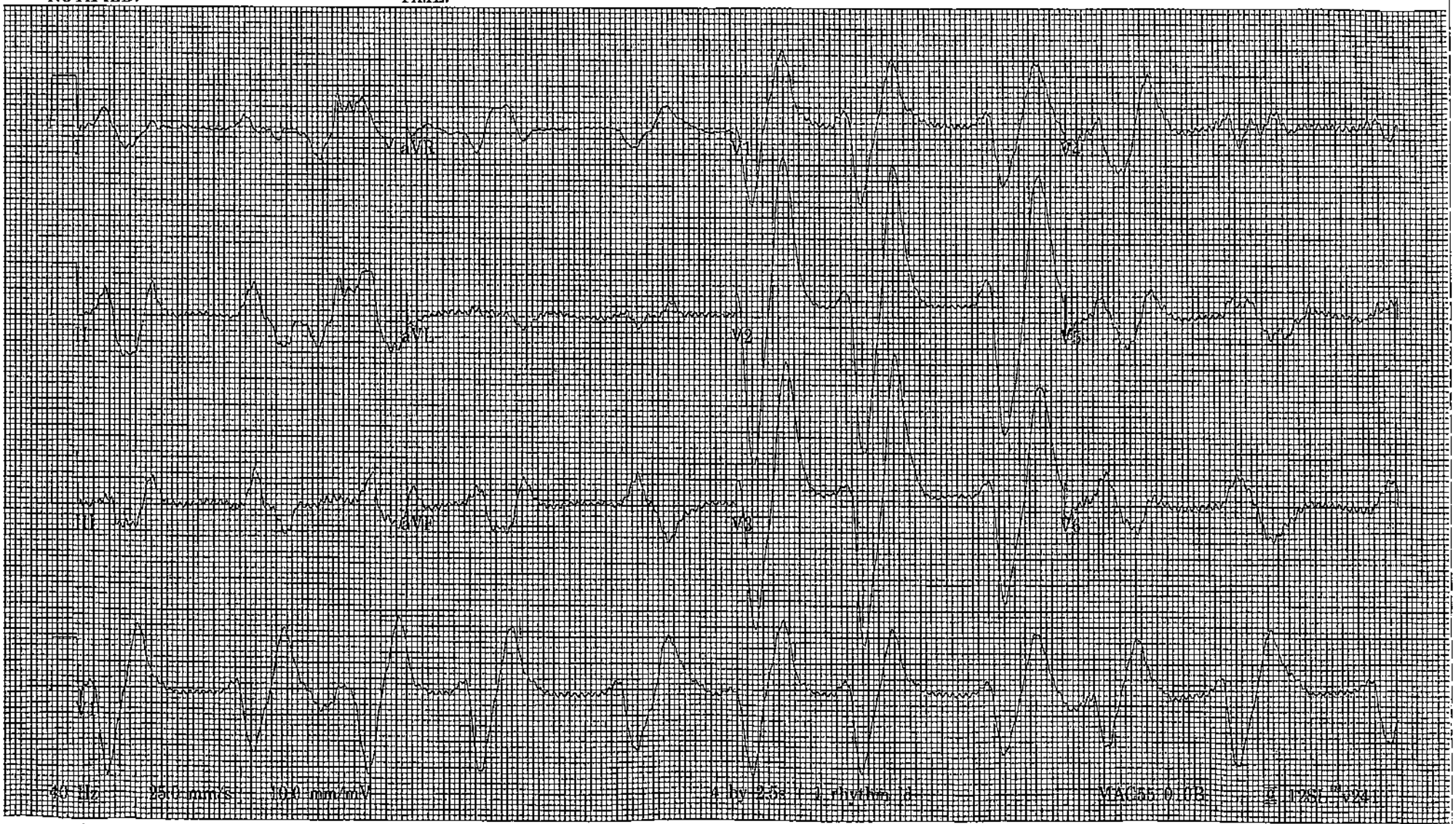
[redacted] Technician: HYNESL

BK 5/11/17

Secondary ID: 1020137

Order no.: 65461673
Unconfirmed

NOTIFIED: TIME:



COVIDIEN Kendall

Printed in USA.

KEARSE, ANDREW [redacted] 11-May-2017 17:41:44 Ellis Hospital

[redacted]

Room: 39
Loc: 72

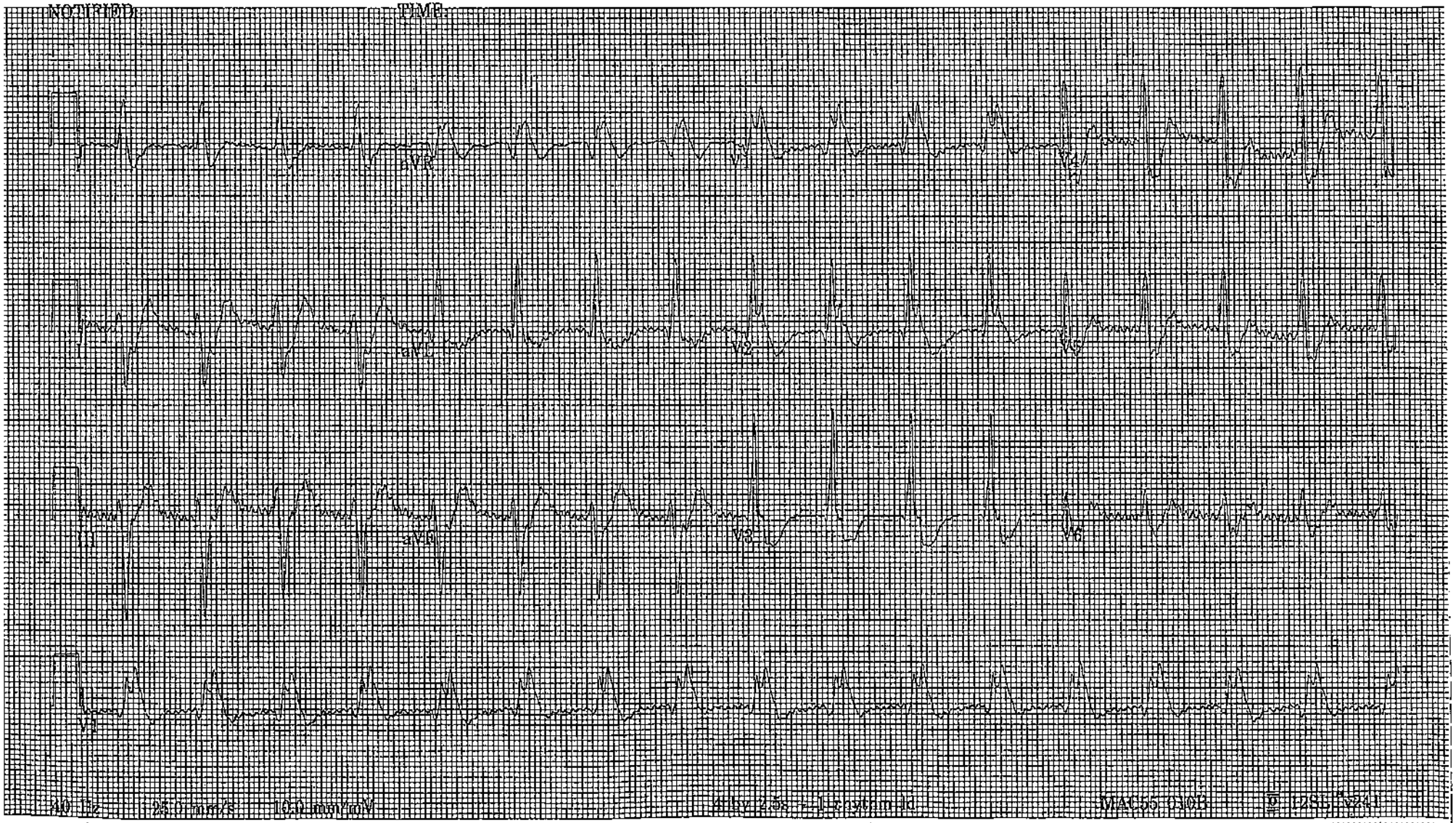
[redacted] Technician: MOSSOM

Vent. rate	100 bpm
PR interval	* ms
QRS duration	178 ms
QT/QTc	378/487 ms
P-R-T axes	* -65 81

Wide QRS rhythm
Right bundle branch block
Left anterior fascicular block
*** Bifascicular block ***
Left ventricular hypertrophy with repolarization abnormality
Cannot rule out Septal infarct, age undetermined
Abnormal ECG

AZVR
BF
6/11/17

Unconfirmed



COVIDIEN Kendall

Printed in USA.

'se, Andrew [redacted] 11-MAY-2017 17:41:44 [redacted] Ellis Hospital-EDD2 ROUTINE RECORD

[redacted](36 yr)
: Unknown

m:39
72

Vent. rate	100	BPM
PR interval	*	ms
QRS duration	178	ms
QT/QTc	378/487	ms
P-R-T axes	* -65	81

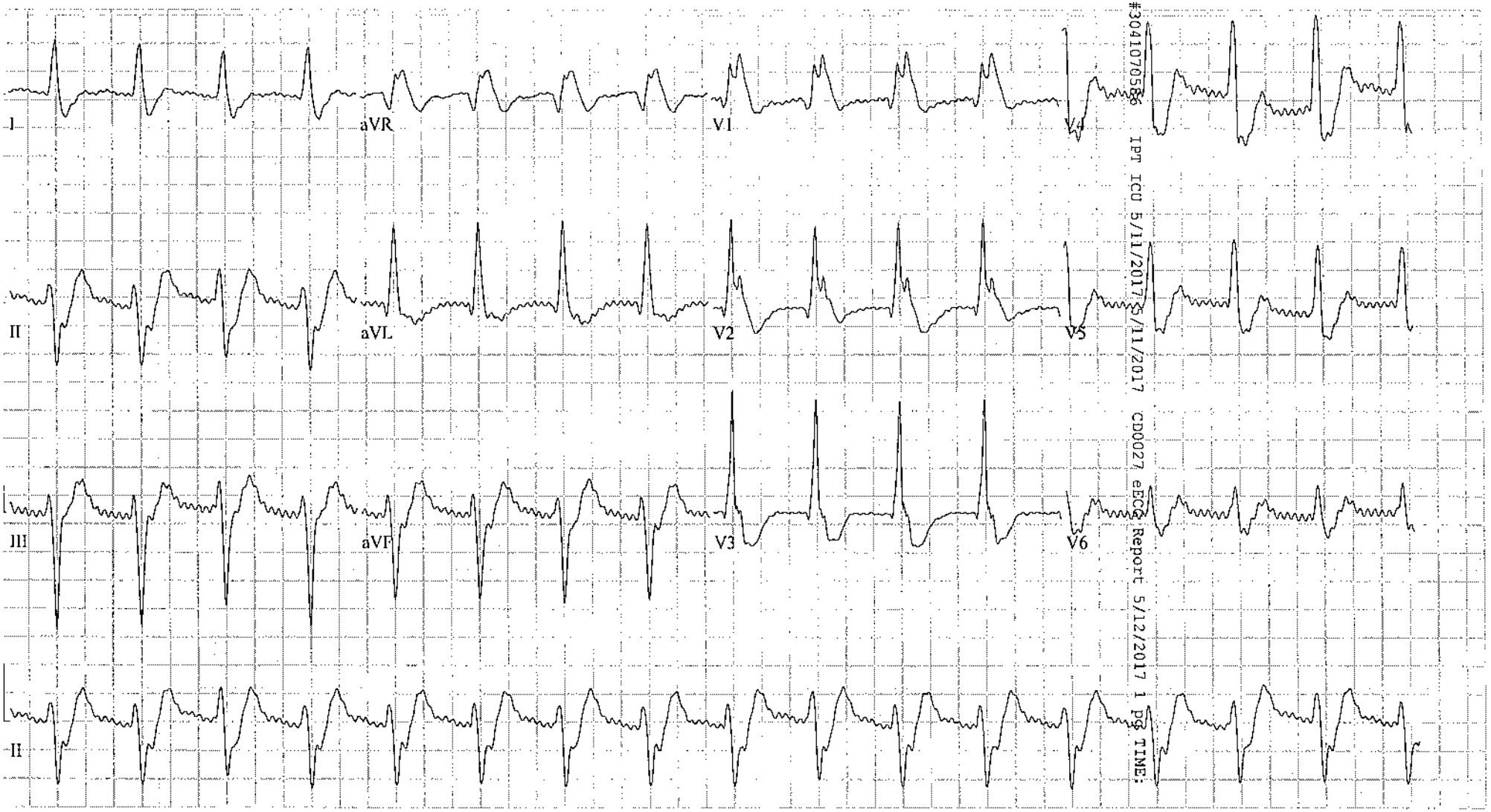
Wide QRS rhythm
Right bundle branch block
Left anterior fascicular block
Bifascicular block
Left ventricular hypertrophy with repolarization abnormality
Cannot rule out Septal infarct , age undetermined
Abnormal ECG
No previous ECGs available
Confirmed by Manor MD, Denis (109) on 5/12/2017 11:36:17 A

Technician: MOSSOM
Test ind:Difficulty Breathing

Referred by:

Confirmed By: Denis Manor MD

'IFIED: TIME:



Ellis KEARSE, ANDREW ECG #3041070586 IPT ICU 5/11/2017 5/11/2017 CD0027 eECG Report 5/12/2017 1 pg TIME:

m/s 10mm/mV 40Hz 8.0 SP2 12SL 241 CID: 5

SID: 1020137 EID:109 EDT: 11:36 12-MAY-2017 ORDER: 65479873 ACCOUNT: 3041070586 VISIT: 3041070586

rse, Andrew [redacted] 11-MAY-2017 19:30:02 [redacted] Ellis Hospital-EDD1 ROUTINE RECORD

[redacted] (36 yr)
e Unknown

m:39
:71

Vent. rate	129	BPM
PR interval	*	ms
QRS duration	162	ms
QT/QTc	336/492	ms
P-R-T axes	* 38	236

*** Poor data quality, interpretation may be adversely affected *
Undetermined rhythm
Abnormal ECG
When compared with ECG of 11-MAY-2017 17:41, (unconfirm
Please repeat EKG.
Confirmed by Manor MD, Denis (109) on 5/12/2017 7:47:33 AM

Technician: HYNESL
Test ind:CARDIAC ARREST

Referred by:

Confirmed By Denis Manor MD

TIFIED:

TIME:

Ellis KEARSE, ANDREW ECG #3041070586 IPT ICU 5/11/2017 5/11/2017 CD0027 eECG Report 5/12/2017 1 PM TIME:

m/s 10mm/mV 40Hz 8.0 SP2 12SL 241 CID: 5

SID: 1020137 EID:109 EDT: 07:47 12-MAY-2017 ORDER: 65461673 ACCOUNT: 3041070586 VISIT: 3041070586

Ventilator Flow Sheet

	Vent Type	Servo I						Pressure EZ		☐ yes	☐ no	Vent Day #							
	Serial #	32841						Anchorfast ETT holder		☐ yes	☐ no	Last Circuit Δ							
	OVP date/time:							Capped/clean Ambu at bedside		○ yes	☐ no	Next Circuit Δ							
	Date	3/11																	
	Time	1750																	
	HOB degrees																		
SETTINGS	Mode	PRVC																	
	Vt or PAP	500																	
	RR	15																	
	Pressure Support	7																	
	PEEP	5																	
	FiO2	100																	
	Insp Time/Peak Flow	0.8																	
	Rise Time	0.5																	
	Sensitivity - Trigger	2																	
	Insp Cycle Off																		
MEASURED	PIP	31																	
	Pplat																		
	PIP-Pplat																		
	Total RR	16																	
	I:E Ratio																		
	Total Minute Volume	8.1																	
	returned Vt	507																	
	spontaneous Vt																		
	SpO2	98/0																	
	auto-PEEP																		
	Cuff Pressure	WNL																	
	VC / NIF																		
	P/F Ratio																		
ALARMS	H / L Pressure Limit	50																	
	L / H Minute Vol	4/20																	
	L / H Resp Rate	5/35																	
	L / H PEEP/CPAP	2/8																	
	Tapnea																		
ABGS	pH																		
	PCO2																		
	PO2																		
	HCO3																		
	O2 sat																		
	Time of ABG:																		
	Initials	SB																	

Kearse, Andrew M 36Y
39-A-1
[redacted]
ATND: Doctor, Emergency,

Ventilator Flow Sheet

				Breath Sounds:						
ETT size:	mm			Lobe	Clear	Absent	Diminished	Fine Crackles	Course Crackles	Wheeze
ETT position:	cm @									
ETT location:	□left	□center	□right	LUL	□	□	□	□	□	□
CASS/ETT patent?	□yes □no Vacuum @			LLL	□	□	□	□	□	□
Trach Tube	Type:	Size:		RUL	□	□	□	□	□	□
Suction Frequency	□ 1 x Shift	□ 2-6/shift	□ hourly	RML	□	□	□	□	□	□
Suctioned Amount	□ minimal	□ moderate	□ large	RLL	□	□	□	□	□	□
Sputum Viscosity / Color:										

Bronchodilator Response: □N/A □none □↓wheezing □↑expiratory flow, improved F/V loop □↓ auto-peep

Assessments:	Yes	No	Changes Implemented:	Yes	No
Evidence of atelectasis, infiltrates, ARDS Or Pneumonia on Chest X-Ray or CT?	□	□	ARDSnet protocol initiated	□	□
Are secretions thick, bloody, copious or are mucous plugs present or pt. requires lavage?	□	□	Airway Clearance Protocol initiated	□	□
Humidity Source? □HH □HME, number of days?_____			Patient switched to heated humidity	□	□

SBT Readiness Trial Assessment:	Pass	Fail
PaO2/FiO2 ≥ 200 on 5 cm H2O PEEP or less?	□	□
Respiratory Rate < 35?	□	□
Presence of inspiratory effort?	□	□
No R/O of MI w/l last 24 hrs or on ACS pathway?	□	□
No infusions of vasopresser agents or paralytics?	□	□
No med/surg procedures scheduled for today?	□	□
Other considerations?	□	□
	□Pass	□Fail

Progress Note:

Print Name _____ Signature / Credentials _____ Date _____ Time _____

Kearse, Andrew M 36Y
39-A-1
[redacted]
ATND: Doctor, Emergency,

Ventilator Flow Sheet

□ SBT withheld per MD order □ SBT withheld per RN □ SBT withheld per RT

	Spontaneous Breathing Trial # 1					Spontaneous Breathing Trial # 2			
Settings:									
Time					Time				
FiO2					FiO2				
CPAP					CPAP				
PSV					PSV				
	1st Five Minutes		6 – 30 minutes			1st Five Minutes		6 – 30 minutes	
Baseline Vitals:	Start	Stop	End			Start	Stop	End	
Respiratory Rate (f)									
Vt									
Heart Rate									
Systolic B/P									
SpO2									
Assessment: (If yes, stop trial)	Yes	No	Yes	No		Yes	No	Yes	No
RR ~ 35 and sustained									
SpO2 <90%									
Change in Pulse >20% - baseline									
Systolic B/P >150 or <90 mmmHg									
Patient Diaphoretic									
Increased anxiety									
New Dysrythmias or new EKG changes									
Onset of Chest Pain									
Evaluation:	Outcome:		Outcome			Outcome		Outcome	
SBT Duration	1 2 3 4 Fail □	5 Pass □	10 15 20 25	30		1 2 3 4 Fail □	5 Pass □	10 15 20 25	30
	30-minute RSBI (f/Vt):					30-minute RSBI (f/Vt):			

Elevate HOB ≥ 30° unless contraindicated. Place patient on CPAP x 5 min, at 5cm H2O and current FiO2 w/ PSV of 5cm H2O. Evaluate pt. at 5 minutes and SBT for up to 30 minutes if appropriate. Upon conclusion, calculate and record RSBI. Return to previous vent settings if pt. fails SBT. If pt. passes SBT and RSBI is < 100, contact MD for weaning orders.

ETT size:	mm		
ETT position:	cm @		
ETT location:	□left	□center	□right
CASS/ETT patent?	□yes □no Vacuum @		
Trach Tube	Type:	Size:	
Suction Frequency	□ 1 x Shift	□ 2-6/shift	□ hourly
Suctioned Amount	□ minimal	□ moderate	□ large
Sputum Viscosity / Color:			

Breath Sounds: Lobe	Clear	Absent	Diminished	Fine Crackles	Course Crackles	Wheeze
LUL	□	□	□	□	□	□
LLL	□	□	□	□	□	□
RUL	□	□	□	□	□	□
RML	□	□	□	□	□	□
RLL	□	□	□	□	□	□

Bronchodilator Response: □N/A □none □↓wheezing □↑expiratory flow, improved F/V loop □↓ auto-peep

Cough Strength: □none □weak □moderate □strong Able to lift head off pillow? □yes □no

Plan of Care:		
□ Maintain current settings, no changes	□ Terminal extubation (notify CDT first)	□ Incentive Spirometer
□ Titrate FiO2 to maintain SpO2 of:	□ Extubate to BIPaP, ____ over ____ at ____ %	□ Goal ____
□ Titrate PSV to maintain Vt of:	□ Extubate to heated high-flow at ____ % and ____ lpm	□ Reviewed with RN
	□ Extubate to Aerosol mask at ____ %	□ Discussed in Rounds

□ Decrease IMV by _____ breaths each _____ hour until IMV reaches _____

Progress Note:

Print Name   Signature / Credentials   Date   Time

Ellis Hospital – Schenectady, NY

Ventilator Flowsheet
Form # E3055 (3/08, 8/11, 11/14, 1/16)   Page 3 of 4

RT0000

Kearse, Andrew   M 36Y
39-A-1
[redacted]
ATND: Doctor, Emergency,

Ventilator Flow Sheet

				Breath Sounds:				Fine	Course	
ETT size:	mm			Lobe	Clear	Absent	Diminished	Crackles	Crackles	Wheeze
ETT position:	cm @									
ETT location:	□left	□center	□right	LUL	□	□	□	□	□	□
CASS/ETT patent?	□yes □no Vacuum @			LLL	□	□	□	□	□	□
Trach Tube	Type:	Size:		RUL	□	□	□	□	□	□
Suction Frequency	□ 1 x Shift	□ 2-6/shift	□ hourly	RML	□	□	□	□	□	□
Suctioned Amount	□ minimal	□ moderate	□ large	RLL	□	□	□	□	□	□
Sputum Viscosity / Color:										

Bronchodilator Response:	□N/A	□none	□↓wheezing	□↑expiratory flow, improved F/V loop	□↓ auto-peep

Assessments:				
Last 48 hours compliance trend:	□N/A	□more compliant	□no change	□less compliant
VAE thresholds exceeded?	□N/A	□yes	□no	
High-touch surfaces cleaned?	□yes	□no		

Progress Note:

Pt. presented to ED in cardiac arrest c size 8.0 ETT secured @ 20cm @ l.p. BLSS present + clear, equal. Pt. manually resuscitated c 100% FiO_2 under duty during compressions until ROSC achieved. Placed pt. on MAV per MD ordered settings. Pt will continue to monitor & treat

Timothy Barnes RRT Timothy Barnes RRT 5/11/17 1953

Print Name Signature / Credentials Date Time

Signature	Initials

Signature	Initials

Kearse, Andrew
[redacted] M 36Y
ATND: Doctor, Emergency.

Ventilator Flow Sheet

Ventilator Flow Sheet

Vent Type	Serv-i	Pressure EZ	☐ yes	☐ no	Vent Day #
Serial #	37841	Anchorfast ETT holder	☐ yes	☐ no	Last Circuit Δ
OVP date/time:		Capped/clean Ambu at bedside	☐ yes	☐ no	Next Circuit Δ

	Date	5/11											
	Time	1750											
	HOB degrees	—											
SETTINGS	Mode	PRVC											
	Vt or PAP	500											
	RR	15											
	Pressure Support	—											
	PEEP	5											
	FiO2	100%											
	Insp Time/Peak Flow	0.8											
	Rise Time	0.15											
	Sensitivity - Trigger	2F											
	Insp Cycle Off	—											
MEASURED	PIP	31											
	Pplat	—											
	PIP-Pplat	—											
	Total RR	16											
	I:E Ratio	—											
	Total Minute Volume	8.1											
	returned Vt	507											
	spontaneous Vt	—											
	SpO2	100											
	auto-PEEP	—											
	Cuff Pressure	MV											
	VC / NIF	—											
	P/F Ratio	—											
ALARMS	H / L Pressure Limit	50											
	L / H Minute Vol	4/20											
	L / H Resp Rate	5/35											
	L / H PEEP/CPAP	2/8											
	Tapnea	—											
ABGS	pH	↓											
	PCO2												
	PO2												
	HCO3												
	O2 sat												
	Time of ABG:												
	Initials	[illegible]											

Ellis Hospital – Schenectady, NY

Ventilator Flowsheet
Form # E3055 (3/08, 6/11, 11/14, 1/16)

RT0000

Kearse, Andrew
M 36Y
39-A-1
[redacted]
ATND: Doctor, Emergency,

Ventilator Flow Sheet

					Breath Sounds:						
ETT size:	mm				Lobe	Clear	Absent	Diminished	Fine Crackles	Course Crackles	Wheeze
ETT position:	cm @										
ETT location:	□left	□center	□right		LUL	□	□	□	□	□	□
CASS/ETT patent?	□yes □no Vacuum @				LLL	□	□	□	□	□	□
Trach Tube	Type:	Size:			RUL	□	□	□	□	□	□
Suction Frequency	□ 1 x Shift	□ 2-6/shift	□ hourly		RML	□	□	□	□	□	□
Suctioned Amount	□ minimal	□ moderate	□ large		RLL	□	□	□	□	□	□
Sputum Viscosity / Color:											

Bronchodilator Response: □N/A □none □↓wheezing □↑expiratory flow, improved F/V loop □↓ auto-peep

Assessments:	Yes	No	Changes Implemented:	Yes	No
Evidence of atelectasis, infiltrates, ARDS Or Pneumonia on Chest X-Ray or CT?	□	□	ARDSnet protocol initiated	□	□
Are secretions thick, bloody, copious or are mucous plugs present or pt. requires lavage?	□	□	Airway Clearance Protocol initiated	□	□
Humidity Source? □HH □HME, number of days?_____			Patient switched to heated humidity	□	□

SBT Readiness Trial Assessment:	Pass	Fail
PaO2/FiO2 ≥ 200 on 5 cm H2O PEEP or less?	□	□
Respiratory Rate < 35?	□	□
Presence of inspiratory effort?	□	□
No R/O of MI w/I last 24 hrs or on ACS pathway?	□	□
No infusions of vasopresser agents or paralytics?	□	□
No med/surg procedures scheduled for today?	□	□
Other considerations?	□	□
	□Pass	□Fail

Progress Note:

Print Name _____ Signature / Credentials _____ Date _____ Time _____

Kearse, Andrew
M 36Y
[redacted]

Ventilator Flow Sheet

☐ SBT withheld per MD order ☐ SBT withheld per RN ☐ SBT withheld per RT

	Spontaneous Breathing Trial # 1				Spontaneous Breathing Trial # 2			
Settings: Time								
FiO2								
CPAP								
PSV								
	1st Five Minutes		6 – 30 minutes		1st Five Minutes		6 – 30 minutes	
Baseline Vitals:	Start	Stop	End		Start	Stop	End	
Respiratory Rate (f)								
Vt								
Heart Rate								
Systolic B/P								
SpO2								
Assessment: (If yes, stop trial)	Yes	No	Yes	No	Yes	No	Yes	No
RR – 35 and sustained								
SpO2 <90%								
Change in Pulse >20% + baseline								
Systolic B/P >150 or <90 mmHg								
Patient Diaphoretic								
Increased anxiety								
New Dysrythmias or new EKG changes								
Onset of Chest Pain								
Evaluation:	Outcome		Outcome		Outcome		Outcome	
SBT Duration	1 2 3 4	5	10 15 20 25	30	1 2 3 4	5	10 15 20 25	30
	Fail ☐	Pass ☐			Fail ☐	Pass ☐		
30-minute RSBI (f/Vt):								

Elevate HOB ≥ 30° unless contraindicated. Place patient on CPAP x 5 min, at 5cm H2O and current FiO2 w/ PSV of 5cm H2O. Evaluate pt. at 5 minutes and SBT for up to 30 minutes if appropriate. Upon conclusion, calculate and record RSBI. Return to previous vent settings if pt fails SBT. If pt. passes SBT and RSBI is < 100, contact MD for weaning orders.

ETT size:	mm		
ETT position:	cm @		
ETT location:	☐left	☐center	☐right
CASS/ETT patent?	☐yes ☐no Vacuum @		
Trach Tube	Type:	Size:	
Suction Frequency	☐ 1 x Shift	☐ 2-G/shift	☐ hourly
Suctioned Amount	☐ minimal	☐ moderate	☐ large

Breath Sounds: Lobe	Clear	Absent	Diminished	Fine Crackles	Course Crackles	Wheeze
LUL	☐	☐	☐	☐	☐	☐
LLL	☐	☐	☐	☐	☐	☐
RUL	☐	☐	☐	☐	☐	☐
RML	☐	☐	☐	☐	☐	☐
RLL	☐	☐	☐	☐	☐	☐

Sputum Viscosity / Color:

Bronchodilator Response: ☐N/A ☐none ☐↓wheezing ☐↑expiratory flow, improved F/V loop ☐↓ auto-peep

Cough Strength: ☐none ☐weak ☐moderate ☐strong Able to lift head off pillow? ☐yes ☐no

Plan of Care:		
☐ Maintain current settings, no changes	☐ Terminal extubation (notify CDT first)	☐ Incentive Spirometer
☐ Titrate FiO2 to maintain SpO2 of:	☐ Extubate to BiPaP, ____ over ____ at ____%	☐ Goal _____
☐ Titrate PSV to maintain Vt of:	☐ Extubate to heated high-flow at ____% and ____lpm	☐ Reviewed with RN
☐ Decrease IMV by ____ breaths each ____ hour until IMV reaches ____	☐ Extubate to Aerosol mask at ____%	☐ Discussed in Rounds

Progress Note:

Print Name | Signature / Credentials | Date | Time

Ventilator Flow Sheet

ETT size:	mm			**Breath Sounds:**				Fine	Course	
ETT position:	cm @			Lobe	Clear	Absent	Diminished	Crackles	Crackles	Wheeze
ETT location:	□left	□center	□right	LUL	□	□	□	□	□	□
CASS/ETT patent?	□yes □no Vacuum @			LLL	□	□	□	□	□	□
Trach Tube	Type:	Size:		RUL	□	□	□	□	□	□
Suction Frequency	□ 1 x Shift	□ 2-6/shift	□ hourly	RML	□	□	□	□	□	□
Suctioned Amount	□ minimal	□ moderate	□ large	RLL	□	□	□	□	□	□
Sputum Viscosity / Color:										

Bronchodilator Response: □N/A □none □↓wheezing □↑expiratory flow, improved F/V loop □↓ auto-peep

Assessments:	
Last 48 hours compliance trend:	□N/A □more compliant □no change □less compliant
VAE thresholds exceeded?	□N/A □yes □no
High-touch surfaces cleaned?	□yes □no

Progress Note:

Pt. presented to ED in cardiac arrest ē size 8.0 ETT secured @ 26cm @ lip. BLBS present + clear, equal. Pt. manually resuscitated ē 100% F_iO_2 ambu bag during compressions. ROSC achieved. Placed pt. on MRV per MD ordered settings. RT will continue to monitor + treat

Timothy Bermer RRT, [signature] RRT 5/11/17 1952
Print Name Signature / Credentials Date Time

Signature	Initials

Signature	Initials

Kearse, Andrew
M 36Y
[redacted]

05/11/2017 21:22 DISCHARGE MEDICATION ADMINISTRATION RECORD

Ellis Hospital

PATIENT NO: [redacted]
MED REC NO:

NAME: KEARSE, ANDREW [redacted]
AGE: 36Y SEX: M
ATN DOCTOR: PARKES, ROBERT J

DSCH LOC: EDD1/39-A-1
DSCH DATE: 05/11/2017
ADMIT DATE: 05/11/2017

*** IVS CURRENT AT THE TIME OF DISCHARGE ***

*** SCHEDULED IVS ***

ORD# 1 UB: A
LVP LARGE VOLUME PARENTERAL
DEXTROSE 5%-WATER 250 ml
PHENYLEPHRINE HYDROCHLORIDE .25 MG
(NEO-SYNEPHRINE INJ SUBSTITUTE)
IV
RATE: ------ RUN-IN: ------
!!!!STAT TO ED 1!!!!!!
START: 05/11/17 18:08 STOP: 05/11/17 18:08
Nrs Verified By:
**** NO OCCURRENCES CHARTED ****

*** PRN IVS ***

ORD# 2 UB: A
LVP LARGE VOLUME PARENTERAL
DEXTROSE 5%-WATER 250 ml
PHENYLEPHRINE HYDROCHLORIDE 25 MG
(NEO-SYNEPHRINE INJ SUBSTITUTE)
IV CONTINUOUS CONTINUOUS
RATE: TITRATE RUN-IN: TITRAT
START AT 10 MCG/MIN
START AT 10 MCG/MIN. TITRATE
EVERY 5 MIN BY 1 MCG/MIN. MAX
30 MCG/MIN.GOAL SBP OF 90
START: 05/11/17 18:22 STOP:
Nrs Verified By:
**** NO OCCURRENCES CHARTED ****

DATE: 5/11/17 LOCATION: ED 39 WAS HOSPITAL-WIDE RESUSCITATION RESPONSE ACTIVATED? ☐ YES ☒ NO

TIME CODE CALLED: 1725 TIME TEAM RESPONDED: 1725 MONITORS PRESENT AT ONSET ☒ CARDIAC MONITOR ☒ PULSE OX

TYPE OF EVENT ☐ RESPIRATORY ☒ CARDIAC WITNESSED? ☐ YES ☒ NO WAS PATIENT CONSCIOUS AT ONSET? ☐ YES ☒ NO

PULSE PRESENT? ☐ YES ☒ NO ADVANCED DIRECTIVES PRESENT? ☐ YES ☒ NO

Page 1 of 2

AIRWAY/VENTILATION	CIRCULATION	OUTCOME
INITIAL: ☐ SPONTANEOUS ☐ APNEA ☐ AGONAL ☒ ASSISTED TYPE OF VENTILATION: ☐ MOUTH-MASK ☐ BVM ☒ ETT ☐ OTHER: ____ FIRST ASSISTED VENTILATION TIME: PTA ETT INTUBATION: TIME PTA SIZE 8 BY WHOM: EMS - Schdy Fire CONFIRMATION: ☒ AUSCULTATION, ☐ EID ☒ OTHER: Capnography BY WHOM: EMS - Schdy Fire ABG DONE? ☐ YES ☒ NO TIME: ____ TIME: ____	INITIAL RHYTHM: VFib TIME CHEST COMPRESSIONS STARTED: PTA RHYTHM: ____ DEFIBRILLATED?: ☒ YES ☐ NO TIME OF FIRST SHOCK: 1732 JOULES: 200 PACEMAKER ON? ☐ YES ☒ NO	TIME RESUSCITATION ENDED: 1840 STATUS: ☐ DEAD ☒ ALIVE REASONS FOR ENDING EFFORTS: ☐ VENTILATION RESTORED ☒ CIRCULATION RESTORED ☐ UNRESPONSIVE TO ALS ☐ ADVANCED DIRECTIVES ☐ FAMILY WISHES DISPOSITION: ____

TIME	BP	RESP RATE/ ((S)SPONTANEOUS /ASSISTED)	PULSE PRESENT (Y/N)	CARDIAC RHYTHM	DEFIB/CARDIOVERSION (JOULES)	AMIODARONE BOLUS (DOSE/ROUTE)	ATROPINE (DOSE/ROUTE)	EPINEPHRINE (DOSE/ROUTE)	SODIUM BICARBONATE (DOSE/ROUTE)	VASOPRESSIN (DOSE/ROUTE)	AMIODARONE INFUSION (DOSE/ml PER HOUR) STANDARD CONCENTRATION	SODIUM BICARBONATE INFUSION (DOSE/ml PER HOUR) STANDARD CONCENTRATION	DOPAMINE INFUSION (DOSE/ml PER HOUR) STANDARD CONCENTRATION	DOBUTAMINE INFUSION (DOSE/ml PER HOUR) STANDARD CONCENTRATION	HYDRATING IV (SPECIFY)	OTHERS (SPECIFY) Norcuron 2mg	COMMENTS
1730		12(A)	N					1									CPR in progress
1732		12A	N	Vfib	200					20 mg							
1734		12A	N	Vfib	200												
1736		12A	N					1									
1737		12A	N	pea													@ card-activity via ULS, ETT to 23 cm @ lip
1739		12A	N					1									CPR continued
1740	101/53	12A	N	SR					1	20 mg							@ pulses @ 1741
1745	106/43															1	
1751	76/54	12A	Y	SB			1										Post. chest xray @ 1753
																	Central Line @ groin by Dr Kurtz
1800	97/63	12A	Y-39				1										

RECORDERS SIGNATURE: Jaime Kearney

CODE CAPTAIN SIGNATURE: Bryan Kurtz

SIGNATURE: ____

Disclaimer – route is considered IVP unless otherwise indicated.

Ellis HOSPITAL | McClellan CAMPUS

600 McClellan Street, Schenectady, NY 12304

ND0290

ELLIS HOSPITAL CODE BLUE TREATMENT RECORD

Kearse, Andrew M 36Y 39-A-1

[redacted]

Form # SC768-60 (replaces SC474) Rev 06/08 *WHITE* - CHART *YELLOW* - NURSING OFFICE *PINK* - PHARMACY

DATE: 5/1/17 LOCATION: ED39 WAS HOSPITAL-WIDE RESUSCITATION RESPONSE ACTIVATED? ☐ YES ☐ NO
TIME CODE CALLED: ______ TIME TEAM RESPONDED: ______ MONITORS PRESENT AT ONSET ☐ CARDIAC MONITOR ☐ PULSE OX
TYPE OF EVENT ☐ RESPIRATORY ☐ CARDIAC WITNESSED? ☐ YES ☐ NO WAS PATIENT CONSCIOUS AT ONSET? ☐ YES ☐ NO
PULSE PRESENT? ☐ YES ☐ NO ADVANCED DIRECTIVES PRESENT? ☐ YES ☐ NO

AIRWAY/VENTILATION	CIRCULATION	OUTCOME
INITIAL: ☐ SPONTANEOUS ☐ APNEA ☐ AGONAL ☐ ASSISTED TYPE OF VENTILATION: ☐ MOUTH-MASK ☐ BVM ☐ ETT ☐ OTHER: ______ FIRST ASSISTED VENTILATION TIME: ______ ETT INTUBATION: TIME ______ SIZE ______ BY WHOM: ______ CONFIRMATION: ☐ AUSCULATION ☐ EID ☐ OTHER: ______ BY WHOM: ______ ABG DONE? ☐ YES ☐ NO TIME: ______ TIME: ______	INITIAL RHYTHM: ______ TIME CHEST COMPRESSIONS STARTED: ______ RHYTHM: ______ DEFIBRILLATED?: ☐ YES ☐ NO TIME OF FIRST SHOCK: ______ JOULES: ______ PACEMAKER ON? ☐ YES ☐ NO	TIME RESUSCITATION ENDED: 1840 STATUS: ☐ DEAD ☒ ALIVE REASONS FOR ENDING EFFORTS: ☐ VENTILATION RESTORED ☐ CIRCULATION RESTORED ☐ UNRESPONSIVE TO ALS ☐ ADVANCED DIRECTIVES ☐ FAMILY WISHES DISPOSITION: ______

TIME	BP	RESP RATE/ (S)SPONTANEOUS/ASSISTED)	PULSE PRESENT (Y/N)	CARDIAC RHYTHM	DEFIB/CARDIOVERSION (JOULES)	AMIODARONE BOLUS (DOSE/ROUTE)	ATROPINE (DOSE/ROUTE)	EPINEPHRINE (DOSE/ROUTE)	SODIUM BICARBONATE (DOSE/ROUTE)	VASOPRESSIN (DOSE/ROUTE)	AMIODARONE INFUSION (DOSE/ml PER HOUR) STANDARD CONCENTRATION	SODIUM BICARBONATE INFUSION (DOSE/ml PER HOUR) STANDARD CONCENTRATION	DOPAMINE INFUSION (DOSE/ml PER HOUR) STANDARD CONCENTRATION	DOBUTAMINE INFUSION (DOSE/ml PER HOUR) STANDARD CONCENTRATION	HYDRATING IV (SPECIFY)	OTHERS (SPECIFY)	COMMENTS
1809	59/29	12A	Y-37	SB													norepinephrine 10mg @1815
1826	62/27	12A	Y-39	SB			1										
1830																	Pacer pads Rate 70, 150j for capture
1840		12A	Y														cardiac activity cont c̄ u/s.

RECORDERS SIGNATURE: [signature] CODE CAPTAIN SIGNATURE: [signature]

Disclaimer – route is considered IVP unless otherwise indicated.

SIGNATURE: ______

Ellis HOSPITAL | McClellan CAMPUS

600 McClellan Street, Schenectady, NY 12304

ND0290

ELLIS HOSPITAL CODE BLUE TREATMENT RECORD

Kearse, Andrew
M 36Y
39-A-1
[redacted]

Form # SC768-60 (replaces SC474) Rev 06/08 *WHITE* - CHART *YELLOW* - NURSING OFFICE *PINK* - PHARMACY

DATE: 5/11/17 LOCATION: ED3G WAS HOSPITAL-WIDE RESUSCITATION RESPONSE ACTIVATED? ☐ YES ☒ NO
TIME CODE CALLED: 1915 TIME TEAM RESPONDED: 1919 MONITORS PRESENT AT ONSET ☒ CARDIAC MONITOR ☒ PULSE OX
TYPE OF EVENT ☐ RESPIRATORY ☒ CARDIAC WITNESSED? ☒ YES ☐ NO WAS PATIENT CONSCIOUS AT ONSET? ☐ YES ☒ NO
PULSE PRESENT? ☐ YES ☒ NO ADVANCED DIRECTIVES PRESENT? ☐ YES ☒ NO

page 1 of 2

AIRWAY/VENTILATION	CIRCULATION	OUTCOME
INITIAL: ☐ SPONTANEOUS ☐ APNEA ☐ AGONAL ☒ ASSISTED TYPE OF VENTILATION: ☐ MOUTH-MASK ☐ BVM ☒ ETT ☐ OTHER: FIRST ASSISTED VENTILATION TIME: PTA ETT INTUBATION: TIME PTA SIZE 8 BY WHOM: EMS CONFIRMATION: ☒ AUSCULATION ☐ Checked via CO2 or Esophageal Detection Device. BY WHOM: EMS & RT on arrival ABG DONE? ☒ YES ☐ NO TIME: 1918 TIME: 1943	INITIAL RHYTHM: VFib TIME CHEST COMPRESSIONS STARTED: 1915 RHYTHM: SB DEFIBRILLATED?: ☐ YES ☐ NO TIME OF FIRST SHOCK: 1926 JOULES: 200 PACEMAKER ON? ☒ YES ☐ NO	TIME RESUSCITATION ENDED: 1947 STATUS: ☒ DEAD ☐ ALIVE REASONS FOR ENDING EFFORTS: ☐ VENTILATION RESTORED ☐ CIRCULATION RESTORED ☒ UNRESPONSIVE TO ALS ☐ ADVANCED DIRECTIVES ☐ FAMILY WISHES DISPOSITION:

TIME	BP	RESP RATE/ ((S)PONTANEOUS /ASSISTED)	PULSE PRESENT (Y/N)	CARDIAC RHYTHM	DEFIB/CARDIOVERSION (JOULES)	AMIODARONE BOLUS (DOSE/ROUTE)	ATROPINE (DOSE/ROUTE)	EPINEPHRINE (DOSE/ROUTE)	SODIUM BICARBONATE (DOSE/ROUTE)	VASOPRESSIN (DOSE/ROUTE)	AMIODARONE INFUSION (DOSE/CC PER HOUR) STANDARD CONCENTRATION	SODIUM BICARBONATE INFUSION (DOSE/CC PER HOUR) STANDARD CONCENTRATION	DOPAMINE INFUSION (DOSE/CC PER HOUR) STANDARD CONCENTRATION	DOBUTAMINE INFUSION (DOSE/CC PER HOUR) STANDARD CONCENTRATION	HYDRATING IV (SPECIFY)	OTHERS (SPECIFY)	COMMENTS
1916		12A	N	PEA				1									CPR progress
1918		12A	N					1									
1921		12A	N					1									
1923		12A	N														Calcium chloride Inj
1925		12A	N					1									
1926		12A	N	VT	200												
1928		12A	Y	SB					2								pH 6.699 + pulses
1932		12A	N					1									CPR resumed
1935		12A	N					1									
1937		12A	N						2								
1938		12A	N					1									

RECORDERS SIGNATURE: Teresa Kearney CODE CAPTAIN SIGNATURE: [signature]

SIGNATURE:

Ellis Hospital
1101 Nott Street
Schenectady, New York 12308

ND0290
FORM # 768-60 (2/12)

ELLIS HOSPITAL CODE BLUE
TREATMENT RECORD

WHITE - CHART *YELLOW* - NURSING OFFICE *PINK* - PHARMACY

Kearse, Andrew
M 36Y
39-A-1
[redacted]

DATE: 3/11/17 LOCATION: ED39 WAS HOSPITAL-WIDE RESUSCITATION RESPONSE ACTIVATED? ☐ YES ☒ NO
TIME CODE CALLED: 1917 TIME TEAM RESPONDED: 1917 MONITORS PRESENT AT ONSET ☒ CARDIAC MONITOR ☒ PULSE OX
TYPE OF EVENT ☐ RESPIRATORY ☒ CARDIAC WITNESSED? ☒ YES ☐ NO WAS PATIENT CONSCIOUS AT ONSET? ☐ YES ☒ NO
PULSE PRESENT? ☐ YES ☒ NO ADVANCED DIRECTIVES PRESENT? ☐ YES ☒ NO

page 2 of 2

AIRWAY/VENTILATION	CIRCULATION	OUTCOME
INITIAL: ☐ SPONTANEOUS ☐ APNEA ☐ AGONAL ☐ ASSISTED TYPE OF VENTILATION: ☐ MOUTH-MASK ☐ BVM ☐ ETT ☐ OTHER: _____ FIRST ASSISTED VENTILATION TIME: _____ ETT INTUBATION: TIME _____ SIZE _____ BY WHOM: _____ CONFIRMATION: ☐ AUSCULATION ☐ Checked via CO2 or Esophageal Detection Device. BY WHOM: _____ ABG DONE? ☐ YES ☐ NO TIME: _____ TIME: _____	INITIAL RHYTHM: _____ TIME CHEST COMPRESSIONS STARTED: _____ RHYTHM: _____ DEFIBRILLATED?: ☐ YES ☐ NO TIME OF FIRST SHOCK: _____ JOULES: _____ PACEMAKER ON? ☐ YES ☐ NO	TIME RESUSCITATION ENDED: _____ STATUS: ☐ DEAD ☐ ALIVE REASONS FOR ENDING EFFORTS: ☐ VENTILATION RESTORED ☐ CIRCULATION RESTORED ☐ UNRESPONSIVE TO ALS ☐ ADVANCED DIRECTIVES ☐ FAMILY WISHES DISPOSITION: _____

TIME	BP	RESP RATE/ (IS)SPONTANEOUS /ASSISTED)	PULSE PRESENT (Y/N)	CARDIAC RHYTHM	DEFIB/CARDIOVERSION (JOULES)	AMIODARONE BOLUS (DOSE/ROUTE)	ATROPINE (DOSE/ROUTE)	EPINEPHRINE (DOSE/ROUTE)	SODIUM BICARBONATE (DOSE/ROUTE)	VASOPRESSIN (DOSE/ROUTE)	AMIODARONE INFUSION (DOSE/CC PER HOUR) STANDARD CONCENTRATION	SODIUM BICARBONATE INFUSION (DOSE/CC PER HOUR) STANDARD CONCENTRATION	DOPAMINE INFUSION (DOSE/CC PER HOUR) STANDARD CONCENTRATION	DOBUTAMINE INFUSION (DOSE/CC PER HOUR) STANDARD CONCENTRATION	HYDRATING IV (SPECIFY)	OTHERS (SPECIFY)	COMMENTS
1941		12A	N					1									Swan ® given by Bill Phillips
1944		12A	N	PEA				1									
1947																	TOD- CPR ended

RECORDERS SIGNATURE: Laura Kearney CODE CAPTAIN SIGNATURE: [signature]

SIGNATURE: _____

Ellis Hospital
1101 Nott Street
Schenectady, New York 12308

ND0290
FORM # 758-60 (2/12)

ELLIS HOSPITAL CODE BLUE TREATMENT RECORD

WHITE - CHART *YELLOW* - NURSING OFFICE *PINK* - PHARMACY

Kearse, Andrew M 36Y
39-A-1
[redacted]

DATE: 5/11/17 LOCATION: ED39 WAS HOSPITAL-WIDE RESUSCITATION RESPONSE ACTIVATED? ☐ YES ☒ NO
TIME CODE CALLED: 1729 TIME TEAM RESPONDED: 1729 MONITORS PRESENT AT ONSET ☒ CARDIAC MONITOR ☒ PULSE OX
TYPE OF EVENT ☐ RESPIRATORY ☒ CARDIAC WITNESSED? ☐ YES ☒ NO WAS PATIENT CONSCIOUS AT ONSET? ☐ YES ☒ NO
PULSE PRESENT? ☐ YES ☒ NO ADVANCED DIRECTIVES PRESENT? ☐ YES ☒ NO

AIRWAY/VENTILATION

INITIAL: ☐ SPONTANEOUS ☐ APNEA ☐ AGONAL ☒ ASSISTED
TYPE OF VENTILATION: ☐ MOUTH-MASK ☐ BVM ☒ ETT ☐ OTHER:
FIRST ASSISTED VENTILATION TIME: PTA
ETT INTUBATION: TIME PTA SIZE 8
BY WHOM: EMS - Schoby Fire
CONFIRMATION: ☒ AUSCULATION, ☐ EID ☒ OTHER: Capnography
BY WHOM: EMS - Schoby Fire
ABG DONE? ☐ YES ☒ NO TIME: TIME:

CIRCULATION

INITIAL RHYTHM: VFib
TIME CHEST COMPRESSIONS STARTED: PTA
RHYTHM:
DEFIBRILLATED?: ☒ YES ☐ NO
TIME OF FIRST SHOCK: 1732 JOULES: 200
PACEMAKER ON? ☐ YES ☒ NO

OUTCOME

TIME RESUSCITATION ENDED: 1840
STATUS: ☐ DEAD ☒ ALIVE
REASONS FOR ENDING EFFORTS:
☐ VENTILATION RESTORED ☒ CIRCULATION RESTORED
☐ UNRESPONSIVE TO ALS ☐ ADVANCED DIRECTIVES
☐ FAMILY WISHES
DISPOSITION:

TIME	BP	RESP RATE/ ((S)PONTANEOUS /ASSISTED)	PULSE PRESENT (Y/N)	CARDIAC RHYTHM	DEFIB/CARDIOVERSION (JOULES)	AMIODARONE BOLUS (DOSE/ROUTE)	ATROPINE (DOSE/ROUTE)	EPINEPHRINE (DOSE/ROUTE)	SODIUM BICARBONATE (DOSE/ROUTE)	VASOPRESSIN (DOSE/ROUTE)	AMIODARONE INFUSION (DOSE/ml PER HOUR) STANDARD CONCENTRATION	SODIUM BICARBONATE INFUSION (DOSE/ml PER HOUR) STANDARD CONCENTRATION	DOPAMINE INFUSION (DOSE/ml PER HOUR) STANDARD CONCENTRATION	DOBUTAMINE INFUSION (DOSE/ml PER HOUR) STANDARD CONCENTRATION	HYDRATING IV (SPECIFY)	OTHERS (SPECIFY) Narcan 2mg	COMMENTS
1730		12(A)	N					1		20 mg							CPR in progress
1732		12 A	N	VFib	200												
1734		12A	N	VFib	200			1									@ card-activity via UIS, ETT to 23 cm @ lip
1736		12A	N														CPR continued
1737		12A	N	pea				1									@ pulses @ 1741
1739		12A	N						1	20 mg						1	
1740	101/53	12A	N	SR													Post chest x-ray @ 1753
1745	76/53						1										Central line @ groin by Dr Kurtz
1751	76/54	12A	Y	SB													
1800	57/63	12A	Y-39				1										

RECORDERS SIGNATURE: Jaime Blearey
CODE CAPTAIN SIGNATURE: Kristen Kurtz
SIGNATURE:

Disclaimer – route is considered IVP unless otherwise indicated.

Ellis HOSPITAL | McClellan CAMPUS
600 McClellan Street, Schenectady, NY 12304

ELLIS HOSPITAL CODE BLUE TREATMENT RECORD

ND0290

WHITE - CHART YELLOW - NURSING OFFICE PINK - PHARMACY

Kearse, Andrew M 36Y
[redacted]

page 2 of 2.

DATE: 5/11/17 LOCATION: ED25 WAS HOSPITAL-WIDE RESUSCITATION RESPONSE ACTIVATED? ☐YES ☐NO
TIME CODE CALLED: _____ TIME TEAM RESPONDED: _____ MONITORS PRESENT AT ONSET ☐CARDIAC MONITOR ☐PULSE OX
TYPE OF EVENT ☐RESPIRATORY ☐CARDIAC WITNESSED? ☐YES ☐NO WAS PATIENT CONSCIOUS AT ONSET? ☐YES ☐NO
PULSE PRESENT? ☐YES ☐NO ADVANCED DIRECTIVES PRESENT? ☐YES ☐NO

AIRWAY/VENTILATION

INITIAL: ☐SPONTANEOUS ☐APNEA ☐AGONAL ☐ASSISTED
TYPE OF VENTILATION: ☐MOUTH-MASK ☐BVM ☐ETT ☐OTHER: _____
FIRST ASSISTED VENTILATION TIME: _____
ETT INTUBATION: TIME _____ SIZE _____
BY WHOM: _____
CONFIRMATION: ☐AUSCULATION ☐EID ☐OTHER: _____
BY WHOM: _____
ABG DONE? ☐YES ☐NO TIME: _____ TIME: _____

CIRCULATION

INITIAL RHYTHM: _____
TIME CHEST COMPRESSIONS STARTED: _____
RHYTHM: _____
DEFIBRILLATED?: ☐YES ☐NO
TIME OF FIRST SHOCK: _____ JOULES: _____
PACEMAKER ON? ☐YES ☐NO

OUTCOME

TIME RESUSCITATION ENDED: 1840
STATUS: ☐DEAD ☒ALIVE
REASONS FOR ENDING EFFORTS:
☐VENTILATION RESTORED ☐CIRCULATION RESTORED
☐UNRESPONSIVE TO ALS ☐ADVANCED DIRECTIVES
☐FAMILY WISHES
DISPOSITION: _____

TIME	BP	RESP RATE/ ((S)PONTANEOUS /ASSISTED)	PULSE PRESENT (Y/N)	CARDIAC RHYTHM	DEFIB/CARDIOVERSION (JOULES)	AMIODARONE BOLUS (DOSE/ROUTE)	ATROPINE (DOSE/ROUTE)	EPINEPHRINE (DOSE/ROUTE)	SODIUM BICARBONATE (DOSE/ROUTE)	VASOPRESSIN (DOSE/ROUTE)	AMIODARONE INFUSION (DOSE/ml PER HOUR) STANDARD CONCENTRATION	SODIUM BICARBONATE INFUSION (DOSE/ml PER HOUR) STANDARD CONCENTRATION	DOPAMINE INFUSION (DOSE/ml PER HOUR) STANDARD CONCENTRATION	DOBUTAMINE INFUSION (DOSE/ml PER HOUR) STANDARD CONCENTRATION	HYDRATING IV (SPECIFY)	OTHERS (SPECIFY)	COMMENTS
1809	59/29	RA	4-3?	SB													Norepinephrine 10mg @1815
1826	62/27	RA	4-3?	SB			1										Pacer pads Rate 70, 150 for capture
1930																	Cardiac activity Cont 5 min.
1840		RA	4														

RECORDERS SIGNATURE: Laura Kearse
CODE CAPTAIN SIGNATURE: _____
SIGNATURE: _____

Disclaimer – route is considered IVP unless otherwise indicated.

Ellis HOSPITAL | McClellan CAMPUS
600 McClellan Street, Schenectady, NY 12304

ND0290

Form # SC768-60 (replaces SC474) Rev 05/08

ELLIS HOSPITAL CODE BLUE TREATMENT RECORD

WHITE - CHART YELLOW - NURSING OFFICE PINK - PHARMACY

Kearse, Andrew M 36Y
39-A-1
[redacted]

DATE: 5/11/17 LOCATION: ED39 WAS HOSPITAL-WIDE RESUSCITATION RESPONSE ACTIVATED? ☐ YES ☒ NO
TIME CODE CALLED: 1915 TIME TEAM RESPONDED: 1915 MONITORS PRESENT AT ONSET ☒ CARDIAC MONITOR ☒ PULSE OX
TYPE OF EVENT ☐ RESPIRATORY ☒ CARDIAC WITNESSED? ☒ YES ☐ NO WAS PATIENT CONSCIOUS AT ONSET? ☐ YES ☒ NO
PULSE PRESENT? ☐ YES ☒ NO ADVANCED DIRECTIVES PRESENT? ☐ YES ☒ NO

page 1 of 2

AIRWAY/VENTILATION

INITIAL: ☐ SPONTANEOUS ☐ APNEA ☐ AGONAL ☒ ASSISTED
TYPE OF VENTILATION: ☐ MOUTH-MASK ☐ BVM ☒ ETT ☐ OTHER:
FIRST ASSISTED VENTILATION TIME: PTA
ETT INTUBATION: TIME PTA SIZE 8
BY WHOM: EMS
CONFIRMATION: ☒ AUSCULATION ☐ Checked via CO2 or Esophageal Detection Device.
BY WHOM: EMS & RT on arrival
ABG DONE? ☒ YES ☐ NO TIME: 1918 TIME: 1943

CIRCULATION

INITIAL RHYTHM: VFib
TIME CHEST COMPRESSIONS STARTED: 1915
RHYTHM: SB
DEFIBRILLATED?: ☐ YES ☐ NO
TIME OF FIRST SHOCK: 1926 JOULES: 200
PACEMAKER ON? ☒ YES ☐ NO

OUTCOME

TIME RESUSCITATION ENDED: 1947
STATUS: ☒ DEAD ☐ ALIVE
REASONS FOR ENDING EFFORTS:
☐ VENTILATION RESTORED ☐ CIRCULATION RESTORED
☒ UNRESPONSIVE TO ALS ☐ ADVANCED DIRECTIVES
☐ FAMILY WISHES
DISPOSITION:

TIME	BP	RESP RATE/ ((S)PONTANEOUS /ASSISTED)	PULSE PRESENT (Y/N)	CARDIAC RHYTHM	DEFIB/CARDIOVERSION (JOULES)	AMIODARONE BOLUS (DOSE/ROUTE)	ATROPINE (DOSE/ROUTE)	EPINEPHRINE (DOSE/ROUTE)	SODIUM BICARBONATE (DOSE/ROUTE)	VASOPRESSIN (DOSE/ROUTE)	AMIODARONE INFUSION (DOSE/CC PER HOUR) STANDARD CONCENTRATION	SODIUM BICARBONATE INFUSION (DOSE/CC PER HOUR) STANDARD CONCENTRATION	DOPAMINE INFUSION (DOSE/CC PER HOUR) STANDARD CONCENTRATION	DOBUTAMINE INFUSION (DOSE/CC PER HOUR) STANDARD CONCENTRATION	HYDRATING IV (SPECIFY)	OTHERS (SPECIFY)	COMMENTS
1916		12 A	N	12A				1									CPR progress
1918		12A	N					1									
1921		12A	N					1									
1923		12A	N														Calcium chloride Inj
1925		12A	N					1									
1926		12A	N	VT	200												
1928		12A	Y	SB					2								pH 6.699 + pulses
1932		12A	N					1									CPR restarted
1935		12A	N					1									
1937		12A	N						2								
1938		12A	N					1									

RECORDERS SIGNATURE: Jessica Kearney CODE CAPTAIN SIGNATURE: [signature]
SIGNATURE:

Ellis Hospital
1101 Nott Street
Schenectady, New York 12308

ND0290
FORM # 768-80 (2/12)

ELLIS HOSPITAL CODE BLUE
TREATMENT RECORD

WHITE - CHART *YELLOW* - NURSING OFFICE *PINK* - PHARMACY

Kearse, Andrew M 36Y
[redacted]
ATND: Doctor, Emergency,

DATE: 5/11/17 LOCATION: EDS9 WAS HOSPITAL-WIDE RESUSCITATION RESPONSE ACTIVATED? ☐YES ☒NO
TIME CODE CALLED: 1917 TIME TEAM RESPONDED: 1917 MONITORS PRESENT AT ONSET ☒CARDIAC MONITOR ☒PULSE OX
TYPE OF EVENT ☐RESPIRATORY ☒CARDIAC WITNESSED? ☒YES ☐NO WAS PATIENT CONSCIOUS AT ONSET? ☐YES ☒NO
PULSE PRESENT? ☐YES ☒NO ADVANCED DIRECTIVES PRESENT? ☐YES ☒NO

page 2 of 2

AIRWAY/VENTILATION	CIRCULATION	OUTCOME
INITIAL: ☐SPONTANEOUS ☐APNEA ☐AGONAL ☐ASSISTED TYPE OF VENTILATION: ☐MOUTH-MASK ☐BVM ☐ETT ☐OTHER:_____ FIRST ASSISTED VENTILATION TIME:_____ ETT INTUBATION: TIME_____ SIZE_____ BY WHOM:_____ CONFIRMATION: ☐AUSCULATION ☐Checked via CO2 or Esophageal Detection Device. BY WHOM:_____ ABG DONE? ☐YES ☐NO TIME:_____ TIME:_____	INITIAL RHYTHM:_____ TIME CHEST COMPRESSIONS STARTED:_____ RHYTHM:_____ DEFIBRILLATED?: ☐YES ☐NO TIME OF FIRST SHOCK:_____ JOULES:_____ PACEMAKER ON? ☐YES ☐NO	TIME RESUSCITATION ENDED:_____ STATUS: ☐DEAD ☐ALIVE REASONS FOR ENDING EFFORTS: ☐VENTILATION RESTORED ☐CIRCULATION RESTORED ☐UNRESPONSIVE TO ALS ☐ADVANCED DIRECTIVES ☐FAMILY WISHES DISPOSITION:_____

TIME	BP	RESP RATE/ ((S)SPONTANEOUS /ASSISTED)	PULSE PRESENT (Y/N)	CARDIAC RHYTHM	DEFIB/CARDIOVERSION (JOULES)	AMIODARONE BOLUS (DOSE/ROUTE)	ATROPINE (DOSE/ROUTE)	EPINEPHRINE (DOSE/ROUTE)	SODIUM BICARBONATE (DOSE/ROUTE)	VASOPRESSIN (DOSE/ROUTE)	AMIODARONE INFUSION (DOSE/CC PER HOUR) STANDARD CONCENTRATION	SODIUM BICARBONATE INFUSION (DOSE/CC PER HOUR) STANDARD CONCENTRATION	DOPAMINE INFUSION (DOSE/CC PER HOUR) STANDARD CONCENTRATION	DOBUTAMINE INFUSION (DOSE/CC PER HOUR) STANDARD CONCENTRATION	HYDRATING IV (SPECIFY)	OTHERS (SPECIFY)	COMMENTS
1941		12A	N					1									Swan @ groin by Bill Phillips
1944		12A	N	PEA				1									
1947																	TOD - CPR ended

RECORDERS SIGNATURE: Laura Harvey CODE CAPTAIN SIGNATURE: [signature]

SIGNATURE:

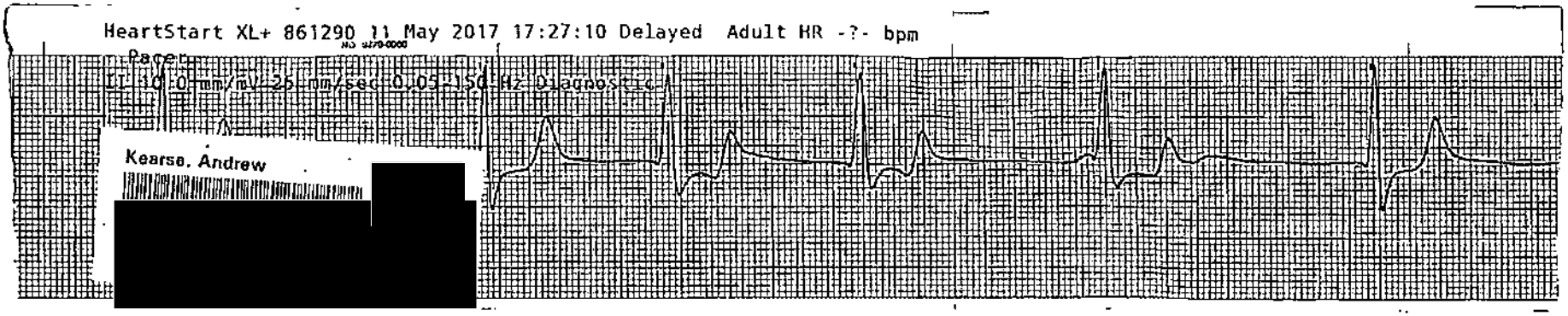
Ellis Hospital
1101 Nott Street
Schenectady, New York 12308

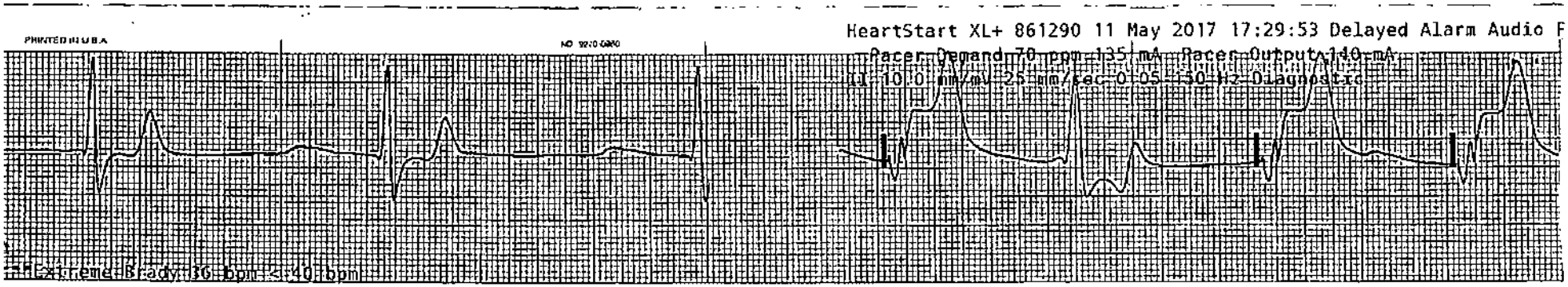
ND0290
FORM # 766-80 (2/12)

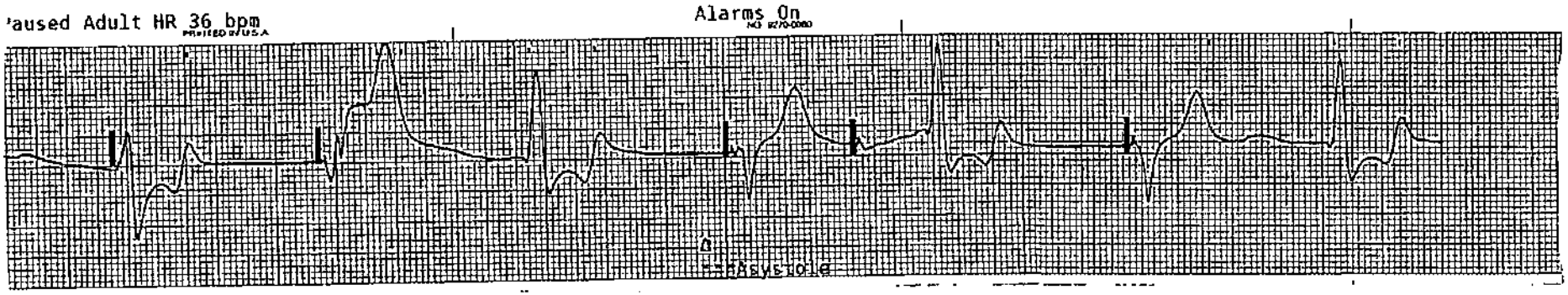
ELLIS HOSPITAL CODE BLUE
TREATMENT RECORD

WHITE - CHART *YELLOW* - NURSING OFFICE *PINK* - PHARMACY

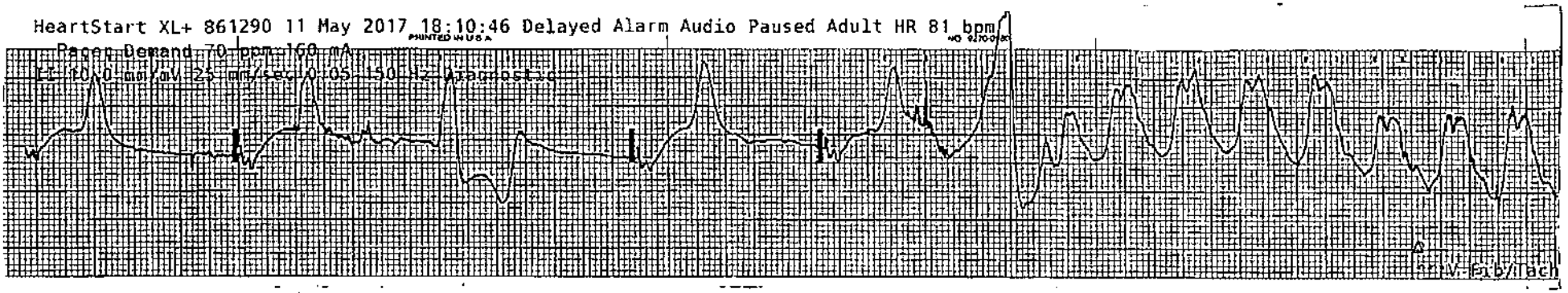
Kearse, Andrew M 38Y
39-A-1
[redacted]
ATND: Doctor, Emergency.

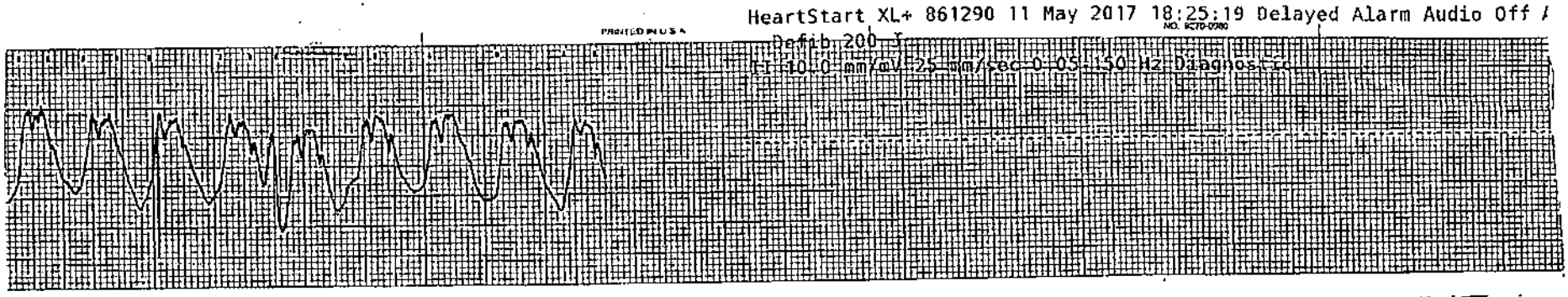


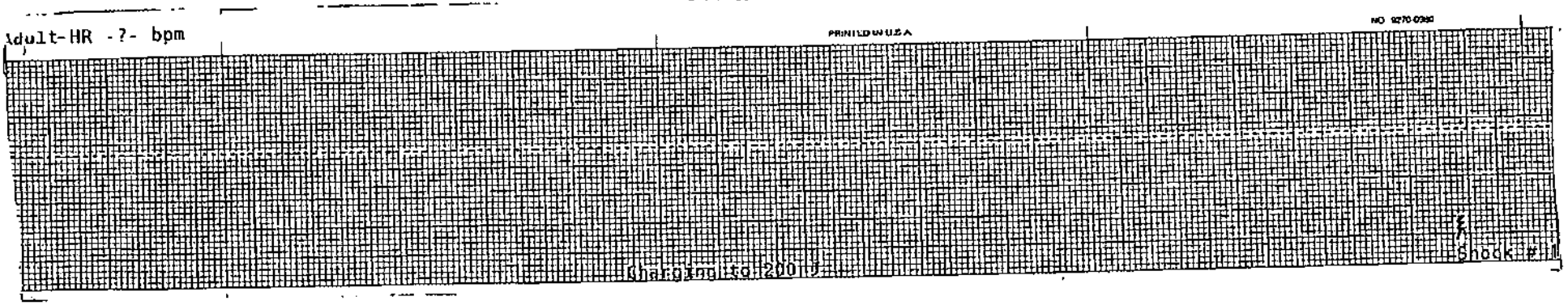


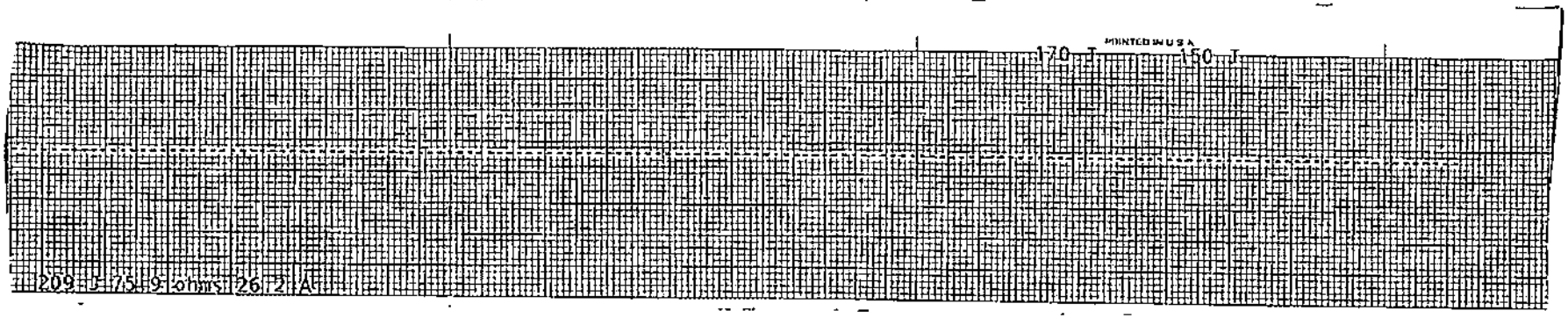


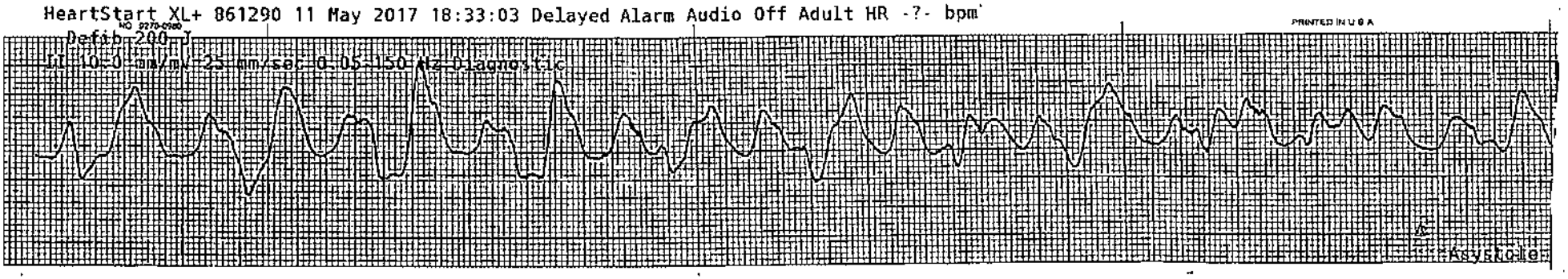
ND0360 - Rhythm Strips

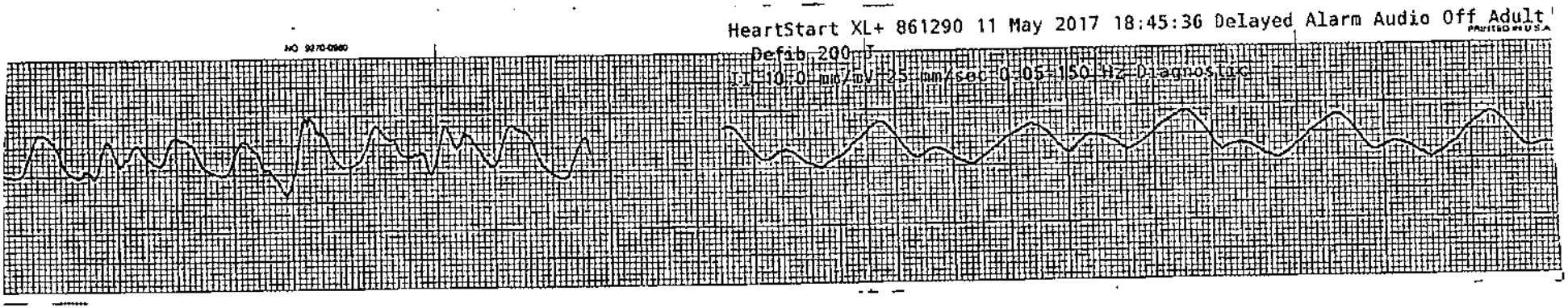

HeartStart XL+ 861290 11 May 2017 18:10:46 Delayed Alarm Audio Paused Adult HR 81 bpm
Pacer Demand 70 ppm 160 mA
I-I 10.0 mm/mV 25 mm/sec 0.05-150 Hz Diagnostic
Manual Fib/Ach

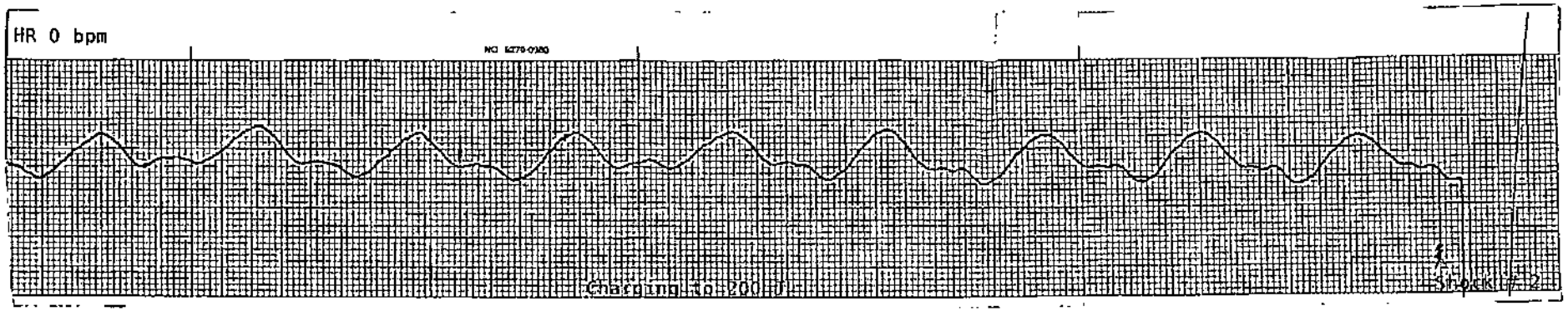

HeartStart XL+ 861290 11 May 2017 18:25:19 Delayed Alarm Audio Off
Defib 200 J
I-I 10.0 mm/mV 25 mm/sec 0.05-150 Hz Diagnostic

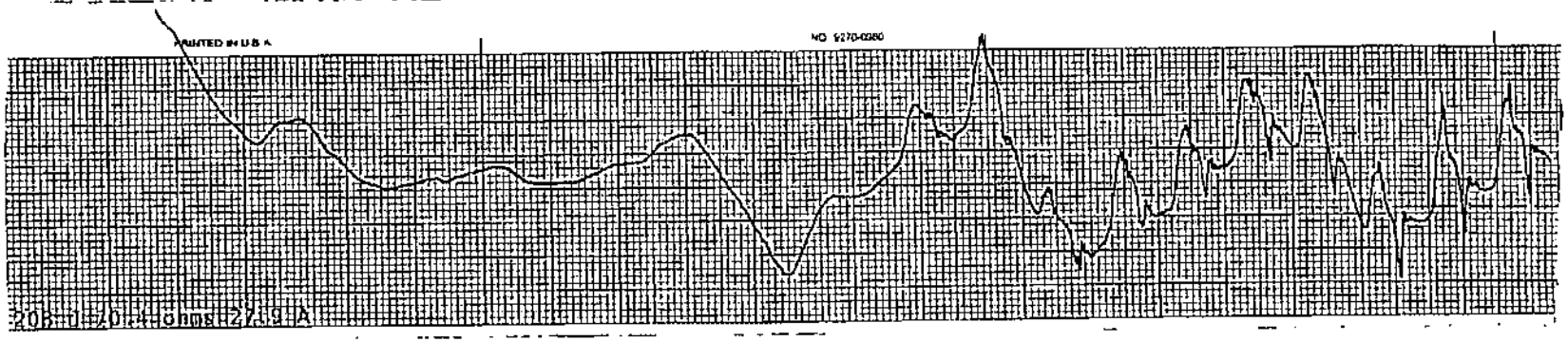

Adult-HR -?- bpm
Charging to 200 J
Shock #1

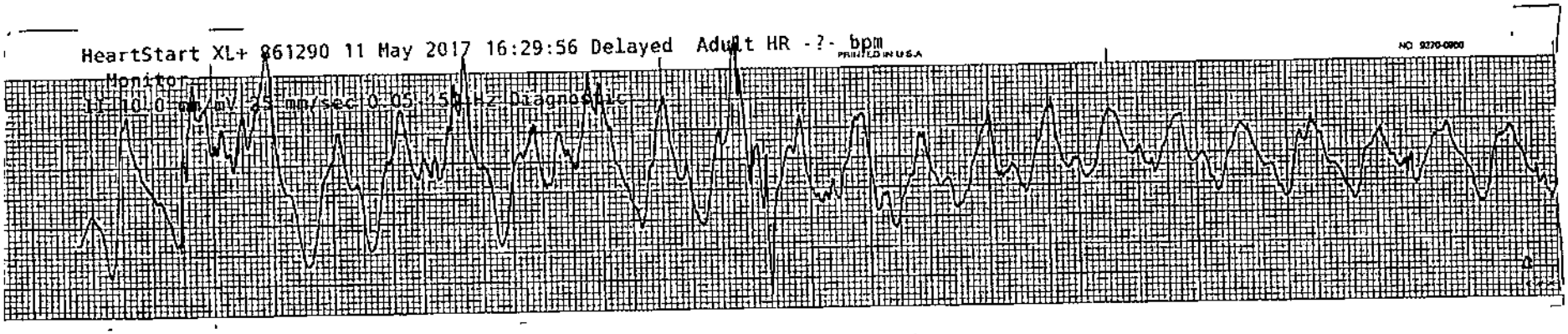

170 J
150 J
209 J 75.9 ohms 26.2 A

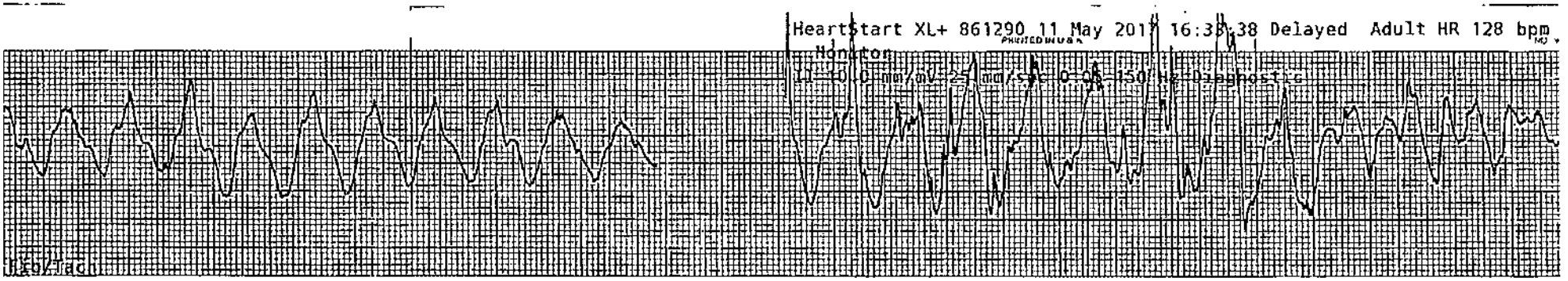

HeartStart XL+ 861290 11 May 2017 18:33:03 Delayed Alarm Audio Off Adult HR -?- bpm
Defib 200 J
Asystole

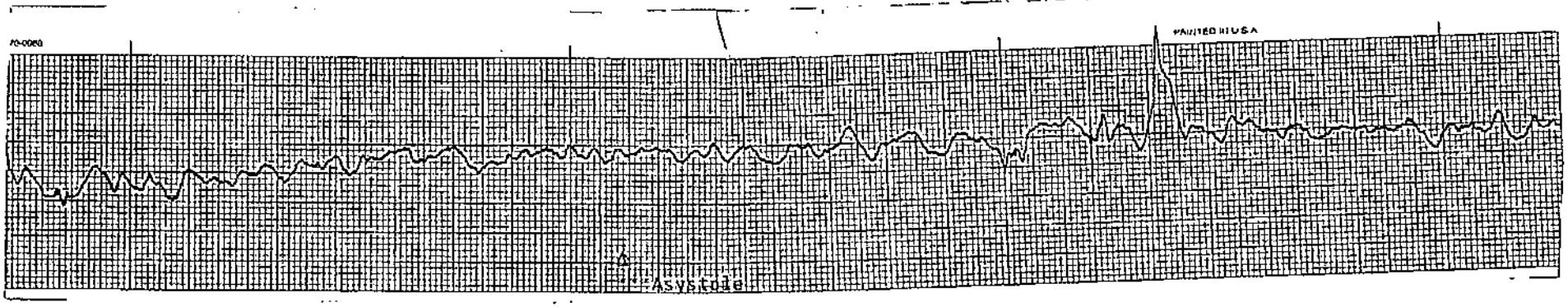

HeartStart XL+ 861290 11 May 2017 18:45:36 Delayed Alarm Audio Off Adult
Defib 200 J

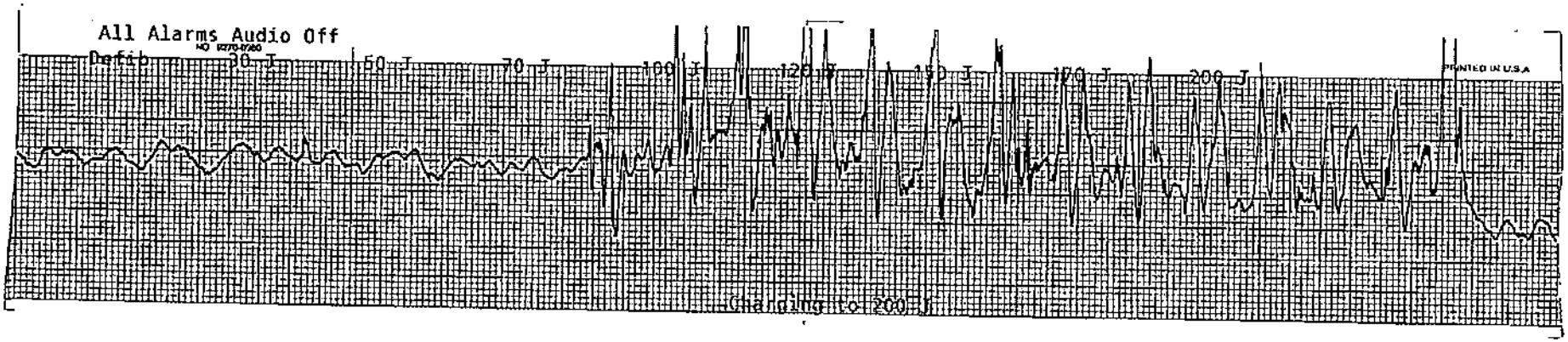

HR 0 bpm
Charging to 200 J
Shock!

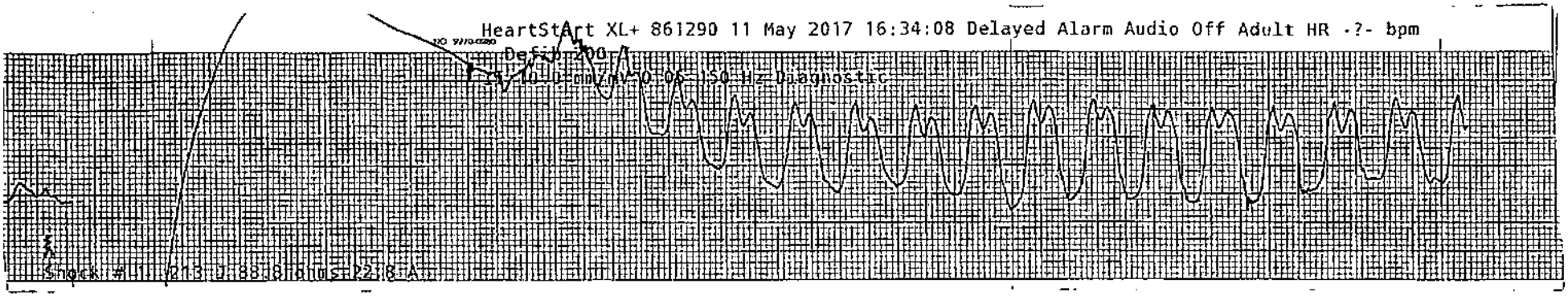

208 J 70.4 ohms 27.9 A

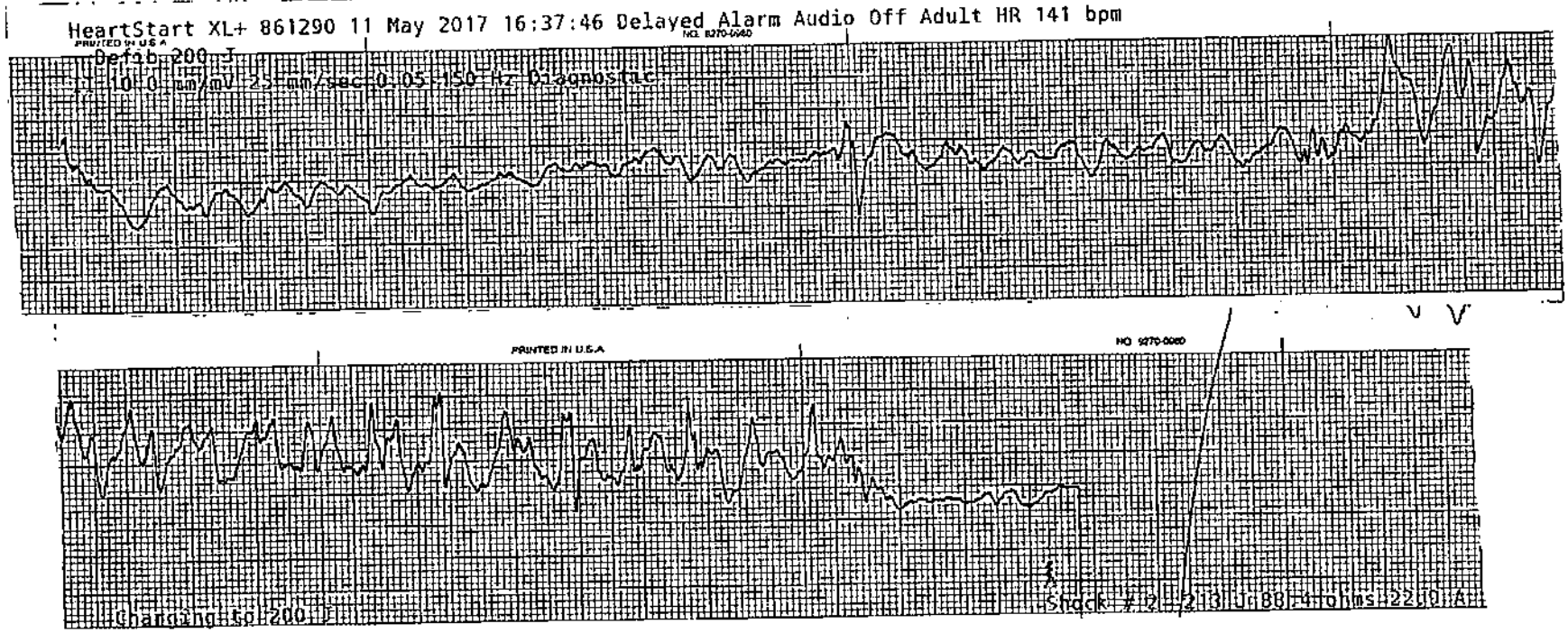

HeartStart XL+ 861290 11 May 2017 16:29:56 Delayed Adult HR -?- bpm
Monitor
10.0 mm/mV 25 mm/sec 0.05-150 Hz Diagnostic


HeartStart XL+ 861290 11 May 2017 16:38:38 Delayed Adult HR 128 bpm
Resp/Tach


Asystole


All Alarms Audio Off
Defib
30 J
50 J
70 J
100 J
120 J
150 J
170 J
200 J
Charging to 200 J


HeartStart XL+ 861290 11 May 2017 16:34:08 Delayed Alarm Audio Off Adult HR -?- bpm
Defib 200 J
Shock # 1 213 J 88 Ohms 22.8 A


HeartStart XL+ 861290 11 May 2017 16:37:46 Delayed Alarm Audio Off Adult HR 141 bpm
Defib 200 J
Charging to 200 J
Shock # 2 213 J 88 Ohms 22.9 A
Kearse, Andrew
M 36Y

Vital Signs

Name
MRN 999999999
Unit ED
Bed 39

Date 11-May-2017
Time 20:09:34
Page 1 of 1

		11-May 17:30	11-May 17:45	11-May 18:00	11-May 18:15	11-May 18:30	11-May 18:45	11-May 19:00	11-May 19:15	11-May 19:30	11-May 19:45	11-May 20:00
ECG-HR	beats/min		74	43	40	32	46	46	40	0	0	
ECG-PVC	#/min		64	45	39	34			17	39	2	
ECG-afibTrend	unitless		NO	NO	NO	NO	NO	NO	NO	NO	NO	
NBP-Sys	mmHg		101...	103...	59...	59...	142...	134...	115...			
NBP-Dias	mmHg		53...	75...	29...	30...	62...	90...	90...			
NBP-Mean	mmHg		72...	84...	39...	39...	89...	105...	99...			
SpO2	%			95	100	100	100	100	98	64		
SpO2-Rate	beats/min			41	42	50	46	45	124	122		
RESP-RR	breaths/min		16	5	5	16	34	32	103	126	122	
CO2-expCO2	mmHg			30	23	19	17	15	13	27	35	
CO2-inspCO2	mmHg			0	0	0	0	0	3	9	6	
CO2-CO2 Rate	breaths/min			15	15	16	17	15	19	15	11	
ECG-ST-I	mm											
ECG-ST-II	mm											
ECG-ST-III	mm											
ECG-ST-V	mm											
ECG-ST-avR	mm											
ECG-ST-avL	mm											
ECG-ST-avF	mm											

GR0000 - Vital Signs Record

Kearse, Andrew
M 36Y
39-A-1

[redacted]

Vital Signs

Name
MRN 999999999
Unit ED
Bed 39

Date 11-May-2017
Time 20:09:34
Page 1 of 1

	11-May 17:30	11-May 17:45	11-May 18:00	11-May 18:15	11-May 18:30	11-May 18:45	11-May 19:00	11-May 19:15	11-May 19:30	11-May 19:45	11-May 20:00
ECG-HR beats/min		74	43	40	32	46	46	40	0	0	
ECG-PVC #/min		64	45	39	34			17	39	2	
ECG-aflbTrend unitless		NO	NO	NO	NO	NO	NO	NO	NO	NO	
NBP-Sys mmHg		101...	103...	59...	59...	142...	134...	115...			
NBP-Dias mmHg		53...	75...	29...	30...	62...	90...	90...			
NBP-Mean mmHg		72...	84...	39...	39...	89...	105...	99...			
SpO2 %			95	100	100	100	100	98	84		
SpO2-Rate beats/min			41	42	50	46	45	124	122		
RESP-RR breaths/min		16	5	5	16	34	32	103	126	122	
CO2-expCO2 mmHg			30	23	19	17	15	13	27	35	
CO2-inspCO2 mmHg			0	0	0	0	0	3	9	6	
CO2-CO2 Rate breaths/min			15	15	16	17	15	19	15	11	
ECG-ST-I mm											
ECG-ST-II mm											
ECG-ST-III mm											
ECG-ST-V mm											
ECG-ST-avR mm											
ECG-ST-avL mm											
ECG-ST-avF mm											

GR0000 - Vital Signs Record

Kearse, Andrew M 36Y
39-A-1
[redacted]

Coding Summary Form

Code Set: ICD 10

Patient Name:	Kearse,Andrew	Facility ID:	EH	Payor:	00
[redacted]		Admission CM:	I49.01	Reimbursement:	$ .00
		Admission Date:	05/11/17	DRG:	196 - CARDIAC ARREST
Sex:	M	Discharge Date:	05/11/17	MDC:	05
Age:	36y	LOS:	1	Weight:	.49
[redacted]		Attending Provider:	210047	AMLOS:	2.2
Patient Type:	I	Discharge Status:	20	GMLOS:	1.76
Visit Type:	I			Coding Status:	COMPLETE

CM	Code	Description
1	I49.01	Ventricular fibrillation
2	I46.9	Cardiac arrest, cause unspecified
3	I48.91	Unspecified atrial fibrillation

PCS	Code	Description	Date	Surgeon
1	5A1935Z	Respiratory Ventilation, Less than 24 Consecutive Hours	05/11/17	120949
2	02HV33Z	Insertion of Infusion Dev into Sup Vena Cava, Perc Approach	05/11/17	120949
3	5A2204Z	Restoration of Cardiac Rhythm, Single	05/11/17	120949
4	5A12012	Performance of Cardiac Output, Single, Manual	05/11/17	120949
5	5A1223Z	Performance of Cardiac Pacing, Continuous	05/11/17	120949
6	02HP32Z	Insertion of Monitor Dev into Pulm Trunk, Perc Approach	05/11/17	120949

CPT	Code	Description	Modifier	Service Date	Surgeon
1	99291	Critical Care, Evaluation & Management		05/11/17	120949
2	99292	Critical Care, Evaluation & Management, Addl 30 Min		05/11/17	120949
3	99292	Critical Care, Evaluation & Management, Addl 30 Min		05/11/17	120949

CMS Notification of Death

☒ Patient expired. No restraint/seclusion utilized during the past 7 days.

☐ Patient expired — was in restraint/seclusion within past 7 days.
Restraints removed on _____ (date) at _____ (time).

☐ Patient expired within 24 hours of being in restraint or seclusion.
Restraints / seclusion removed on _____ (date) at _____ (time).

☐ Patient expired while in restraints or seclusion.

TYPE OF RESTRAINT USED:

☐ Vest ☐ Soft Cloth Wrist ☐ Belt ☐ 4 point ☐ 5 point ☐ 4 siderails ☐ mitts

☐ Rigid Wrist ☐ Geri Chair with locked tray ☐ Manual ☐ Chemical ☐ Seclusion

RN Signature: [signature] Date: 5/11/17 Time: 1810

Complete above section of form and send with chart to admitting.

Note: If only soft cloth wrist restraint used, enter information in the Restraint Log and document in the patient record the date and time that the death was recorded in this log.
Notification to CMS for this type of restraint use is not required but must be tracked.

Determination of requirement for notification of CMS:

Notification required: ☐ No ☐ Yes

Information from chart review: _____

Signature of chart reviewer: _____ Date: _____ Time: _____

Notified CMS via fax at: _____ (date) _____ (time)

Signature of person faxing to CMS: _____

Signature of person completing Restraint Log: _____

If reported to CMS, this document must be filed in Medical Record.

Ellis Hospital Schenectady, NY

CMS Notification of Death
Form # E0717 (01/2013) 1 of 1

DD0560

Kearse, Andrew M 36Y
[redacted]

EXHIBIT 4

Beginning Time: 9:30 AM

Supporting Deposition (CPL 100.20)

The People of the State of New York
vs.

Location of Incident	**Location of Deposition**
State of New York Local Criminal Court	State of New York
County of Schenectady	County of Schenectady
City of Schenectady	City of Schenectady

I, Mark E. Weekes, date of birth [redacted] residing at an address known to the State Police am making the following written statement to Investigators Kevin E. Noto and Robert Martin of the New York State Police of my own free will.

I am employed as a Patrolman for the Schenectady Police Department. I have been employed by the Police Department for approximately nine years. I currently work the 3:00 PM to 11:00 PM shift.

On May 11, 2017, I was working my normal shift and was in marked patrol car SPD 915. SPD 915 is a standard patrol car which has a plexi-glass cage separating the front seats from the back seat. There is a partition window in the plexi-glass which has a metal grid. There is also metal grid on the side windows in the back. The car has four cameras; two forward facing cameras and two rear facing cameras. The two forward facing cameras record footage of the exterior of the vehicle. The two rear facing cameras show the interior of the patrol car. The one camera covers the front seat and the rear seat through the partition. The other camera covers the rear seat.

At approximately 4:30 PM, I was in SPD 915 on Albany Street at Brandywine when I heard one of the Sergeants, who was in a 920 series car (which is a Sergeant's car), radio something to the effect that someone was fleeing. I thought I heard him say Ward Avenue but I wasn't sure because that is normally a quiet area. I heard someone else call for the cross streets to get clarification on the location. I pulled over and waited to hear the clarification on the location. As I was pulled over, I saw one of the Schenectady Police Department SUVs travelling southbound on Brandywine and then turned east on Albany Street. The SUV had its lights and sirens on. I activated my lights and sirens and followed the SUV. We went down Albany Street, made a left on Dartmouth, right onto State Street, left onto Consaul, left onto Ivy, and then a right onto Ward Avenue. The SUV that was in front of me pulled over to the left. I saw the Sergeant's vehicle was pulled into the driveway behind a white SUV so I knew which house to be looking at. I saw Sergeant DeMartino right in front of the stairs for the front door with a white female. The female was in real close proximity to Sergeant DeMartino and I saw him push her away and tell the female to get away from and not to touch him. I pulled into the driveway and stopped to the right of the Sergeant's SUV. As soon as I got out of the car I looked over to Sergeant DeMartino. I thought we were there for her but he told me to go to the back. I ran to the right side of the house. As I approached the back yard I saw a black male subject who was about halfway in the backyard. He was running away towards the back of the yard and was looking over his shoulder towards me. He was a medium skinned black male who was wearing a white t-shirt and pajama pants. I yelled that he was running out the back. There was wire fence which I had to jump over to get into the back yard. Patrolman Dan Coppola came up behind me and he went over the fence after I went over it. There was a shed in the backyard. I slowed down as I got to the shed and looked around it to see if the man was there, but he wasn't. There was a

stockade fence behind the shed. I couldn't see the man so I climbed up on the stockade fence. I could see the man running to the front fence of the next yard which was a house on Donald Avenue. I radioed the man's description and his direction of travel. I figured that the stockade fence was going to give me the highest vantage point so I could monitor his direction of travel and radio the information to the other officers. I saw him heading in the direction of Parkview Cemetery so I thought that might be where he was heading. I didn't think I was going to catch him so I ran back to my patrol car so I could attempt to cut him off in the cemetery. As I was running towards my patrol car I saw Patrolman Kietlinski running towards Donald Avenue through a neighbor's backyard. I heard him ask the neighbor who was on his back porch and ask if he could go through his yard. When I got to my patrol car I got in and drove down to Ivy and headed towards Consaul Road. When I got to the intersection of Consaul Road and Ivy I heard someone radio that they had one in custody. I made a U-turn and drove back to Donald Avenue.

As I drove down Donald Avenue, I saw something in the backyard of one of the residences on the right hand side. I stopped and got out of the car and ran into the backyard and saw Patrolman Kietlinski who was on his knees. There was a male subject either on his side or laying down. Both Patrolman Kietlinski and the male subject were breathing heavily and appeared out of breath. The male subject that Patrolman Kietlinski had was the same subject I had observed running through the backyard on Ward Avenue. Patrolman Coppola came up behind me. Because Patrolman Kietlinski was out of breath either Patrolman Coppola or I told him that we would relieve him. Since the male subject was not responding to our verbal commands to stand up, Patrolman Coppola and I assisted the male subject to his feet. The male subject was handcuffed behind his back. I used my left arm to pick him up underneath his right armpit. Patrolman Coppola used his right arm to pick him up underneath his left armpit. We told him to stand up which he did at this point. We began to walk with him and he took a few steps. He was still out of breath from fleeing the police and was taking deep breaths. While walking to the police car, he refused to walk on his feet. Patrolman Coppola and I lowered him down to his knees. He said that he could walk on his knees. He began to walk on his knees. Patrolman Kietlinski stated that he could help by lifting his feet so we could carry him. Patrolman Coppola and I were still holding the male subject by the arm. When Patrolman Kietlinski picked up the male subject's feet we carried him in a horizontal position to the side of my patrol car. The male subject did not make any complaints as we did this. We put him down on the ground a few feet from my car. Someone opened the rear passenger side door of my patrol car. I don't remember how the male subject got in to the patrol car. The male subject was given verbal instructions to get into the patrol car but he did not comply. He was placed in a seated position on the backseat with his feet still outside the car. I don't remember if it was before he was seated or after but at one point I went to the rear driver side door of my patrol car and opened the door. Because he wouldn't sit entirely in the patrol car I reached in and guided him into the vehicle. We closed the doors to the car. It was after the subject was placed in the patrol car that I changed the live-feed on the monitor in the car to show me the camera covering the backseat so I could monitor the male subject. I don't know if the camera started recording the rear seat when I did this or if it was recording before I changed cameras. We were there for a short time before I transported him back over to Ward Avenue. While I was driving back to Ward Avenue the male subject told me something to the effect that he couldn't breathe. He did not make any other complaints. I looked at the in-car monitor and saw that the male subject was still sitting upright but facing sideways. From my first responder training I received in the police academy, the military, and my professional experience, I was taught that if someone can speak they can breathe.

I drove back to the residence on Ward Avenue where Sergeant DeMartino had been and I parked on the east side of the street. Both the rear windows were up in the car and the partition window was closed. I had the climate control on in the vehicle and I had the driver side window down. I exited the vehicle and began speaking with Sergeant DeMartino. We were standing on the front yard of the residence so the width of Ward Avenue was between us and my patrol vehicle. I could hear the male subject yelling from inside the vehicle. I heard him yell that he couldn't breathe. Since Sergeant DeMartino did not need the subject at the scene, and because he was yelling loudly, I advised Sergeant DeMartino that I was going to transport the male subject back to the station.

As soon as I got back in the car the male subject said that he couldn't breathe. He also asked me to open the window but I told him that I wouldn't. For safety reasons I don't open the back windows because the back doors can be opened from outside. If a subject in custody has managed to remove their handcuffs and the windows are open they can open the door and create a safety risk for them and me. Given the events that had occurred; the subject had fled from the police and was not compliant in getting into the patrol car, I was concerned that he was asking for the windows to be lowered as a ruse to escape custody. The drive from Ward Avenue to the station was approximately ten minutes. During that trip I continued to monitor the male subject through the monitor. Throughout the course of the trip the male subject made statements that he couldn't breathe and he asked me to open the window. He also yelled that he couldn't breathe. At one point he said that he was going to throw up. I monitored him during the trip and I could see that when I made motions with the vehicle, such as turning onto another street, he would upright himself. The male subject never complained of any pain. He never asked for medical assistance. Because the male subject was able to sit upright, correct his positioning during the drive to the station, and was talking, it was clear that he could breathe. After he made the statement about throwing up, he made a regurgitation sound. Shortly before we arrived at the station I made a right hand turn. I heard the male subject fall back on the plastic seat. By then we were close to the station. We have two entrances to the parking lot, the entrance to the sally port has a security gate. Because he had slumped over I wanted to get to the station quicker so I went to the other entrance and pulled into the sally port entrance which is at the rear of the station. I stopped the in-car monitor (because I knew there was a camera covering the sally port entrance) and exited the vehicle. I opened the rear driver side door and saw that he was still laying down. I told him something to the effect for him to get up. Patrolman R. Flood was walking by at that point and I asked him if he could help me get the male subject out of the car. We had some difficulty getting him out of the vehicle because his foot got stuck so I went over to the passenger side. Patrolman Flood pulled him out and laid him down on his back on the sidewalk, parallel to the vehicle. As I was on the passenger side of the vehicle I turned on the in-car camera again because the subject wasn't being compliant and there may have been a medical issue, I wanted to ensure that what was happening was being recorded. I told him a few times to get up, but he didn't. I checked his pulse at this time. Since he was not responding, I called dispatch and requested that the medics respond. I originally gave our physical location, 531 Liberty Street, and then clarified by saying the station. I saw that his eyes were partially open. I could see parts of his pupils, so they hadn't rolled back. Lieutenant Macherone walked by and I got his attention. He said that he would be right back. He went inside. I then called for a supervisor. We sat him up against the building. He began to lean a little to the left so I stabilized him with my leg. I noticed that his eyes were still open and that he hadn't blinked. When I noticed this, I asked Patrolman Winch to expedite the medics which she did. Patrolman Flood checked the subject for a pulse and said that he couldn't feel one. I asked Patrolman

Winch if she had expedited the medics and she said she did. She radioed dispatch again and repeated her request to expedite the medics. I said that we should remove the handcuffs from the subject so one of the other officers removed the handcuffs. We laid the subject back down on the sidewalk on his back and I began chest compressions. Another officer came with an AED. While I was doing chest compressions, the other officers lifted up his shirt and began to apply the pads for the AED. As they were applying the pads the medics arrived. Patrolman Coppola told me to stand clear but I continued chest compressions, I then heard the AED state that there was body movement detected and stop body movement so I stopped the chest compressions. The medics came up to us and I got out of the way so they could begin to treat him. One of the supervisors then brought me inside the station.

NOTICE: In a written instrument, any person who knowingly makes a false statement which such person does not believe to be true has committed a crime under the laws of the state of New York punishable as a class A misdemeanor.

Affirmed under penalty of perjury this 13th day of May, 2017

Signed: _____

Witnessed: _____

Investigator ~~Kevin E. Noto~~ _____

Time ended: 1240 P

EXHIBIT 5

SCHENECTADY POLICE DEPARTMENT

ORDER NO. IO 92 - 4

INTERIM ORDER	ISSUE DATE: APRIL 16, 1992	EFFECTIVE DATE: APRIL 16, 1992
SUBJECT: MEDICAL TREATMENT ILL OR INJURED PERSONS OR PRISONERS.	ISSUING AUTHORITY: Charles M. Mills	PAGE 1 OF 1
DISTRIBUTION: ALL COMMANDS		REEVALUATION DATE:
REVISES ORDER #:	SUPERSEDES ORDER #:	ACCREDITATION OFFICE INDEX: I.O.-ILL OR INJURED

Whenever, a person is brought to the station and appears to have an injury or illness, no matter how minor, or; whenever a person in the custody of this department complains of an illness or injury, it is the responsibility of the Desk Officer to:

1. Ensure that the Schenectady Fire Department Paramedics are notified to respond to examine the person, whether or not the injured/ ill person requests medical attention.

2. Enter in the Desk Log Book, the time S.F.D. was called, the persons name, and the Paramedics recommendation regarding further treatment.

3. In the event that the person refuses medical attention by the Paramedics, a copy of the refusal form will be forwarded to the Commanding Officer of the Field Services Bureau.

4. Abide by the medical opinion of the Paramedics as to the necessity of any further treatment that may be required.

EXHIBIT 6

DOH-1961 (8/2011)

RECORDED DISTRICT 9601
REGISTER NUMBER 518

NEW YORK STATE
DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

* Corr per DOH-1999 (06/12/2017 SP)

1. NAME: FIRST Andrew MIDDLE LAST Kearse
2. SEX: MALE [X] FEMALE [ ]
3A. DATE OF DEATH: MONTH 5 DAY 11 YEAR 2017
3B. HOUR: 7:47 P

4A. PLACE OF DEATH (Check one): HOSPITAL OBA [ ] ER [X] HOSPITAL OUTPATIENT [ ] HOSPITAL INPATIENT [ ] NURSING HOME [ ] PRIVATE RESIDENCE [ ] HOSPICE FACILITY [ ] OTHER (Specify) [ ]
4B. IF FACILITY, DATE ADMITTED: MONTH 5 DAY 11 YEAR 2017
4C. NAME OF FACILITY: Ellis Hospital
4D. LOCALITY: CITY [X] VILLAGE [ ] TOWN [ ] Schenectady
4E. COUNTY OF DEATH: Schenectady
4F. MEDICAL RECORD NO. 1715034
4G. WAS DECEDENT TRANSFERRED FROM ANOTHER INSTITUTION? NO [X] YES [ ]

5. DATE OF BIRTH: [redacted]
6A. AGE IN YEARS: 36 yrs.
6B. IF UNDER 1 YEAR ENTER: months / days
6C. IF UNDER 1 DAY ENTER: hours / minutes
7A. CITY AND STATE OF BIRTH: BRONX N.Y.
7B. IF AGE UNDER 1 YEAR, NAME OF HOSPITAL OF BIRTH:

8. SERVED IN U.S. ARMED FORCES? NO [X] YES [ ]
9. DECEDENT OF HISPANIC ORIGIN: A [X] No, not Spanish/Hispanic/Latino; B [ ] Yes, Mexican, Mexican American, Chicano; C [ ] Yes, Puerto Rican; D [ ] Yes, Cuban; E [ ] Yes, Other Spanish/Hispanic/Latino (Specify)
10. DECEDENT'S RACE: A [ ] White/Caucasian; B [X] Black or African American; C [ ] Asian Indian; D [ ] Chinese; E [ ] Filipino; F [ ] Japanese; G [ ] Korean; H [ ] Vietnamese; J [ ] Native Hawaiian; K [ ] Guamanian or Chamorro; M [ ] Samoan; N [ ] American Indian or Alaska Native (specify); P [ ] Other Asian (specify); R [ ] Other Pacific Islander (specify); S [ ] Other (specify)

11. DECEDENT'S EDUCATION: 1 [ ] ≤ 8th grade; 2 [ ] 9th-12th grade, no diploma; 3 [X] High school graduate or GED; 4 [ ] Some college credit, but no degree; 5 [ ] Associate's degree; 6 [ ] Bachelor's degree; 7 [ ] Master's degree; 8 [ ] Doctorate/Professional degree

[redacted]
13. MARITAL STATUS: NEVER MARRIED [ ] MARRIED [X] WIDOWED [ ] DIVORCED [ ] SEPARATED [ ]
14. SURVIVING SPOUSE: Angelique Negroni

15A. USUAL OCCUPATION: Laborer
15B. KIND OF BUSINESS OR INDUSTRY: Construction
15C. NAME AND LOCALITY OF COMPANY OR FIRM:

16A. RESIDENCE: State or Country: New York
16B. County: Bronx
16C. LOCALITY: CITY [X] VILLAGE [ ] TOWN [ ] New York
16F. IF CITY OR VILLAGE, IS RESIDENCE WITHIN CITY OR VILLAGE LIMITS? [X] YES [ ] NO

[redacted]

17. BIRTH NAME OF FATHER/PARENT: FIRST Mark MI Scott LAST Heyliger
18. BIRTH NAME OF MOTHER/PARENT: FIRST Sharon LAST Kearse

19A. NAME OF INFORMANT: Angelique Negroni Kearse [redacted]

20A. [X] Burial MONTH 6 DAY 6 YEAR 2017 [redacted]

21A. NAME AND ADDRESS OF FUNERAL HOME: R.G Ortiz Funeral Home inc. 2121 Westchester Ave Bx NY 10462
21B. REGISTRATION NUMBER: 01403
22A. NAME OF FUNERAL DIRECTOR: Louis G. Cava Jr.
22B. SIGNATURE OF FUNERAL DIRECTOR: Louis G. Cava Jr.
22C. REGISTRATION NUMBER: 0601
23A. SIGNATURE OF REGISTRAR: Shirley Park, Deputy
23B. DATE FILED: 06 01 2017
24A. Shirley Park, Deputy
24B. DATE ISSUED: 06 01 2017

ITEMS 25 THRU 33 COMPLETED BY CERTIFYING PHYSICIAN -- OR -- CORONER/CORONER'S PHYSICIAN OR MEDICAL EXAMINER

25A. CERTIFICATION: To the best of my knowledge, death occurred at the time, date and place and due to the causes stated.
Certifier's Name: Michael Sikirica MD License No.: 227488 Signature: Date: 05 12 2017
Certifier's Title: 0 [ ] Attending Physician; 0 [ ] Physician acting on behalf of Attending Physician; 1 [ ] Coroner; 2 [X] Medical Examiner / Deputy Medical Examiner
Address: 50 Broad St, Waterford NY
25B. If coroner is not a physician, enter Coroner's Physician's name & title:
25C. If certifier is not attending physician, enter Attending Physician's name & title:
26A. Attending physician attended deceased: From / To
26B. Deceased last seen alive by attending physician:
26C. Pronounced Dead: 05 11 2017 at 7:47 P

27. MANNER OF DEATH: NATURAL CAUSE [X] ACCIDENT [ ] HOMICIDE [ ] SUICIDE [ ] UNDETERMINED CIRCUMSTANCES [ ] PENDING INVESTIGATION [X] (struck)
28. WAS CASE REFERRED TO CORONER OR MEDICAL EXAMINER? NO [ ] YES [X]
29A. AUTOPSY? NO [ ] YES [X] REFUSED [ ]
29B. IF YES, WERE FINDINGS USED TO DETERMINE CAUSE OF DEATH? NO [ ] YES [ ]

CONFIDENTIAL — SEE INSTRUCTION SHEET FOR COMPLETING CAUSE OF DEATH — CONFIDENTIAL

30. DEATH WAS CAUSED BY: (ENTER ONLY ONE CAUSE PER LINE FOR (A), (B), AND (C).)

PART I.	Cause	Approximate interval between onset and death
(A) Immediate cause	* ~~Pending further studies~~ Cardiac arrhythmia	minutes
(B) Due to or as a consequence of	due to cardiomegaly and left ventricular hypertrophy	years
(C) Due to or as a consequence of		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN IN PART I (A):
DID TOBACCO USE CONTRIBUTE TO DEATH? 0 [X] NO 1 [ ] YES 2 [ ] PROBABLY 3 [ ] UNKNOWN

31A. IF INJURY, DATE: HOUR:
31B. INJURY LOCALITY:
31C. DESCRIBE HOW INJURY OCCURRED:
31D. PLACE OF INJURY:
31E. INJURY AT WORK? NO [ ] YES [ ]
31F. IF TRANSPORTATION INJURY, SPECIFY: 1 [ ] Driver/Operator 2 [ ] Passenger 3 [ ] Pedestrian 4 [ ] Other (specify)
32. WAS DECEDENT HOSPITALIZED IN LAST 2 MONTHS? NO [X] YES [ ]
33A. IF FEMALE: 0 [ ] Not pregnant within last year; 1 [ ] Pregnant at time of death; 2 [ ] Not pregnant, but pregnant within 42 days of death; 3 [ ] Not pregnant, but pregnant 43 days to 1 year before death; 4 [ ] Unknown if pregnant within past year
33B. DATE OF DELIVERY:

For use by physician or institution: NAME OF DECEDENT: Andrew Kearse DATE OF DEATH: 5-11-17 TIME OF DEATH: 747 PM

MICHAEL SIKIRICA, M.D.
50 Broad Street
Waterford, New York 12188
TEL (518) 237-3211
FAX (518) 237-7423

I, Michael Sikirica, M.D., Forensic Pathologist, certify to the best of my knowledge, that the attached nineteen page report is a true and accurate copy of the original final autopsy report dated June 08, 2017, following the autopsy that I performed on the body of Andrew Kearse on May 12, 2017, at the Albany Medical Center, Albany, New York.

Michael Sikirica, M.D.
Forensic Pathologist
DATED: June 09, 2017

FINAL AUTOPSY REPORT

CASE #:	MS-17-249 OC-17-126 (Albany Medical Center)
DECEDENT:	Andrew Kearse
DATE OF BIRTH:	[redacted]
PRONOUNCEMENT DATE:	May 11, 2017
PRONOUNCEMENT TIME:	7:47 PM
DATE OF AUTOPSY:	May 12, 2017, 10:15 AM
PLACE OF AUTOPSY:	Albany Medical Center, Albany, NY
PROSECTOR:	Michael Sikirica M.D.
ASSISTING:	Mrs. Sarah Bourdon and Ms. Sarah Strakosch
MEDICOLEGAL DEATH INV.:	Ms. Laura Nealon, Schenectady County
MEDICAL EXAMINER:	Dr. Nadarajah Balasubramaniam, Schenectady County

Cause of Death:	Cardiac arrhythmia due to cardiomegaly and left ventricular hypertrophy
Manner of Death:	Natural

Michael Sikirica, M.D./nw
DATE: 6-8-2017

External Description

The body is received in a white plastic body pouch. There is a tag attached to the pouch with number 831288. The decedent's name is also written in ink on the pouch along with the name of Detective Barrett and what appears to be the name of Investigator Bird and lock number 831288. The decedent's date of birth and case number 17-215907 are also listed on the pouch. The body is that of a 76", 246 pound normally-developed, well nourished adult black male appearing the reported age of 36 years with full rigor mortis and slight posterior fixed livor mortis. The body temperature is cool to the touch after refrigeration. The general appearance of the body is of good health and hygiene.

The body is received with a hospital gown overlying the body and a cut white t-shirt behind the body in the pouch. There is no jewelry present on the body or included with it.

The scalp hair is black measuring approximately ½" in length and there is a black mustache and beard. The irides are brown. The right and left pupils each measure 3 mm in diameter. The corneas are clear and the sclerae and conjunctivae are unremarkable. No conjunctival petechiae are noted. The face is symmetric and the facial bones are intact to palpation. There are no materials in the mouth, nose or ears. The teeth are natural and in fair to good condition. There is no injury to the lips, teeth or gums. The neck is free from masses. There are no unusual marks or lesions on the skin of the neck. The larynx is midline and the thyroid not palpable. The chest is of normal contour. The breasts are those of an adult male. The abdomen is flat and soft.

The posterior torso shows no significant abnormalities. The upper extremities are symmetric, and the fingernails are intact and show no foreign material. There is black fingerprint ink on several fingers. No clubbing or cyanosis is noted. The external genitalia are those of a mature male. There is no evidence of injury or abnormal secretions. The buttocks and anus are unremarkable. The skin is black in color and smooth. There are numerous tattoos noted. There is a tattoo of the words "Live Your Life Not Mine," along the left lateral upper forehead and a tattoo of a name or word with the letters "Ch" present along the left neck. There is a tattoo of the words "Real" and "Right" tattooed across the front of the right and left shoulders. There is a tattoo of what appears to be a letter "B" along the lateral right upper chest and a tattoo labeled "For Your Eyes Only" with two eye tattoos along the left upper chest. There is also an "X" shaped tattoo along the anterior lower lateral left shoulder. There is a tattoo of the name "CRYSTAL" extending along the posterior shoulders. There is a demon with a female scene tattoo along the anterior and lateral left upper arm and a demon and geometric design tattoo along the right upper arm. There are illegible letters along the ventral right forearm and a marijuana leaf more distally along the ventral right forearm. There is a star and rectangular design tattoo on the upper ventral left forearm. There is a tattoo of a wall with a street sign with what appears to be an address of "Dehater" and "195 st" on the dorsal right forearm. There is a cross and chain design tattoo on the dorsal left forearm. There is a skull and crown tattoo on the dorsal left hand and a tattoo of the word love on the dorsal aspect of the right middle finger. There is a large tattoo of the words "Endangered Species" along the abdomen located above and below the umbilicus. There is no evidence of acute or chronic intravenous narcotism. Passive

motion of the head, neck and extremities reveals no abnormal mobility or crepitus. There is no unusual odor about the body.

Evidence of Recent Medical Therapy

There is an endotracheal tube protruding outward from the oral cavity and strapped around the cheeks. There is a large defibrillator pad along the right upper and medial chest and a second along the left lower chest. There are square EKG pads present along the right clavicular area, lateral left shoulder, anterior lower left shoulder, anterior left axilla, right lower medial chest, left anterior abdomen and left lateral abdomen. There are small monitor pads in place as follows: one along the lateral right upper arm, one along the lateral left upper arm, two along the medial right lower chest. one along the medial left nipple region, four extending horizontally along the left lower chest and one along the mid portion of each calf. There is an IV line inserted into the left antecubital area and taped in place. There are small puncture marks with a slight amount of associated bleeding along the ventral portion of the right antecubital region. There is a hospital identification bracelet in place around the right wrist listing the decedent's name with a date of birth of [redacted] and a [redacted] There is a large bore catheter inserted into the right femoral area and a triple lumen catheter inserted into the more medial right femoral area. There is a bandage over a small puncture wound along the dorsal right hand. There is an intraosseous port inserted into the bony tissue of the right upper calf.

Evidence of Injury

Present along the midline of the chest at the approximately level of the nipples is a 14 x 10 cm zone of pink ecchymosis injury surrounding several small red abrasions and the injuries are consistent with resuscitation.

There are two small scratches extending into the right axillary region along the right upper arm and located distal to these are two somewhat vertically oriented thin scratch type marks with the lateral measuring 8 cm in length and the medial measuring 7 cm in length.

There are several small abrasions along the posterior right elbow region with the largest measuring 2 x 1 cm in size.

There is a small red abrasion along the upper right flank.

There is a patch of red abrasion injury along the ventral medial left wrist measuring 6 x 2 cm in size.

There is slight scraping type injury to the skin along the lateral aspect of the knuckle of the left index finger and a 4 mm superficial laceration along the medial portion of the left palm. There is a small somewhat circular burn type mark or healing abrasion along the lateral basilar portion of the right thumb.

There is a small red abrasion along the upper lateral portion of the left knee.

There is a thin scratch type mark along the distal medial portion of the right thigh just above the knee and a 2 x 1.5 cm red abrasion along the frontal portion of the right knee. There is an additional 20 x 10 mm abrasion along the medial portion of the right knee and a 10 x 2 mm scratch type mark along the inferior aspect of the right knee.

There is slight red abrasion injury along the distal medial left ankle and a small scrape type mark along the upper portion of the left instep with a larger 2 cm scraping of the skin along the more lateral distal portion of the left instep.

There is no other evidence of significant antemortem injury.

Procedure and Specimens

The organs are exposed utilizing the standard Y-shaped thoracoabdominal and posterior scalp incisions. Femoral blood, vitreous fluid, bile, urine and gastric contents are taken for toxicologic evaluation and submitted to the Forensic Toxicology Laboratory at the Albany Medical Center. Additional blood samples are also collected from the admission at Ellis Hospital on 05/11/2017 and submitted for testing if required. An additional lavender top blood sample tube is retained for further testing if needed. Representative portions of the major viscera are retained in formalin and appropriate sections processed for microscopic slides. Pertinent findings at autopsy are recorded by digital photographs by the officers present. Present at the autopsy are Investigator Ronald Enfield of the Attorney General's Office, Senior Investigator Drew McDonald, Investigator Timothy Ayers, Investigator Erin Manns and Trooper Ryan Bishop of the New York State Police and Schenectady County Medicolegal Death Investigator Ms. Laura Nealon. A copy of the decedent's recent emergency room records from Ellis Hospital is received with the decedent and lists the decedent's name and medical [redacted] Additional records are also received from the Schenectady New York Fire Department EMS Service and list REMO Run 14751. Copies of portions

of the decedent's medical records from the New York State Department of Corrections are also later received and evaluated and list the decedent's name and DIN number of [redacted] Copies of multiple supporting depositions are also available for review including copies of statements from Molly S. Winch, Mark E. Weekes (DOB [redacted]), Daniel A. Coppola, Ryan Macherone, Ross S. Flood, Michael McLaughlin, Theresa Carr [redacted] Joseph J. Vanblarcom ([redacted] Ann Von Stetina ([redacted] Dean M. DeMartino ([redacted] and Brandon S. Kietlinski. Several DVD discs are also available for review including camera footage and radio transmissions of the decedent in the patrol car when he became unresponsive, images of the decedent at the police station and from another vehicle as the decedent was apprehended. Fingerprints were obtained prior to autopsy for confirmation of identity. X-rays are not taken of evaluated. The decedent's t-shirt is retained by the officers present but no additional material is retained as evidence. The autopsy is assisted by autopsy assistants Mrs. Sarah Bourdon and Ms. Sarah Strakosch.

Internal Examination

Thoracoabdominal incision reveals 3 to 4 cm of normal appearing abdominal panniculus. The thoracic and abdominal viscera have normal anatomic relationships with no evidence of trauma.

Body Cavities

There are no significant fluids in the pleural or peritoneal cavities. There are no adhesions.

Musculoskeletal System

The skeletal muscles are firm and normally developed. There are fractures along the anterior lateral aspects of left ribs 2, 3, and 4 with hemorrhage and right ribs 2 and 3 with slight hemorrhage along the anterior and lateral aspects. There is a fracture through the sternum between the insertion of the 2nd and 3rd ribs without significant hemorrhage. The fractures are consistent with resuscitation. There are no additional fractures noted.

Neck Organs

The larynx and thyroid gland are unremarkable. The thyroid is homogeneously tan/brown without nodularity. The laryngeal cartilages and hyoid bone are intact. There are no laryngeal hemorrhages or hemorrhages in the soft tissues of the neck. There is a small amount of purple hemorrhage along the right posterior aspect of the tongue. The carotid arteries and jugular veins are intact. The cervical spine is intact.

Respiratory System

The right lung weighs 1200 grams, the left 1020 grams. The pleural surfaces are smooth and glistening. There is severe vascular congestion. There is minimal anthracotic pigmentation bilaterally and there are no focal lesions. The tracheobronchial and arterial trees are unremarkable. No aspirated material or thromboemboli are found.

Cardiovascular System

The pericardial sac is intact and contains a few mls of normal serous pericardial fluid. The heart is significantly enlarged at 560 grams and has a glistening epicardial surface and a normal amount of epicardial fat. The myocardium is firm and red/brown and shows no focal lesions. The left ventricular chamber is reduced in size due to concentric left ventricular hypertrophy. The remaining cardiac chambers are of normal size and contain clotted blood. The right ventricle measures 3 mm and the left ventricle measures up to 20 mm in concentric thickness. The cardiac valves are normally formed and appear in good functional condition with thin pliable valve leaflets and thin discrete tendineae chordae. The mitral valve measures 11 cm, the tricuspid 13 cm. the pulmonary 8.2 cm and the aortic 8.2 cm in circumference. The endocardium is smooth and glistening and there is patchy subendocardial purple infarction along the upper portion of the left ventricle. The coronary arteries arise normally and follow their normal distribution. The ostium of the right coronary artery and the artery itself is small in diameter. The diameters of the left common, left anterior descending coronary artery and circumflex coronary artery are all of normal size. There is no evidence of significant atheromatous plaque formation. The atria and appendages are normal. The aorta is of normal caliber and branching distribution and is intact with no significant atherosclerosis. The vena cavae is intact and unremarkable.

Liver and Biliary Tree

The liver is enlarged at 2610 grams and has a smooth capsule and normal brown lobular architecture. Upon sectioning there are no focal lesions. There is no evidence of fibrosis or cirrhosis. The gallbladder is intact and contains approximately 30

mls of green/brown bile without stones. The remainder of the extrahepatic biliary system is unremarkable.

Spleen

The spleen weighs 270 grams and has a smooth thin intact capsule. The parenchyma is firm with indistinct white pulp.

Pancreas

Firm lobulated tan parenchyma.

Adrenals

Thin bright yellow/orange cortical ribbons and tan medullae.

Genitourinary System

The right kidney weighs 150 grams, the left 180 grams. The capsules strip easily to reveal smooth purple cortical surfaces. There are no parenchymal lesions. The ureters are patent into the bladder, which contains a trace of yellow urine and is otherwise unremarkable. The prostate gland is not enlarged. Both testes are palpable in the scrotal sac and are removed and show no evidence of injury or natural disease.

Gastrointestinal System

The esophagus is unremarkable. The stomach contains 100 to 120 mls of reddish fluid without identifiable digestate. There are no recognizable fragments of tablets or capsules. The mucosa and rugae are flat and autolyzed but otherwise unremarkable. The small and large intestines and appendix have a normal configuration and are otherwise unremarkable.

Brain

The scalp is retracted by an intermastoidal incision. There are no subgaleal hemorrhages. The bones of the calvarium and base of the skull are intact. The fresh brain weighs 1460 grams. The cerebral hemispheres are symmetric with a moderate diffuse cerebral edema. There is no evidence of a midline shift. There is no evidence of epidural, subdural or subarachnoid hemorrhage. The meninges are clear. The cerebral vasculature is intact and shows no significant atherosclerosis or vascular anomalies. Serial coronal sections through the cerebrum, cerebellum and brainstem reveal no focal lesions. Stripping the dura reveals no fractures. The pituitary gland is not enlarged.

Microscopic Examination (slides 1-35)

Portions of the major internal organs are examined microscopically including sections of brain, heart, lungs, liver, kidneys and additional tissues and organs as required. Sections of the adrenal glands and thyroid gland are unremarkable. A portion of liver reveals only acute passive congestion. Sections of the kidneys reveal vascular congestion with a normal renal architecture. No significant crystals are noted under polarized light examination. A section of prostate gland is unremarkable. Sections of the lungs reveal normal appearing airspaces and airways without evidence of significant blockage or inflammation. A few areas do display increased numbers of foreign body macrophages in the alveolar spaces. A section of the tongue does reveal slight hemorrhage in the submucosal tissue and more extensive acute hemorrhage in the

deeper muscular tissue. A section of stomach is unremarkable. Sections of the brain including portions of cerebral cortex, cerebellum, midbrain and medulla are unremarkable. A portion of basal ganglia of the brain does reveal a few small specs of calcification around blood vessels with no other significant abnormalities. A section of pancreas reveals diffuse postmortem autolysis. Sections of the testes show no evidence of significant natural disease or injury. A portion of spleen reveals acute congestion. A section of trachea is unremarkable. Sections of the myocardium of the left ventricle reveal scattered very small foci of interstitial fibrosis and areas of myocyte nuclear and cytoplasmic hypertrophy with elongated myocyte nuclei (boxcar nuclei). There is evidence of focal fiber splitting and fiber separation. There is evidence of acute subendocardial congestion and focal infarction but no evidence of significant deeper ischemic injury. A section of right ventricular myocardium reveals only mild fatty infiltration.

Anatomic Diagnoses

I. Cardiac arrhythmia due to cardiomegaly and left ventricular hypertrophy.
   a. History of decedent suddenly becoming unresponsive while transported in a police patrol car and after complaints of dyspnea.
   b. History of exertion while avoiding capture by police with markings of the skin consistent with climbing over fencing during pursuit.
   c. Significantly enlarged appearing heart (560 grams) with left ventricular hypertrophy (approximately 20 mm, concentric).

i. Gross and microscopic evidence of subendocardial infarction of the left ventricle consistent with acute ischemia.

ii. Microscopic evidence of myocyte nuclear and cytoplasmic hypertrophy, mild interstitial fibrosis and fiber splitting.

d. Medical history of hypertension with hydrochlorothiazide prescribed to the decedent.

i. Blood pressure taken on 04/03/17 of 159 over 103.

ii. Blood pressures taken on 02/08/17 of 171 over 111 and 133 over 94.

iii. Multiple other prior readings of elevated blood pressure.

II. No evidence of significant antemortem injury or other significant natural disease.

FORENSIC TOXICOLOGY REPORT

ALBANY MEDICAL CENTER, 43 NEW SCOTLAND AVENUE
ALBANY, NEW YORK 12208-3478 (518) 262-3523
N.Y.S. FORENSIC LABORATORY PERMIT #PFI 1899
ACCREDITED BY THE AMERICAN BOARD OF FORENSIC TOXICOLOGY

LABORATORY DIRECTORS
Thomas G. Rosano PhD, DABFT
Thomas A. Swift PhD

Subject: Kearse, Andrew
[redacted]
Case Number: FT17-205
[redacted]
DOD: 05/11/2017
Collect Date: 05/12/2017
Received Date: 05/16/2017
Report Date: 06/05/2017

Agency: Schenectady Medical Examiner
Address: Nadarajah Balasubramaniam
Ellis Hospital Dept. of Pathology
Schenectady, NY 12309
Requestor: Dr. Michael Sikirica
Address: Forensic Medical Services
50 Broad Street
Waterford, NY 12188

Test Results

Initial Tests:	Sample	Result	Detection Limit/Unit	Method
Chloride	Vitreous Humor	137	mEq/L	Ion Selective Electrode
Glucose	Vitreous Humor	16	mg/dL	Spectrophotometry
Ketones	Vitreous Humor	Negative	Detection Limit 100 mg/dl	Color Spot Test
Potassium	Vitreous Humor	12	mEq/L	Ion Selective Electrode
Sodium	Vitreous Humor	158	mEq/L	Ion Selective Electrode
Urea Nitrogen	Vitreous Humor	9	mg/dL	Spectrophotometry
Creatinine	Vitreous Humor	0.57	mg/dl	Spectrophotometry
Confirmatory Testing:				
NMS General Unknown Screen	Blood, Femoral	See NMS Labs Report	See NMS Report	See NMS Report
Synthetic Cannabinoids	Blood, Femoral	See NMS Report	See NMS Report	See NMS Report

Specimens

SAMPLE #	TYPE	COLLECTION	AMOUNT
1	Plasma, Premortem	Fluoride/Oxalate (gray top vacutainer tube)	1.0 grams
	Comment: Specimen drawn on 05/11/2017 at 1757		
2	Plasma, Premortem	Heparin (green top vacutainer tube)	4.2 grams
	Comment: Specimen drawn on 05/11/2017 at 1758		
3	Serum, Premortem	No Preservatives	4.7 grams
	Comment: Specimen drawn on 05/11/2017 at 1757		
4	Plasma, Premortem	EDTA (lavender top vacutainer tube)	3.9 grams
	Comment: Specimen drawn on 05/11/2017 at 1757		
5	Plasma, Premortem	Citrate (light blue top vacutainer tube)	4.3 grams
	Comment: Specimen drawn on 05/11/2017 at 1757		
6	Plasma, Premortem	Fluoride/Oxalate (gray top vacutainer tube)	0.9 grams
	Comment: Specimen drawn on 05/11/2017 at 1756		
7	Plasma, Premortem	Fluoride/Oxalate (gray top vacutainer tube)	1.2 grams
	Comment: Specimen drawn on 05/11/2017 at 1905		
8	Plasma, Premortem	Fluoride/Oxalate (gray top vacutainer tube)	0.8 grams
	Comment: Specimen drawn on 05/11/2017 at 1905		
9	Blood, Femoral	Fluoride/Oxalate (gray top vacutainer tube)	5.8 grams
10	Blood, Femoral	Fluoride/Oxalate (gray top vacutainer tube)	5.8 grams
11	Blood, Femoral	Fluoride/Oxalate (gray top vacutainer tube)	5.7 grams
12	Blood, Femoral	Fluoride/Oxalate (gray top vacutainer tube)	5.3 grams
13	Blood, Femoral	Fluoride/Oxalate (gray top vacutainer tube)	5.2 grams
14	Blood, Femoral	EDTA (lavender top vacutainer tube)	1.1 grams
15	Urine	No Preservatives	4.7 grams
16	Vitreous Humor	No Preservatives	4.5 grams
17	Bile	No Preservatives	4.9 grams
18	Gastric Contents	No Preservatives	68.2 grams

Comments:

NMS testing performed at 3701 Welsh Road, Willow Grove PA 19090 (06/05/17)

I certify that the specimen(s) identified by the name and/or referring number above have been examined upon receipt, determined to be acceptable unless otherwise noted, analyzed in accordance with New York State Health Department regulations, and that the results set forth are for those specimen(s). Documentation of chain of custody throughout collection, transport, laboratory receipt and testing was reviewed and found to be acceptable, unless otherwise noted. Positive specimens are retained for a minimum of one year, unless otherwise requested. This report has an associated forensic toxicology case file.

Thomas G. Rosano PhD, DABFT
Certifying Scientist (Print)

Certifying Scientist (Signature)

06/05/2017
Date

NMS Labs
3701 Welsh Road, PO Box 433A, Willow Grove, PA 19090-0437
Phone (215) 657-4900 Fax: (215) 657-2972
e-mail: nms@nmslabs.com
Robert A. Middleberg, PhD, F-ABFT, DABCC-TC, Laboratory Director

CONFIDENTIAL

Supplemental Report

Report Issued 06/05/2017 12:01
Last Report Issued 05/25/2017 17:04

To: **30037**
Albany Medical Center
Forensic Toxicology Lab
43 New Scotland/M.C. 22
Albany, NY 12208

Patient Name KEARSE, ANDREW
Patient ID FT17-205/MS-17-249
Chain 17154458
Age Not Given **DOB** Not Given
Gender Not Given
Workorder 17154458

Positive Findings:

Compound	Result	Units	Matrix Source
Atropine	Positive	ng/mL	001 - Femoral Blood
Nicotine	Positive	ng/mL	001 - Femoral Blood
Cotinine	Positive	ng/mL	001 - Femoral Blood
Delta-9 THC	6.2	ng/mL	001 - Femoral Blood

See Detailed Findings section for additional information

Testing Requested:

Analysis Code	Description
6092B	Postmortem, Expert, Blood (Forensic)
9566B	Postmortem, Synthetic Cannabinoids (Add-On), Blood

Specimens Received:

ID	Tube/Container	Volume/ Mass	Collection Date/Time	Matrix Source	Miscellaneous Information
001	Gray Vial	5 mL	05/12/2017 11:08	Femoral Blood	
002	Gray Vial	5 mL	05/12/2017 11:08	Femoral Blood	

All sample volumes/weights are approximations.

Specimens received on 05/18/2017

Detailed Findings:

Analysis and Comments	Result	Units	Rpt. Limit	Specimen Source	Analysis By
Atropine	Positive	ng/mL	12	001 - Femoral Blood	GC/MS
Nicotine	Positive	ng/mL	12	001 - Femoral Blood	GC/MS
Cotinine	Positive	ng/mL	12	001 - Femoral Blood	GC/MS
Delta-9 THC	6.2	ng/mL	0.50	001 - Femoral Blood	LC-MS/MS

Other than the above findings, examination of the specimen(s) submitted did not reveal any positive findings of toxicological significance by procedures outlined in the accompanying Analysis Summary.

Reference Comments:

1 Atropine (d,l-Hyoscyamine) - Femoral Blood:

Atropine is an anticholinergic alkaloid used in pre-anesthetic therapy to control airway secretions and as an antispasmodic to control gastrointestinal spasms. It is frequently used as an antidote in the treatment of anticholinesterase-type pesticides. It can be obtained naturally from deadly nightshade or jimson weed. Atropine is also used in resuscitative attempts. The reported qualitative result for this substance is indicative of a finding commonly seen following a resuscitative attempt and is usually not toxicologically significant. If confirmation testing is required please contact the laboratory.

2 Cotinine - Femoral Blood:

Cotinine is a metabolite of nicotine and may be encountered in the fluids and tissues of an individual as a result of tobacco exposure. Anabasine is a natural product occurring in tobacco, but not in pharmaceutical nicotine and a separate test for anabasine in urine can be used to distinguish tobacco from pharmaceutical nicotine use. The reported qualitative result for this substance is indicative of a finding commonly seen following typical use and is usually not toxicologically significant. If confirmation testing is required please contact the laboratory.

3. Delta-9 THC (Active Ingredient of Marijuana) - Femoral Blood:

Marijuana is a DEA Schedule I hallucinogen. Pharmacologically, it has depressant and reality distorting effects. Collectively, the chemical compounds that comprise marijuana are known as Cannabinoids.

Delta-9-THC is the principle psychoactive ingredient of marijuana/hashish. It rapidly leaves the blood, even during smoking, falling to below detectable levels within several hours. Delta-9-carboxy-THC (THCC) is the inactive metabolite of THC and may be detected for up to one day or more in blood. Both delta-9-THC and THCC may be present substantially longer in chronic users.
THC concentrations in blood are usually about one-half of serum/plasma concentrations. Usual peak levels in serum for 1.75% or 3.55% THC marijuana cigarettes: 50 - 270 ng/mL at 6 to 9 minutes after beginning smoking, decreasing to less than 5 ng/mL by 2 hrs.

4. Nicotine - Femoral Blood:

Nicotine is a potent alkaloid found in tobacco leaves at about 2 - 8% by weight. It is also reportedly found in various fruits, vegetables and tubers, e.g., tomatoes and potatoes, but at a smaller per weight fraction. As a natural constituent of tobacco, nicotine is found in all commonly used smoking or chewing tobacco products. It is also in smoking cessation products, e.g., patches. Nicotine has been used as a pesticide, although not as widely since the advent of more effective agents. Toxic effects of nicotine overdose include nausea, vomiting, dizziness, sweating, miosis, EEG and ECG changes, tachycardia, hypertension, respiratory failure, seizures and death. Anabasine is a natural product occurring in tobacco, but not in pharmaceutical nicotine. A separate test for anabasine in urine can be used to distinguish tobacco from pharmaceutical nicotine use. The reported qualitative result for nicotine is indicative of a finding commonly seen following typical use and is usually not toxicologically significant. If confirmation testing is required please contact the laboratory.

Unless alternate arrangements are made by you, the remainder of the submitted specimens will be discarded six (6) months from the date of this report; and generated data will be discarded five (5) years from the date the analyses were performed.

Workorder 17154458 was electronically signed on 06/05/2017 11:09 by:

Edward J. Barbieri, Ph.D.
Forensic Toxicologist

Analysis Summary and Reporting Limits:

All of the following tests were performed for this case. For each test, the compounds listed were included in the scope. The Reporting Limit listed for each compound represents the lowest concentration of the compound that will be reported as being positive. If the compound is listed as None Detected, it is not present above the Reporting Limit. Please refer to the Positive Findings section of the report for those compounds that were identified as being present.

Acode 52198B - Cannabinoids Confirmation, Blood (Forensic) - Femoral Blood

-Analysis by High Performance Liquid Chromatography/ TandemMass Spectrometry (LC-MS/MS) for:

Compound	Rpt. Limit	Compound	Rpt. Limit
11-Hydroxy Delta-9 THC	1.0 ng/mL	Delta-9 THC	0.50 ng/mL
Delta-9 Carboxy THC	5.0 ng/mL		

Acode 8092B - Postmortem, Expert, Blood (Forensic) - Femoral Blood

-Analysis by Enzyme-Linked Immunosorbent Assay (ELISA) for:

Compound	Rpt. Limit	Compound	Rpt. Limit
Benzodiazepines	100 ng/mL	Opiates	20 ng/mL
Buprenorphine / Metabolite	0.50 ng/mL	Oxycodone / Oxymorphone	10 ng/mL
Cannabinoids	10 ng/mL	Salicylates	120 mcg/mL
Cocaine / Metabolites	20 ng/mL		

-Analysis by Gas Chromatography/Mass Spectrometry (GC/MS) for: Anesthetics, Anticoagulant Agents, Antifungal Agents, Antihypertensive Agents, Anxiolytics (Benzodiazepine and others), Hypnosedatives (Barbiturates, Non-Benzodiazepine Hypnotics, and others) and Non-Steroidal Anti-Inflammatory Agents (excluding Salicylate).

-Analysis by Gas Chromatography/Mass Spectrometry (GC/MS) for: The following is a general list of compound classes included in the Gas Chromatographic screen. The detection of any particular compound is concentration-dependent. Please note that not all known compounds included in each specified class or heading are included. Some specific compounds outside these classes are also included. For a detailed list of all compounds and reporting limits included in this screen, please contact NMS Labs.
Amphetamines, Analgesics (opioid and non-opioid), Anorectics, Antiarrhythmics, Anticholinergic Agents, Anticonvulsant Agents, Antidepressants, Antiemetic Agents, Antihistamines, Antiparkinsonian Agents, Antipsychotic Agents, Antitussive Agents, Antiviral Agents, Calcium Channel Blocking Agents, Cardiovascular Agents (non-digitalis), Local Anesthetics Agents, Muscle Relaxants and Stimulants (Amphetamine-like and others).

-Analysis by Headspace Gas Chromatography (GC) for:

Compound	Rpt. Limit	Compound	Rpt. Limit
Acetone	5.0 mg/dL	Isopropanol	5.0 mg/dL
Ethanol	10 mg/dL	Methanol	5.0 mg/dL

Acode 9566B - Postmortem, Synthetic Cannabinoids (Add-On), Blood - Femoral Blood

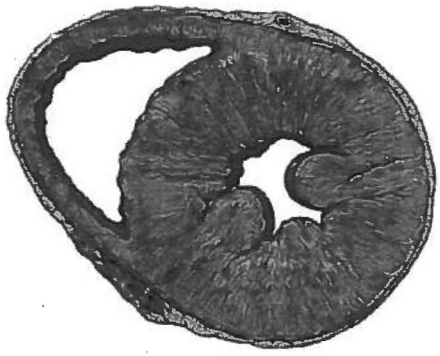
Left ventricular hypertrophy

From Wikipedia, the free encyclopedia

Left ventricular hypertrophy (LVH) is thickening of the heart muscle of the left ventricle of the heart, that is, left-sided ventricular hypertrophy.

Contents

Left ventricular hypertrophy



A heart with left ventricular hypertrophy in short-axis view

Classification and external resources

Specialty	Cardiology
ICD-10	I51.7 (http://apps.who.int/classifications/icd10/browse/2016/en#/I51.7)
ICD-9-CM	429.3 (http://www.icd9data.com/getICD9Code.ashx?icd9=429.3)
DiseasesDB	7659 (http://www.diseasesdatabase.com/ddb7659.htm)
MeSH	D017379 (https://www.nlm.nih.gov/cgi/mesh/2017/MB_cgi?field=uid&term=D017379)

Causes

While ventricular hypertrophy occurs naturally as a reaction to aerobic exercise and strength training, it is most frequently referred to as a pathological reaction to cardiovascular disease, or high blood pressure.[1] It is one aspect of ventricular remodeling.

While LVH itself is not a disease, it is usually a marker for disease involving the heart.[2] Disease processes that can cause LVH include any disease that increases the afterload that the heart has to contract against, and some primary diseases of the muscle of the heart.

Causes of increased afterload that can cause LVH include aortic stenosis, aortic insufficiency and hypertension. Primary disease of the muscle of the heart that cause LVH are known as hypertrophic cardiomyopathies, which can lead into heart failure.

Long-standing mitral insufficiency also leads to LVH as a compensatory mechanism.

Diagnosis

The principal method to diagnose LVH is echocardiography, with which the thickness of the muscle of the heart can be measured. The electrocardiogram (ECG) often shows signs of increased voltage from the heart in individuals with LVH, so this is often used as a screening test to determine who should undergo further testing.

Echocardiography

Two dimensional echocardiography can produce images of the left ventricle. The thickness of the left ventricle as visualized on echocardiography correlates with its actual mass. Normal thickness of the left ventricular myocardium is from 0.6 to 1.1 cm (as measured at the very end of diastole. If the myocardium is more than 1.1 cm thick, the diagnosis of LVH can be made.

ECG criteria

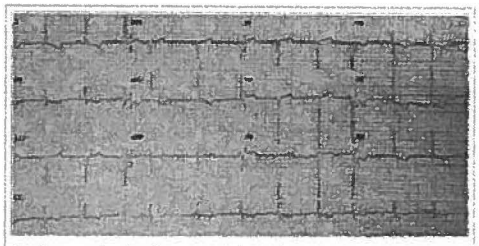
There are several sets of criteria used to diagnose LVH via electrocardiography.[3] None of them is perfect, though by using multiple criteria sets, the sensitivity and specificity are increased.

The **Sokolow-Lyon index**:[4][5]

- S in V_1 or V_2 + R in V_5 or V_6 (whichever is larger) ≥ 35 mm (≥ 7 large squares)
- R in aVL ≥ 11 mm

The **Cornell voltage criteria**[6] for the ECG diagnosis of LVH involve measurement of the sum of the R wave in lead aVL and the S wave in lead V_3. The Cornell criteria for LVH are:

- S in V_3 + R in aVL > 28 mm (men)
- S in V_3 + R in aVL > 20 mm (women)



Left ventricular hypertrophy with secondary repolarization abnormalities as seen on ECG

The **Romhilt-Estes point score system** ("diagnostic" >5 points; "probable" 4 points):

ECG Criteria	Points
Voltage Criteria (any of):	
1. R or S in limb leads ≥20 mm 2. S in V_1 or V_2 ≥30 mm 3. R in V_5 or V_6 ≥30 mm	3
ST-T Abnormalities:	
▪ ST-T vector opposite to QRS without digitalis	3
▪ ST-T vector opposite to QRS with digitalis	1
Negative terminal P mode in V_1 1 mm in depth and 0.04 sec in duration (indicates left atrial enlargement)	3
Left axis deviation (QRS of -30° or more)	2
QRS duration ≥0.09 sec	1
Delayed intrinsicoid deflection in V_5 or V_6 (>0.05 sec)	1

Other voltage-based criteria for LVH include:

- Lead I: R wave > 14 mm
- Lead aVR: S wave > 15 mm
- Lead aVL: R wave > 12 mm
- Lead aVF: R wave > 21 mm
- Lead V_5: R wave > 26 mm
- Lead V_6: R wave > 20 mm

Treatment

The enlargement is not permanent in all cases, and in some cases the growth can regress with the reduction of blood pressure.[7]

LVH may be a factor in determining treatment or diagnosis for other conditions. For example, LVH causes a patient to have an irregular ECG. Patients with LVH may have to participate in more complicated and precise diagnostic procedures, such as imaging, in situations in which a physician could otherwise give advice based on an ECG.[8][9]

Associated genes

- OGN, osteoglycin

See also

- Cardiomegaly
- Ventricular hypertrophy
- Primary hyperparathyroidism

References

1. "Ask the doctor: Left Ventricular Hypertrophy" (http://www.clevelandclinic.org/heartcenter/pub/guide/a Retrieved 2007-12-07.
2. Meijs MF, Bots ML, Vonken EJ, et al. (2007). "Rationale and design of the SMART Heart study: A prediction model for left ventricular hypertrophy in hypertension" (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1995

Neth Heart J. **15** (9): 295–8. doi:10.1007/BF03086003 (https://doi.org/10.1007%2FBF03086003). PMC 1995099 (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1995099) ⓐ. PMID 18030317 (https://www.ncbi.nlm.nih.gov/pubmed/18030317).
3. "Lesson VIII - Ventricular Hypertrophy" (http://library.med.utah.edu/kw/ecg/ecg_outline/Lesson8 Retrieved 2009-01-07.
4. Sokolow M, Lyon TP. The ventricular complex in left ventricular hypertrophy as obtained by unipolar precordial and limb leads. Am Heart J. 1949;37:161–186.
5. "Time-Voltage QRS Area of the 12-Lead Electrocardiogram : Detection of Left Ventricular Hypertrophy -- Okin et al. 31 (4): 937 -- Hypertension" (http://hyper.ahajournals.org/cgi/content/full/31/4/937#I Retrieved 2007-12-07.
6. Casale PN, Devereux RB, Alonso DR, Campo E, Kligfield P (1987). "Improved sex-specific criteria of left ventricular hypertrophy for clinical and computer interpretation of electrocardiograms: validation with autopsy findings". *Circulation.* **75** (3): 565–72. doi:10.1161/01.CIR.75.3.565 (https://doi.org/10.1161%2F01.CIR.75.3.565). PMID 2949887 (https://www.ncbi.nlm.nih.gov/pubmed/2949887).
7. Gradman AH, Alfayoumi F (2006). "From left ventricular hypertrophy to congestive heart failure: management of hypertensive heart disease". *Prog Cardiovasc Dis.* **48** (5): 326–41. doi:10.1016/j.pcad.2006.02.001 (https://doi.org/10.1016%2Fj.pcad.2006.02.001). PMID 16627048 (https://www.ncbi.nlm.nih.gov/pubmed/16627048).
8. American Society of Nuclear Cardiology, "Five Things Physicians and Patients Should Question" (https://web.archive.org/web/20120416220538/http://choos content/uploads/2012/04/5things_12_factsheet_Amer_Soc_Nuc_Carc (PDF), *Choosing Wisely: an initiative of the ABIM Foundation*, American Society of Nuclear Cardiology, archived from the original (http://choosingwisely.org/wp-content/uploads/2012/04/5things_12_factsheet_Amer_Soc_Nuc_Carc (PDF) on April 16, 2012, retrieved August 17, 2012
9. Anderson, J. L.; Adams, C. D.; Antman, E. M.; Bridges, C. R.; Califf, R. M.; Casey, D. E.; Chavey, W. E.; Fesmire, F. M.; Hochman, J. S.; Levin, T. N.; Lincoff, A. M.; Peterson, E. D.; Theroux, P.; Wenger, N. K.; Wright, R. S. (2007). "ACC/AHA 2007 Guidelines for the Management of Patients with Unstable Angina/Non-ST-Elevation Myocardial Infarction: Executive Summary: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Writing Committee to Revise the 2002 Guidelines for the Management of Patients with Unstable Angina/Non-ST-Elevation Myocardial Infarction): Developed in Collaboration with the American College of Emergency Physicians, the Society for Cardiovascular Angiography and Interventions, and the Society of Thoracic Surgeons: Endorsed by the American Association of Cardiovascular and Pulmonary Rehabilitation and the Society for Academic Emergency Medicine". *Circulation.* **116** (7): 803. doi:10.1161/CIRCULATIONAHA.107.185752 (https://doi.org/10.1161%2FCIRCULATIONAHA.107.185752).

EXHIBIT 7

Yale
NewHaven
Health
Bridgeport
Hospital

September 18, 2018

Nicholas N. Viorst
Deputy Chief- Special Investigations and Prosecutions Unit
New York State Attorney General's Office
120 Broadway
New York, New York, 10271-0332

Re: Review of death of Andrew Kearse

Dear Mr. Viorst,

Your office has asked me to render a professional opinion, to as high a degree of medical certainty as possible, as to whether at any time after he was taken into custody, Andrew Kearse's death or other serious physical injury could have been prevented with appropriate medical intervention. You have defined "serious physical injury" for me as "impairment of a person's physical condition which creates a substantial risk of death, which causes death or serious and protracted disfigurement, protracted impairment of health, or protracted loss or impairment of the function of any bodily organ, or severe and prolonged physical pain."

I am currently Chief of Cardiovascular Medicine at Bridgeport Hospital and an Associate Clinical Professor of Medicine at Yale University School of Medicine. I am active in clinical cardiology and have several decades of experience as a medical expert in the field of cardiology.

I have reviewed the following records, which, in addition to my expertise, form the basis of my opinion:

1. Medical records of Andrew Kearse from Rikers Island (2011-2015)
2. Medical records of Andrew Kearse from Dept. of Correction (2015-2017)
3. Medical records of Andrew Kearse from Ellis Hospital (May 11, 2017)
4. Video footage related to the death of Andrew Kearse
5. Autopsy report of Andrew Kearse performed on 5/12/17 by Michael Sikirica, MD
6. Death certificate of Andrew Kearse

Cardiology Department
267 Grant Street
P.O. Box 5000
Bridgeport, CT 06610-0120

Phone: 203-384-3844
Fax: 203-330-7497

bridgeporthospital.org

Andrew Kearse was a 36-year-old male who died on May 11, 2017, at Ellis Hospital in Schenectady, New York. Earlier that same day, Mr. Kearse was driving a car in Schenectady and was pursued by a police car attempting to pull him over. The car driven by Mr. Kearse eventually pulled into a residential driveway, and he fled from the police officer on foot. After a short chase, Mr. Kearse was taken into custody, placed in the back seat of a police patrol car, and, following a stop of approximately five minutes, transported to the police station.[1] During the approximately five-minute stop, Mr. Kearse was initially alone in the police car for over two minutes, and started to complain of shortness of breath and to appear restless. After roughly five minutes, the police officer returned to the patrol car and began to drive to the station, at which point he told Mr. Kearse to slow down and take deep breaths and verbally attributed Mr. Kearse's physical condition to his flight from the police. Mr. Kearse continued to complain of shortness of breath, and after another nine minutes of driving, they arrived at the station house.

However, approximately three minutes prior to arrival at the station, Mr. Kearse started getting much quieter, and approximately two minutes before arrival at the station, he slumped over in the backseat and fell silent. Upon arrival at the police station, Mr. Kearse was removed from the patrol car and moved to the sidewalk, and about five minutes later, after officers had assessed Mr. Kearse's respirations and pulse, CPR was administered. By that time, EMS had been called and arrived promptly thereafter. Mr. Kearse received Narcan and was "shocked" approximately three times by an automatic defibrillator before being transferred to the hospital. In the hospital, he was noted by treating physicians to be in ventricular fibrillation and could not be successfully resuscitated. At autopsy, there was no evidence for atherosclerotic coronary artery disease (blockage with cholesterol plaque) or a blood clot in the arteries causing a typical acute myocardial infarction (heart attack). The cause of death was determined to be cardiac arrhythmia in the setting of cardiomegaly and left ventricular hypertrophy likely due to hypertension. The body of the autopsy report also notes "patchy subendocardial purple infarction," but this was not determined to have contributed to Mr. Kearse's death. Subendocardial injury is common after a cardiac arrest event due to the heart being deprived of oxygen for a prolonged period.

[1] I understand that the officers who initially apprehended Mr. Kearse reported that Mr. Kearse complained of pain in his legs and stated that he could not walk, and that the officers carried him to the police car. Difficulty walking is not typically a symptom of the cardiac condition (discussed below) from which I believe Mr. Kearse was suffering.

Cardiology Department
267 Grant Street
P.O. Box 5000
Bridgeport, CT 06610-0120

Phone: 203-384-3844
Fax: 203-330-7497

bridgeporthospital.org

Based on the factual record identified above and my own medical training and experience, I have concluded that Mr. Kearse had previously developed left ventricular hypertrophy, which is excessive thickening of the heart due to high blood pressure. This condition leads to an increased risk of malignant arrhythmias, which are in effect "extra" heartbeats which can cause a cardiac arrest. Due to both the mental stress and physical stress from fleeing the police (both the car chase and on foot), I believe Mr. Kearse developed an arrhythmia after being placed in the back seat of the patrol car, which progressed over time to his cardiac arrest. One important fact that contributes to my conclusion is that Mr. Kearse never complained of chest discomfort, which could indicate a potential heart attack. (Arrhythmia does not typically cause chest pain.) In addition, arrhythmia would explain Mr. Kearse's sensation that he could not breathe. With the heart failing to pump properly, blood backs up in the blood vessels of the lungs and fluid leaks into the lungs themselves, impeding breathing. No evidence of a heart attack or blocked coronary arteries were found at autopsy. The video from the patrol car is not of sufficient quality for me to ascertain exactly when Mr. Kearse stopped breathing or when his arrhythmia started. Given these factual uncertainties, it is difficult to reach a definitive conclusion regarding when medical intervention would have saved Mr. Kearse's life, or when medical intervention could have spared him death or other serious physical injury, as you have defined that term for me.

In general, left ventricular hypertrophy rarely leads to malignant arrhythmias and sudden death in younger, otherwise healthy patients. Accordingly, one explanation for the circumstances of Mr. Kearse's death is that Mr. Kearse in fact had early coronary disease, which could have triggered the extra heartbeats, again in the setting of mental and physical stress, and evidence of this early coronary disease was missed at autopsy. Alternatively, Mr. Kearse's coronary arteries could have gone into spasm, which is a muscular constriction of the artery, which can starve the heart muscle of oxygen. Thus, when Mr. Kearse entered the patrol car originally, he was somewhat exhausted from the chase and breathing heavily. However, by the time the officer returned to the vehicle and began to drive, Mr. Kearse should have regained his breath and started to breathe more normally, given his overall apparent physical condition and age. Because that did not occur, I believe that around the time the patrol car began driving towards the station, Mr. Kearse was likely developing an arrhythmia. Mr. Kearse initially tolerated the arrhythmia, but the irregular heartbeats set up a downward spiral in which the heart was not functioning well enough out of its normal rhythm to maintain an adequate blood pressure. Thus, around eight minutes after the patrol car began driving towards the

Cardiology Department
267 Grant Street
P.O. Box 5000
Bridgeport, CT 06610-0120

Phone: 203-384-3844
Fax: 203-330-7497

bridgeporthospital.org

station, at the 23:56 mark on the compilation video I reviewed, Mr. Kearse appeared to be unconscious.

As Mr. Kearse's blood pressure began to drop, even prior to his going unconscious, the risk of some kind of serious physical injury would arise. At some point, with an inadequate blood supply to his brain and the percentage of oxygen in the blood dropping, Mr. Kearse would be suffering from hypoxia (insufficient oxygen supply) of the brain. Although it is impossible to identify the point precisely, it is likely that Mr. Kearse had reached this point by the time he went still and silent, at about 21:50 on the video. Mr. Kearse would now be at risk, even if he were to live, of permanent brain damage. He would also be at risk of, among other serious injuries, a stroke, a permanent shutdown of the kidneys, or damage to the liver.

Ultimately, in the absence of medical therapy or electrical shock to correct the arrhythmia, Mr. Kearse would almost certainly die, as was the case here. In order to address his medical condition and substantially reduce the risk of death, the following would need to have occurred. First, Mr. Kearse would have needed to have EMS personnel arrive at his location, or get to a medical facility, as soon as possible after the arrhythmia developed. A brief history and physical exam would have been performed and an ECG would have been obtained. The ECG, with a high degree of medical certainty, would have shown a malignant arrhythmia that would have then been promptly treated with either medical therapy or electrical shock. As the electrical shocks that Mr. Kearse did receive were ineffective, I conclude that Mr. Kearse would have needed treatment earlier (prior to when he slumped over in the car and became unconscious). Thus, from the time the officer re-entered the patrol car to the time of potential life-saving intervention was approximately 10 to 12 minutes.

In summary, roughly 12 minutes transpired from the time the officer noted Mr. Kearse's breathlessness (at the 10:28 timestamp on the compilation video I reviewed) and the time he slumped over in the back of the patrol car (at the 22:30 timestamp). Approximately six minutes later, the police officers at the station began resuscitation attempts, and EMS personnel arrived shortly after. Despite resuscitation attempts (which appear to have been administered properly by the police and EMS), Mr. Kearse could not be revived. Within a reasonable degree of medical certainty, Mr. Kearse was likely to survive this event only if medical intervention to address the arrhythmia had begun before he slumped over in the back of the patrol car, apparently unconscious.

Cardiology Department
267 Grant Street
P.O. Box 5000
Bridgeport, CT 06610-0120

Phone: 203-384-3844
Fax: 203-330-7497

bridgeporthospital.org

Advance Cardiac Life Support[2] guidelines say that the "point of no return" for a patient to survive a loss of oxygen to the brain is four minutes. Within that time limit, even if the heart returns to functioning, the patient would likely have significant neurological injury, as the brain is extremely sensitive to sustaining ill effects due to loss of oxygenated blood.

As I noted before, within a reasonable degree of medical certainty, the only realistic opportunity to intervene on Mr. Kearse's arrhythmia and successfully save his life was before he slumped over in the back of the patrol car. In order to provide the necessary intervention, Mr. Kearse would have to have reached a hospital or ambulance, or at a minimum be receiving well-performed CPR with trained medical intervention soon thereafter, before that point. If that had occurred, I believe there is a high likelihood that Mr. Kearse would have survived, and a 70% to 80% chance of surviving without any residual brain damage.

Given that Mr. Kearse did not complain of chest pain, nor did the autopsy reveal any evidence of serious coronary blockage, this is a very unusual case of sudden cardiac death in the setting of excess thickening of the heart from high blood pressure. His only symptom was shortness of breath, which was apparently attributed to his recent chase with the police. Moreover, Mr. Kearse was a relatively young man who had demonstrated he was physically capable of running and jumping fences, and was exhibiting symptoms that did not have the hallmarks of a classic cardiac incident (but were, for example, equally consistent with a panic attack, absent further medical assessment).

Had I encountered Mr. Kearse with these symptoms – in particular, with complaints of difficulty breathing – I would likely have as an initial matter probed him for further details about his condition (e.g,, did he have chest pain? Heart palpitations? Was he coughing up blood? Did it hurt to take a deep breath?). The answers to these questions might have helped determine whether Mr. Kearse was suffering from a cardiac condition. But because sometimes the only symptom of arrhythmia is shortness of breath, it is unclear whether I would have been able to elicit any medically useful information from Mr. Kearse from these questions. Even I, as a trained cardiologist, would not

---

[2] Advance Cardiac Life Support (or "ACLS") refers to a set of clinical interventions for the urgent treatment of cardiac arrest, stroke, and other life-threatening medical emergencies, as well as the knowledge and skills to deploy those interventions.

Cardiology Department
267 Grant Street
P.O. Box 5000
Bridgeport, CT 06610-0120

Phone: 203-384-3844
Fax: 203-330-7497

bridgeporthospital.org

necessarily have recognized that Mr. Kearse required ACLS measures, absent further testing of the type available in an ambulance or hospital (e.g. an ECG machine), until the point at which he appeared to lose consciousness.

Dr. Stuart Zarich

Cardiology Department
267 Grant Street
P.O. Box 5000
Bridgeport, CT 06610-0120

Phone: 203-384-3844
Fax: 203-330-7497

bridgeporthospital.org

EXHIBIT 8

Section: General Regulations		Procedure No: 203-11	
USE OF FORCE			
DATE ISSUED: 01/01/2000	DATE EFFECTIVE: 01/01/2000	REVISION NUMBER:	PAGE: 1 of 2

USE OF FORCE

All uniformed members of the service are responsible and accountable for the proper use of force under appropriate circumstances. Members of the service are reminded that the application of force must be consistent with existing law and with New York City Police Department Values, by which we pledge to value human life and respect the dignity of each individual. Depending upon the circumstances, both federal and state laws provide for criminal sanctions and civil liability against uniformed members of the service, when force is deemed excessive, wrongful or improperly applied.

The primary duty of all members of the service is to preserve human life. Only that amount of force necessary to overcome resistance will be used to effect an arrest or take a mentally ill or emotionally disturbed person into custody. Deadly physical force will be used ONLY as a last resort and consistent with Department policy and the law.

At the scene of a police incident, many members of the service may be present and some members may not be directly involved in taking police actions. However, this does not relieve any member present of the obligation to ensure that the requirements of the law and Department regulations are complied with. Members of the service are required to maintain control or intervene if the use of force against a subject clearly becomes excessive. Failure to do so may result in both criminal and civil liability. EXCESSIVE FORCE WILL NOT BE TOLERATED.

All members of the service at the scene of a police incident must:

a. Immediately establish firearms control
b. Use minimum necessary force
c. Employ non-lethal alternatives, as appropriate.

Members of the New York City Police Department will NOT use chokeholds. A chokehold shall include, but is not limited to, any pressure to the throat or windpipe, which may prevent or hinder breathing or reduce intake of air.

Whenever it becomes necessary to take a violent or resisting subject into custody, responding officers should utilize appropriate tactics in a coordinated effort to overcome resistance (for example see *P.G. 216-05, "Aided Cases-Mentally Ill or Emotionally Disturbed Persons"*). The patrol supervisor, if present, should direct and control all activity. Whenever possible, members should make every effort to avoid tactics, such as sitting or standing on a subject's chest, which may result in chest compression, thereby reducing the subject's ability to breathe.

USE OF FORCE (continued)

Persons taken into custody (i.e., arrest, mentally ill, emotionally disturbed, etc.) shall be rear cuffed at the earliest opportunity to reduce the potential for resistance, which may cause injuries. In addition, alternate restraining devices (Velcro straps, mesh restraining blankets, etc.) shall be used, at the earliest opportunity, to restrain or further restrain a subject whose actions or behavior may cause injury to himself/herself or others.

After an individual has been controlled and placed under custodial restraint using handcuffs and other authorized methods, the person should be positioned so as to promote free breathing. The subject should not be maintained or transported in a face down position.

The member assuming custody of the subject should closely observe him or her for any apparent injuries. If the area is dark, a flashlight or other source of illumination should be used to maintain a clear view of the subject at all times.

If a person appears to be having difficulty breathing or is otherwise demonstrating life-threatening symptoms, medical assistance will be requested immediately. The patrol supervisor will direct that alternate means to maintain custody be utilized, if appropriate.

The use of restraints to "hog-tie" (restraining person by connecting or tying rear cuffed hands to cuffed or shackled ankles or legs) subjects and the transportation of subjects in a face down position within any vehicle are prohibited.

EXHIBIT 9

9-100 Adult Arrests

9-101 FELONY ARRESTS – ADULTS (05/29/02)

(A-B)

All probable cause adult felony arrests must be authorized at the scene of arrest whenever possible. In the event the supervisor is unable to respond to the scene of the arrest, authorization may be given by radio, telephone or MDT/MDC. The probable cause felony arrest may be authorized by:

- The arresting officer's supervisor, or
- An investigator from the concerned investigative unit/division, or
- Any other supervisor

Supervisors will add their remarks via MDT/MDC to indicate their approval of probable cause and also whether they made the approval at the scene or via radio/telephone or MDT/MDC.

Arrests made on the basis of warrants or PC pickups do not require supervisor's approval.

Prior to transporting arrestees to Hennepin County Adult Detention Center (HCADC), officers should consider a debriefing session. Arrestees shall be taken to HCADC for processing unless requested to be transported to the concerned investigative unit.

The Authority to Detain form (HC 6377) shall be completed. The approving supervisor's name and badge number must be listed in the remarks section of the Authority To Detain form. The name of the supervisor approving the arrest and continued detention of the suspect must be included in the narrative section of the CAPRS report.

The original will be left at the HCADC and the carbon copy shall be given to the Police Typist to accompany the CAPRS report. The 36-Hour Expiration Advisory (HC 6400) shall be completed. In order to comply with the Supreme Court imposed 48-Hour Rule, officers shall note the exact time of arrest. The time of arrest is not when the suspect was booked or when the reports were made. The original 36-Hour Expiration Advisory shall be left at HCADC and the carbon copy will be forwarded with the case to the appropriate investigative unit.

Arrests for criminal sexual conduct (CSC), including PC Pick-ups, require an officer to complete a Criminal Sexual Assault Victim Notification form (HC 6170).

9-101.01 FELONY AND GROSS MISDEMEANOR

ARREST REPORT REQUIREMENTS PUBLIC INFORMATION – JUDICIAL PROBABLE CAUSE (05/29/02)

(A-B)

For felony and gross misdemeanor arrests, the following guidelines apply:
In Supplement Zero (0) of the CAPRS data entry screen, a pre-written prompt entitled "Public Information" appears. Following this prompt, officers are to briefly detail an incident/arrest. No names, addresses or any other information that would identify a victim or witness shall be entered in this section of the report.
The next prompt is the Judicial Probable Cause Oath statement.
Following this prompt, officers shall write approximately one to two paragraphs detailing the probable cause for the arrest.
Supplement One (1) of the CAPRS report shall describe the entire incident in detail.
In cases of an arrest based on a PC arrest bulletin (PC Pick-up), officers shall attach a PC Pick-up to the CAPRS report. Copies of the PC Pick-up may be obtained from the Transcription Unit's file or MPD Net.
After administering a written or oral oath, peace officers can sign a written report of another officer for the purpose of providing probable cause for the underlying arrest.
Officers shall swear to and sign their Judicial Probable Cause statement in front of an MPD notary. Peace Officers can sign a Probable Cause statement written by another officer for the purpose of providing probable cause for arrest.
MPD notaries shall witness the swearing and signing, and after such fact, shall sign the statement with their signature, license number, and the date their license expires.
The senior officer making the arrest is responsible for making sure all Probable Cause statements are notarized.
Transcription Unit staff shall distribute the signed and sworn statements to the Criminal History Unit during weekend and holiday hours and to the investigative units during normal work hours.
Criminal History staff shall fill out the court form and attach it to the arrest report.
This policy also applies to felony arrests of juveniles and to gross misdemeanor arrests.

9-102 GROSS MISDEMEANOR ARRESTS – ADULTS (05/29/02)

(A-B)

Supervisor approval is not needed for gross misdemeanor arrests. All other felony arrest procedures apply to gross misdemeanor arrests.

9-103 MISDEMEANOR ARRESTS – ADULTS (05/29/02) (09/16/04) (09/14/18)

(A-B)

A. Non-Payable Offenses

9-300 Warrants
10-100 Crime Scene Reporting
10-200 Investigative Procedures
10-300 Investigative Case Management
10-400 Property and Evidence
Records & Reports +
Recruiting (Jobs) +
Report a Crime +

1. Adult misdemeanor violators shall be issued citations in lieu of arrest *unless* the officer believes that one of the following circumstances exists:
   a. To prevent bodily harm to the accused or another.
   b. To prevent further criminal conduct.
   c. There is a substantial likelihood that the accused will fail to respond to a citation.
   d. The officer has found that the accused has an outstanding warrant (not including Sign and Release warrants).
2. Officers making an arrest under one of the circumstances listed above must be able to articulate to the court and shall document in their report the reason(s) why it was necessary to arrest a person rather than issuing a citation.

B. Payable Offenses

When the only misdemeanor charge is a payable offense, officers shall either issue a citation or refer the case for a complaint.

C. Proper Identification

1. Proper identification includes, but is not limited to:
   - Minnesota DVS database
   - State-issued identification card or Driver's License
   - Consular ID or matricula consular
   - U.S. or foreign passport
2. In cases where a citation would be issued in lieu of arrest, and
   - The officer cannot establish proper identification of the accused person, *and*
   - The officer has a specific articulable reason to believe the identification information provided is false;

   a. The officer may transport the accused person to the Hennepin County Jail and the jail will use IBIS to identify them.
   b. Once the process is finished the officer shall issue the citation or forward for charging by complaint, *and:*
      i. Transport the person back to the original location; *or*
      ii. If requested, transport the person to another mutually agreed-upon location in Minneapolis in the general vicinity of the original location; *or*
      iii. If requested, release the person outside the Hennepin County Jail.
   c. If the person was not identified through IBIS, the officer shall still release the person after issuing the citation or forwarding for charging by complaint.
3. Officers shall document the attempts made to identify the individual, the reasons for any transport, and any requests for release or transport outside of the original location.

9-104 ARRESTS FOR DRIVING WHILE INTOXICATED (DWI) (05/29/02)

(A-B)

When suspects are arrested for DWI, they shall be taken to the Chemical Testing office, Room 19, for testing and video taping procedures. Suspects may be released after testing and issued a citation if they meet the conditions for issuing a citation in lieu of arrest.

9-104.01 ARRESTS FOR CRIMES OF VIOLENCE (05/29/02)

(A)

Minn. Stat. §629.72 requires that victims of crimes of violence be notified of an arrested person's release. Domestic assault victims must also be notified of other relevant case information.

In order to comply with these laws, officers shall complete a Crime of Violence/Attempt Crime of Violence Information Form (HC 6194). This form shall be left at HCADC when the suspect is booked.

When a juvenile is booked at the Juvenile Detention Center for a crime of violence, a Victim Information Form must be completed. The forms are available at the Juvenile Detention Center.

9-105 ARREST REPORTS/ADULT DETENTION CENTER (05/29/02)

(A)

MPD is required to provide HCADC with a copy of the arrest report. Arrest reports are automatically routed to HCADC via the CAPRS system.

In the event that the CAPRS system is down, arrest reports shall be entered off-line and printed. Officers shall deliver a photocopy of the arrest report to HCADC.

9-106 CITATIONS IN LIEU OF ARREST AND ARREST REPORTS (05/29/02) (03/17/03)

(A)

A CAPRS report must be completed when a citation is issued for the following:

- A non-traffic offense;
- A traffic offense charged in connection with an accident;
- Any citizen's arrest;
- Driving after Revocation (DAR);
- Driving after Suspension (DAS);
- Driving after Cancellation (DAC);
- On charges of DWI, Careless Driving, Reckless Driving or any violation of the Open Bottle law.

NOTE: See Volume 8 for procedures for handling Juvenile traffic, criminal and status offenses.

9-107 CITIZEN'S ARRESTS (05/29/02)

(A-B)

Citizen arrests for misdemeanor crimes can only be made when the crime was committed in the complainant's presence.

Citizens making arrests must complete a Citizen's Arrest Form (MP-3406). Security personnel from businesses that make arrests on a regular basis may be allowed to use the standard CAPRS offense report instead of the Citizen's Arrest form.

Officers shall determine whether the circumstances justify taking the accused into custody. If officers feel that the arrest is illegal, the officer shall refer the complainant to the City Attorney's Office.

If the accused is to be taken into custody, officers shall verify the identity of the complainant and assist in completing the Citizen's Arrest Report. Complainants should be advised that the City Attorney will notify them if a formal complaint is needed.

Note: See Manual Section for Citizen's Arrest - Traffic Violation.

9-108 ARREST OR DETENTION OF INJURED ADULTS (05/29/02) (05/19/08) (06/13/14)

(A-B)

A. Adult arrestees, who are in need of medical attention and are not cleared for booking by EMS or jail staff shall be transported to Hennepin County Medical Center (HCMC) or to a local hospital for medical evaluation and treatment.
B. Arrested subjects who have a high probability of requiring hospitalization, including those with known or suspected drug ingestion, shall be brought to HCMC whenever possible. Note: HCSO's contract is with HCMC and they prefer to take custody of arrestees at HCMC.
C. Officers are responsible for the custody of their arrestees while receiving medical attention.
D. If an injured arrestee is delayed at the hospital longer than the arresting officers are able to wait, officers shall contact a supervisor. Hospital personnel or hospital security will not hold or guard an arrestee.
E. Officers shall retain custody of arrested felons needing medical attention until the arrestee can be transported to HCJ.
F. In the case of felony arrestees admitted to the hospital, the arresting officers shall notify their on-duty supervisor, who shall then contact the on-duty jail supervisor to arrange for relief.
G. Officers assigned to the precinct where the arrest was made shall have custodial responsibility until properly relieved by the Hennepin County Sheriff's Office (HCSO).

9-109 HANDCUFFING ARRESTEES/DETAINEES (05/29/02)

(A-B)

All detainees/arrestees shall be handcuffed behind the back, unless a physical condition or other circumstances including sickness, injury or disability, does not allow for it. Handcuffs should also be double locked as soon as possible. Prisoners being transported to HCADC shall be handcuffed. Prisoners shall be handcuffed whenever taken outside the confines of the jail, except when handcuffing would deter the completion

of an investigation.
Plastic handcuffs may be used to supplement standard handcuffs in emergency situations. They may also be used in mass arrest situations and are available in all sergeants' vehicles. Plastic handcuffs should not be used in felony arrests or for restraining mentally ill individuals.

9-110 PRISONER CONTROL, SAFETY AND TRANSPORTATION (05/29/02) (07/19/18)

(A-B)

A. When feasible, a two-officer squad shall be used to transport a felony prisoner.

B. One-officer squads may transport misdemeanor prisoners.

C. When feasible, a two-officer squad shall transport an arrestee of the opposite sex.

1. Officers transporting an arrestee of the opposite sex shall give MECC their destination and odometer reading.
   a. Officers shall immediately notify MECC of any delay.
   b. Upon arrival at their destination, officers shall notify MECC.

D. All prisoners shall remain within sight of the transporting officers at all times until the custody of the prisoner is transferred to a responsible authority, except in emergency situations.

E. Transporting officers are responsible for ensuring the safety of their prisoners.

1. Prisoners shall be secured with fastened seatbelts during transport in any vehicle equipped with seat belts.
   a. If the vehicle is not equipped with seat belts in the transportation area, officers shall document in their report the lack of seat belts and the reason(s) that particular vehicle was used for the transport.
   b. If circumstances prevent officers from safely securing the prisoner, the prisoner will be transported unsecured. The officers must document the specific reason(s) for the unsecured transport in their report.
2. Transporting officers shall not stop or interrupt prisoner transport responsibilities unless exigent circumstances exist and the risk to the prisoner is minimal.
3. Under no circumstances shall a prisoner be transported in the prone position. (06/13/14)

F. When transporting prisoners to a detention facility, officers shall comply with MPD rules, regulations and requirements until the prisoner is secure within the destination facility. Officers will then comply with the rules, regulations and procedures of the receiving facility. (06/13/14)

G. Once the subject is secured, an officer shall watch for any of the following signs: (06/13/14)

- Significant change in behavior or level consciousness;
- Shortness of breath or irregular breathing;
- Seizures or convulsions;

- Complaints of serious pain or injury; and/or
- Any other serious medical problem.

H. If officers observe any serious medical issue, they shall immediately contact EMS or transport directly to a local hospital. Officers shall also notify a supervisor. (06/13/14)

I. In the event of a prisoner escape during transport, the transporting officers shall immediately do the following:

1. Notify the dispatcher of the event and location.
2. Attempt pursuit if possible.
3. Notify a supervisor or proper jurisdictional authority of the escape.
4. Complete the original arrest report, noting the escape from custody.

9-111 LEGISLATIVE IMMUNITY (05/29/02)

(A)

Officers shall observe legislators' privilege from arrest as set forth in the State of Minnesota Constitution, Article IV, Section 10:
"The members of each house shall in all cases, except treason, felony, and breach of the peace be privileged from arrest during the session of their respective houses, and in going to or returning from the same."

9-112 DIPLOMATIC AND CONSULAR IMMUNITY (05/29/02)

(A)

Under international and federal law, diplomatic and consular officials are granted varying degrees of immunity and personal inviolability (i.e. freedom from arrest, detention, search etc.) depending on the position they hold. However, the privilege of personal inviolability must be balanced with the responsibility of the United States and its government bodies to protect the safety of its citizens. Police authorities may intervene to the extent necessary to halt activity that poses imminent danger to the safety of the public or when it is apparent that a serious crime may otherwise be committed.

1. Diplomatic agents, family members recognized as part of their household, and members of their administrative and technical staff and their households enjoy full immunity from arrest, detention, criminal prosecution, and search of their person, property or residence.
   Members of their service staff have no privileges or immunities except for immunity from prosecution for acts related to performance of their official duties. Family members of the service staff have no privileges or immunity.
   Family members of diplomatic agents who are also U.S. citizens have no privileges or immunities. Staff members or their families who are U.S. citizens or permanent residents of the U.S. have no privileges or immunities.
2. Consular officials, their families and staffs have no privileges or

immunity related to arrest, detention, or search and seizure. The only exception is that career consular officers enjoy immunity from arrest unless the arrest is pursuant to a felony warrant.

The only authoritative document that can reliably identify a diplomatic or consular official is the identity card issued by the Department of State, Protocol Office. Other documents such as foreign diplomatic passports, U.S. diplomatic visas, tax exemption cards, or vehicle registration issued by the State Department do not conclusively indicate the diplomatic status of an individual. Officers presented with this type of identification should assume that the suspect might have some degree of immunity and attempt to verify further the diplomatic status of the suspect.

The on-duty Watch Commander must be notified of any incidents involving diplomats or consular officials. These incidents must still be fully documented on the CAPRS reports. The federal government, acting through the State Department may be able to take corrective action against foreign diplomats who violate U.S. criminal law.

9-113 ARREST AND/OR DETENTION OF FOREIGN NATIONALS (05/29/02)

(A)

It is the obligation of the United States, including local municipalities, to notify foreign authorities when foreign nationals are arrested or otherwise detained.

If a foreign national is arrested or detained, the following must be done:

1. Immediately inform the foreign national of his/her right to have his/her government notified concerning the arrest or detention.

2. If the foreign national asks that such notification be made, do so without delay by informing the consulate or embassy.

3. In the case of certain countries, such notification must be made without delay regardless of whether the arrestee/detainee so wishes. The Operations Development Unit and MECC have a copy of the Foreign Consular Offices in the United States that contains all pertinent phone numbers for Consular/Embassy offices. These are:

    - Algeria
    - Antigua and Barbuda
    - Armenia
    - Azerbaijan
    - Bahamas
    - Barbados
    - Belarus
    - Belize
    - Brunei
    - Bulgaria
    - China
    - Cost Rica
    - Cyprus
    - Czech Republic
    - Dominica

- Fiji
- Gambria
- George
- Ghana
- Grenada
- Guyana
- Hong Kong
- Hungary
- Jamaica
- Kazakhstan
- Kiribati
- Kuwait
- Kyrgyzstan
- Malaysia
- Malta
- Mauritius
- Moldova
- Mongolia
- Nigeria
- Philippines
- Poland (only non-permanent residents)
- Romania
- Russian Federation
- St. Kitts/Nevis
- St. Lucia
- St. Vincent/Grenadines
- Seychelles
- Sierra Leone
- Singapore
- Slovakia
- Tajikistan
- Tanzania
- Tonga
- Trinidad/Tobago
- Tunisia
- Turkmenistan
- Tuvalu
- Ukraine
- United Kingdom
- Uzbekistan
- Zambia
- Zimbabwe

Foreign consular officials have the right to visit their arrested/detained nationals unless the arrestee/detainee objects to such visits.

9-114 POLICE AUTHORITY IN IMMIGRATION MATTERS (05/29/02) (04/02/18)

A. The United States Code, 8 U.S.C. §1101, empowers the U.S.

Citizenship and Immigration Services (USCIS) and Immigration and Customs Enforcement (ICE), Department of Homeland Security, as the sole authority in immigration matters.

B. The MPD works cooperatively with all federal agencies, but the MPD does not operate its programs for the purpose of enforcing federal immigration laws. In addition, City of Minneapolis Ordinance §19.30 prohibits undertaking "any law enforcement action for the purpose of detecting the presence of undocumented persons, or to verify immigrations status," except for a narrow exception for enforcing criminal laws such as relating to human trafficking and smuggling where immigration status is an element of the crime.

C. Officers shall not undertake any law enforcement action for the purpose of detecting the presence of undocumented persons, or to verify immigration status, including but not limited to questioning any person about their immigration status.

1. The **only exception** to this prohibition is when immigration status is an element of a crime. This is a very limited exception and applies only to the types of federal crimes prohibited under 8 U.S.C. §1324, that relate to the crimes of human trafficking and smuggling.
2. When questioning, arresting, or detaining any person under this exception, the officer must articulate and document the reason the officer believes the exception applies.

D. Officers will take reports for missing, lost or stolen identification cards for foreign nationals in accordance with P&P 4-600 Specific Report Policies and Procedures.

9-115 FEDERAL PRISONERS - INCLUDING AWOLS (05/29/02)

(A)

For the purposes of this section, AWOL is Absent Without Leave from Military Service.

If an officer has a prisoner that they believe has a federal warrant, the officer shall confirm the warrant with Channel 7. The prisoner shall be transported to the Hennepin County Adult Detention Center where the prisoner will be received into custody per Minn. Stat. §641.03.

EXHIBIT 10

GENERAL ORDER

DISTRICT OF COLUMBIA

Title **Use of Force**		
Topic	Series	Number
RAR	**901**	**07**
Effective Date **November 3, 2017**		
Replaces: GO-RAR -901.07 (Use of Force), Effective Date December 1, 2016 **Related to:** GO-OPS-301.03 (Vehicular Pursuits) GO-RAR-306.01 (Canine Teams) GO-RAR-901.01 (Handling of Service Weapons) GO-RAR-901.04 [Oleoresin Capsicum (OC) Spray Dispensers] GO-RAR-901.08 (Use of Force Investigations) GO-RAR-901.09 (Use of Force Review Board) GO-RAR-901.11 (Force-Related Duty Status Determination)		

I. BACKGROUND

Regulations pertaining to the use of force by law enforcement officers are outlined in chapter six of the District of Columbia Code of Municipal Regulations (DCMR), the Fourth Amendment of the United States (U.S.) Constitution, and various other sections in the Official Code of the District of Colombia (D.C. Official Code). The DCMR provides guidance regarding a law enforcement officer's use of force including, but not limited to, outlining the circumstances permitting appropriate levels of force and imposing restrictions on firearm discharges. The Fourth Amendment of

the U.S. Constitution guarantees people “the right to be secure in their persons” and provides a framework in which the courts can evaluate the use of force by law enforcement officers, including the “objective reasonableness” standard established in *Graham v. Connor* 490 U.S. 386 (1989). The purpose of this order is to outline when members may use force.

II. POLICY

The policy of the Metropolitan Police Department (MPD) is to value and preserve the sanctity of human life at all times, especially when lawfully exercising the use of force. Therefore, MPD members shall use the minimum amount of force that the objectively reasonable officer would use in light of the circumstances to effectively bring an incident or person under control, while protecting the lives of the member or others. When using force, members shall continuously reassess the perceived threat in order to select the reasonable use of force response, or one that is proportional to the threat faced by him, her, or others.

III. DEFINITIONS

When used in this directive, the following terms shall have the meanings designated:

1. Active resistance – physically evasive movements to defeat or deflect the member’s attempts to control a subject, including but not limited to, bracing, tensing, pushing, or verbally signaling an intention not to be taken into or retained in custody, provided that the intent to resist has been clearly manifested.

2. Carotid artery hold ("sleeper hold" or "v hold") – any technique which is applied in an effort to control or disable a person by applying pressure or force to the carotid artery or the jugular vein or the sides of the neck with the intent or purpose of controlling a person's movement or rendering a person unconscious by constricting the flow of blood to and from the brain (D.C. Official Code, § 5-125).

3. Less lethal weapon – any object or device deployed with the intent or purpose of nullifying a threat without causing death (e.g., rubber bullets, oleoresin capsicum spray, and tactical batons).

4. Member – sworn or civilian employee of MPD or MPD Reserve Corps member.

5. Non-deadly force – any use of force that, when employed in accordance with Department training, is neither likely nor intended to cause death or serious physical injury.

6. Objective reasonableness – the standard requiring the reasonableness of a particular use of force must be judged from the perspective of a reasonable member on the scene in light of the facts and circumstances confronting the member.

7. Resisted handcuffing – occurs when a person actively resists being placed in handcuffs, and the member must forcibly move the person's wrists or arms, or physically maneuver the person's body so that the handcuffs can be applied. The "resistance" may range from an active struggle to a person simply "locking" his or he arms to prevent their being moved to the handcuff position.

8. Serious physical injury – any injury or illness that results in admission to the hospital or that creates a substantial risk of death, serious disfigurement, loss of consciousness, disability, a broken bone, or protracted loss or impairment of the functioning of any body part or organ.

   NOTE: Admission to the hospital must be *directly associated* with the use of force, and should not include treatment or hospitalization for those injuries incurred prior to the use of force (e.g., drug or alcohol use, medical conditions such as high blood pressure).

9. Serious use of force – actions by members including:

   a. All firearm discharges by a member with the exception of range and training incidents, and discharges at animals;

   b. All uses of force by a member resulting in a serious physical injury;

   c. All head strikes with an impact weapon;

   d. All uses of force by a member resulting in a loss of consciousness, or that create a substantial risk of death, serious disfigurement, disability or impairment of the functioning of any body part or organ;

   e. All incidents where a person receives a bite from an MPD canine;

   f. All uses of force by an MPD member involving the use of neck restraints or techniques intended to restrict a subject's ability to breathe; and

   g. All other uses of force by a member resulting in a death.

10. Service weapon – any instrument issued or authorized by the Department that is used to control or overcome a subject, carried or kept readily available by MPD members.

11. Take down – maneuver in which a subject is forcibly brought to the ground.

12. Trachea hold ("arm bar hold" or "bar-arm hold") – any technique using the member's arm, a long or short police baton, or a flashlight or other firm object that attempts to control or disable a person by applying force or pressure against the trachea, windpipe, or the frontal area of the neck with the purpose or intent of controlling a person's movement or rendering a person unconscious by blocking the passage of air through the windpipe. (D.C. Official Code, § 5-125.02)

13. Use of force – any physical coercion used to effect, influence or persuade an individual to comply with an order from an officer.

    a. The following actions are designated "reportable uses of force":

        (1) Deadly force;

        (2) Serious use of force;

        (3) Use of a less-than-lethal weapon;

        (4) Any use of force indicating potential criminal conduct by a member; and

        (5) Any use of force resulting in injury or a complaint of injury or pain where the injury or pain is directly associated with a member's use of force.

    b. The following actions are designated "reportable force incidents" as long as the use of force does not result in injury or a complaint of injury or pain:

        (1) All solo or team takedowns, where there is no complaint of pain or injury; and

        (2) The drawing and pointing of a firearm at, or in the direction of, another person when no other force was used.

    NOTE: Minor injury or discomfort resulting from the application and general wearing of handcuffs is not, in and of itself, considered a "reportable use of force" or a "reportable force incident".

14. Use of force framework – an adaptation of the decision making model (Attachment A) specifically applicable to situations potentially resulting in the use of force. The use of force framework contains five categories of perceived threats and responses, all of which are fluid, dynamic, and non-sequential. The use of force framework allows officers to

determine which action or actions are objectively reasonable and proportional, given the perceived threat.

15. Use of force indicating potential criminal conduct by a member – includes, but is not limited to, all strikes, blows, kicks or other similar uses of force against a handcuffed subject and all accusations or complaints of excessive force made against the member. This includes any use of force that **clearly** goes beyond that which an objectively reasonable officer would use in light of the circumstances under which the force was used, or any use of force which may rise to the level of a criminal act.

16. Vehicle ramming attack – form of attack in which a perpetrator deliberately rams, or attempts to ram, a motor vehicle at a crowd of people with the intent to inflict fatal injuries.

IV. REGULATIONS

A. All members who encounter a situation where the possibility of violence or resistance to lawful arrest is present, shall, if possible, first attempt to defuse the situation through advice, warning, verbal persuasion, tactical communication, or other de-escalation techniques. Members shall attempt to defuse use of force situations with de-escalation techniques whenever feasible.

B. When using force, members must be able to articulate the facts and circumstances surrounding their tactics, decision making, and the extent of force used in any given situation.

C. When any force response is employed, members shall:

1. Conduct a visual and verbal check of the subject to ascertain whether the subject is in need of medical care.

2. Summon medical assistance immediately if a person is injured, complains of pain, or demonstrates life-threatening symptoms as established in GO-PCA-502.07 (Medical Treatment and Hospitalization of Prisoners).

3. Render first aid as soon as the scene is safe.

D. Any excessive force by a member may subject him or her to disciplinary action and possible criminal prosecution or civil liability.

E. Use of Force Framework (Attachment B)

1. The use of force framework contains five categories of perceived threats and responses, all of which are fluid, dynamic, and non-sequential.

a. Member's Perception of the Threat:

(1) Cooperative – the subject responds in a positive way to a member's presence and is easily directed with verbal requests and commands. The subject who requires control or searching offers no resistance.

(2) Passive resister – the subject displays a low level of noncompliant resistance. The noncompliance is passive, and offers no physical or mechanical energy. The subject does not respond to a member's lawful request or commands and may be argumentative.

(3) Active resister – the subject is uncooperative and will not comply with the member's requests or comments. The subject exhibits physical and mechanical defiance, including evasive movements to defeat the member's attempt at control, including but not limited to, bracing, tensing, pushing, or verbally signaling an intention not to be taken into or retained in custody, provided that the intent to resist has been clearly manifested.

(4) Assaultive – the subject has gone beyond the level of simple non-cooperativeness, and is actively and aggressively resisting the officer's attempt to arrest. The subject has demonstrated a lack of concern for the member's safety; however, the subject does not pose an immediate threat of death or serious bodily injury to the member or others.

(5) Serious injury or death – the subject poses an immediate danger of death or serious physical injury to the member or to another person, but not himself or herself. The subject's actions demonstrate his or her intent to inflict death or serious injury upon the member or another person immediately.

b. Member's Force Response:

(1) Cooperative controls – the least physical force response category on the use of force framework. Cooperative controls include communication skills with cooperative subjects and are often achieved by non-verbal acts such as gestures, stance, and facial expressions in accordance with Department training and standards.

(2) Contact controls – low-level mental and physical tactics to gain control and cooperation. The contact controls can

be psychologically manipulative (e.g., strong verbal persuasion) as well as physical (e.g., soft empty hand control, firm grip, and escorting), and can include additional verbal persuasion skills or waiting for backup to show strength in numbers in accordance with Department training and standards.

(3) Compliance techniques – actions [e.g., control holds, joint locks, and oleoresin capsicum (OC) spray, solo or team takedowns] that may induce pain or cause discomfort to the subject who is actively resisting until control is achieved, but will not generally cause an injury when used in accordance with Department training and standards.

(4) Defensive tactics – actions to forcibly render the subject into submission; however, these actions are not likely nor designed to cause death or serious physical injury. The purpose of defensive tactics is primarily the safety of the member and others. Examples of “defensive tactics” include the use of ASP baton strikes, chemical agents, and electronic control devices (ECDs) in accordance with Department training and standards.

(5) Deadly force – any use of force likely to cause death or serious physical injury. The primary purpose of deadly force is to neutralize a subject who poses an immediate threat of death or serious injury to the member or others; however, this does not include a subject who poses a threat solely to himself or herself. Examples include, but are not limited to, the use of a firearm or a strike to the head with a hard object.

2. In response to a perceived threat, members shall apply the proportionate and objectively reasonable force response, as outlined in the use of force framework. To ensure the force response is objectively reasonable and proportionate to the perceived threat, members shall:

a. Continuously assess the threat and develop strategies, consider their authority and Department policies, identify options and contingencies, take action and review, and gather information. This approach requires members to:

(1) Consider the seriousness of the crime, the level of threat or resistance presented by the suspect, the imminence of danger, the suspect’s mental capacity, his or her access to weapons, agency policies, and available options (e.g., calling upon members with specialized training for assistance).

(2) Initiate the proportionate and objectively reasonable force response, when feasible, to overcome resistance.

(3) Modify their level of force in relation to the amount of resistance offered by a suspect. As the subject offers less resistance, the member shall lower the amount or type of force used. Conversely, if resistance escalates, members are authorized to respond in an objectively reasonable manner.

(4) Intervene in and subsequently report any use of force incident in which they observe another member utilizing excessive force or engaging in any type of misconduct.

3. Members shall not use techniques or defensive weapons when employing force unless they have received the requisite training and the technique or weapon has been approved for use by the Department. However, members may employ force as necessary to protect the life of a civilian or member subject to the imminent threat of death or serious physical injury, when no other options are feasible, and the force is objectively reasonable and proportionate to the perceived threat.

F. Conditions that May Authorize the Use of Non-Deadly Force

1. A member's decision to use non-deadly force shall involve one or more of the following considerations:

a. To protect life or property;

b. To make a lawful arrest;

c. To prevent the escape of a person in custody;

d. To control a situation, or subdue and restrain a resisting individual; or

e. To effect a lawful stop of a fleeing individual.

2. A member shall use the force response that is reasonably necessary to bring the situation under control. If de-escalation tactics are not effective, the member may use an increasing level of force to overcome the level of resistance, as long as the force response remains proportionate to the perceived threat. As soon as the incident is under control, the member's use of force response shall diminish proportionally.

G. Conditions that May Authorize the Use of Deadly Force

1. Authorized Use of Deadly Force:

a. Defense of Life

Members may use deadly force in the performance of police duties under the following circumstances:

(1) When it is necessary and objectively reasonable; **and**

(2) To defend themselves or another from an actual or threatened attack that is imminent and could result in death or serious bodily injury; **and**

(3) When all other options have been exhausted **or** do not reasonably lend themselves to the circumstances.

b. Fleeing Felon

To apprehend a fleeing felon **only** when every other reasonable means of affecting the arrest or preventing the escape has been exhausted; **and**

(1) The suspect fleeing poses an immediate threat of death or serious bodily harm to the member or others; **or**

(2) There is probable cause to believe the crime committed or attempted was a felony that involved an actual or threatened attack that could result in death or serious bodily harm; **and**

(a) There is probable cause to believe the person fleeing committed or attempted to commit the crime, **and**

(b) Failure to immediately apprehend the person places a member or the public in immediate danger of death or serious bodily injury; **and**

(c) The lives of innocent persons will not be endangered if deadly force is used.

2. Unauthorized Use of Deadly Force

a. Members shall not use deadly force in any circumstance other than those outlined Part IV.G.1.

b. Members shall not utilize deadly force against subjects that only present a threat of harm to themselves.

H. Less Lethal Weapons

1. The objective of less lethal weapons is to preserve human life and prevent further escalation of force.

2. Less lethal weapons may only be used by members with the appropriate specialized training.

3. During instances of civil disobedience, members shall follow use of force procedures outlined in Department SOP-16-01 (Handling First Amendment Assemblies and Mass Demonstrations).

I. Positional Asphyxia Precautions

1. In order to avoid asphyxiation, members shall:

a. Whenever possible, avoid tactics that may impede a subject's ability to breathe, result in chest or throat compressions, or airway blockage.

b. Position the individual in a manner to allow free breathing once the subject has been controlled and placed under custodial restraint using handcuffs or other authorized methods.

c. Seek medical assistance immediately if a person appears to be having difficulty breathing or is otherwise demonstrating life-threatening symptoms. An official shall direct that alternative means to maintain custody be utilized, if appropriate.

2. Members are prohibited from:

a. Placing a person in a prone position (i.e., lying face down) for a prolonged period of time or during transport except during exigent circumstances. Prisoners shall be carefully monitored while in a prone position as a prone position may be a contributing factor to cause a prisoner to suffocate, also referred to as positional asphyxiation.

b. Employing unauthorized use of restraints while transporting a subject in a vehicle.

c. Attaching handcuffs or flex-cuffs to leg restraints in such fashion that forces the legs and hands to be close to one another (i.e., "hog-tying").

J. Neck Restraints

1. The use of neck restraints of any kind including, but not limited to, the use of “trachea holds” and “carotid artery holds” as they are defined in D.C. Official Code § 5-125.02 are not authorized use of force options and are prohibited.

   NOTE: Members are reminded of the legal restrictions against certain types of neck restraints outlined in D.C. Official Code § 5-125.01, *et seq.* (Limitation on Chokehold), and that members who use a “trachea hold” or “carotid artery hold” may be found in violation of the law.

2. In the event that a member employs a neck restraint or chokehold of any kind, he or she shall request emergency medical services immediately.

K. Use of the Department-Issued Firearm

1. When feasible, members shall identify themselves as a police officer and issue a verbal warning before discharging a firearm.

2. No member shall discharge his or her firearm under the following circumstances:

   a. As a warning;

   b. Into a crowd;

   c. In a felony case which does not involve an actual attack, but involves a threatened attack, unless the member has reasonable cause to believe the threatened attack is imminent and could result in death or serious bodily injury;

   d. In any misdemeanor offense, unless under exceptional circumstances;

   e. Solely to protect property interests; or

   f. To stop an individual on mere suspicion of a crime simply because the individual flees.

3. Members shall not discharge their firearms either at or from a moving vehicle unless deadly force is being used against the member or another person. For purposes of this order, a moving vehicle is not considered deadly force except when it is reasonable to believe that the moving vehicle is being used to conduct a vehicle ramming attack. Members shall, as a rule, avoid tactics that could place them in a position where a vehicle could be used against them.

4. No member shall draw and point a firearm at or in the direction of another person unless there is a reasonable perception of a substantial

risk that the situation may escalate to the point where deadly force would be permitted.

a. When it is determined that the use of deadly force is not necessary, as soon as practicable, firearms shall be secured or holstered.

b. Drawing and pointing a firearm at or in the direction of a person is a reportable incident and members shall notify an official in accordance with SO-06-06 [Instructions for Completing the Reportable Incident Form (RIF: PD Forms 901-g and 901-h).

5. In accordance with GO-RAR-901.01 (Handling of Service Weapons), no member of the Department shall carry, use, or discharge any unauthorized ammunition in their issued service weapons. Members shall not obtain service ammunition from any source except through official Department channels. Members are further required to carry only the requisite amount of service ammunition as applicable to the authorized service weapon they are utilizing.

L. Carrying Prohibited Weapons

1. Members shall not:

a. In the normal exercise of their responsibilities, carry, use or discharge any firearm or other weapon, except those issued or approved for use by the MPD under direction of the Chief of Police.

b. Carry any Department-issued weapon prior to successfully completing Department-approved training courses directed by the Chief of Police.

c. Carry a non-Department-issued weapon (e.g., blackjack, sap, nunchaku, kenpo stick, brass knuckle, or weighted glove).

M. Pain or Injury Associated with Handcuffing

1. Members are reminded the proper application and general wearing of handcuffs may lead to complaints of minor pain or injury (e.g., pinching of skin or scratches).

2. When a subject complains of pain or injury that is associated with the application or wearing of handcuffs, members shall notify an official.

a. The official shall investigate the complaint or injury and document his or her findings in the PD Form 313 (Prisoner Illness/Injury Report) in accordance with GO-PCA-502.07 (Medical Treatment and Hospitalization of Prisoners).

(1) If the investigating official determines the subject's injury or complaint of pain is exclusively the result of the application and wearing of handcuffs, no further force-related investigation or reporting is necessary.

Example: A member places handcuffs on a non-resistant subject. The subject claims the handcuffs are causing him discomfort but the official concludes the pain is due exclusively to discomfort associated with wearing handcuffs.

(2) If the investigating official determines the subject's injury or complaint of pain is not exclusively the result of the application and wearing of handcuffs or force was required to apply the handcuffs, he or she shall initiate a use of force investigation in accordance with GO-RAR-901.08 (Use of Force Investigations).

Example: The subject complains of discomfort in his right wrist. During the investigation, the arresting member tells the official he had to twist the subject's right wrist in order to place him in handcuffs. The official concludes the subject's discomfort is associated with the member's action of twisting the subject's wrist, not exclusively the discomfort associated with wearing handcuffs.

b. Investigating officials shall provide counseling and conduct an administrative investigation as appropriate for policy violations in cases where, based on the totality of circumstances, a member applied the handcuffs improperly, but the associated injury does not warrant a use of force investigation.

Example: The arresting member places handcuffs on an unresisting subject but neglects to activate the double-lock function. Since the handcuffs are not double-locked, the subject inadvertently tightens them on himself while he is transported back to the station. The tightening of the handcuffs results in a minor rash on the prisoner's right wrist. This injury is due to the wearing of handcuffs and is therefore not a reportable use of force; however, it would not have occurred if the member had applied the handcuffs properly.

N. Members are prohibited from employing any use of force technique or defensive weapon against a subject in handcuffs **unless** the subject is engaged in assaultive behavior as described in this order or the subject is attempting to escape police custody or resisting members' efforts to maintain custody of the individual (e.g., the subject will not get out of the transport vehicle). In these cases, members shall limit their force responses to the

minimum amount of force that the objectively reasonable officer would use in light of the circumstances to effectively bring an incident or person under control.

O. Civilian Employees of the Department

1. Civilian employees of the department are prohibited from receiving or carrying Department-issued weapons of any kind.

   NOTE: Civilian employees may handle weapons when required as part of their assigned duties (e.g., civilian firearm instructors, civilian firearm examination technicians, civilian evidence technicians).

2. Civilian members shall only use force in defense of themselves or others.

P. Reporting Use of Force Incidents

1. All incidents involving a reportable use of force, as defined in Part III.13.A of this order, shall be reported in accordance with SO-10-14 [Instructions for Completing the Use of Force Incident Report (UFIR: PD Forms 901-e and 901-f)]. All reportable force incidents shall be reported in accordance with SO-06-06 [Instructions for Completing the Reportable Incident Form (RIF: PD Forms 901-g and 901-h)].

   Example 1: A member uses OC Spray on a subject. This is a reportable use of force and requires the completion of a PD Form 901-e (commonly referred to as a “UFIR”) in accordance with SO-10-14.

   Example 2: A member employs a takedown technique to bring a resistive subject to the ground so he or she can be placed in handcuffs. The takedown and handcuffing does not result in injury or complaint of pain or injury. The use of a takedown is a reportable force incident and requires the completion of a PD Form 901-g (commonly referred to as a “RIF”) in accordance with SO-06-06.

2. Members who are aware of a complaint regarding the use of force by another member shall notify their supervisor.

V. ATTACHMENTS

Attachment A: Decision Making Model

Attachment B: Use of Force Framework

VI. CROSS REFERENCES

A. Directives

1. GO-OPS-304.10 (Police-Citizen Contacts, Stops, and Frisks)

2. GO-PCA-502.07 (Medical Treatment and Hospitalization of Prisoners)

3. GO-RAR-901.01 (Handling of Service Weapons)

4. SO-06-06 [Instructions for Completing the Reportable Incident Form (RIF: PD Forms 901-g and 901-h)]

5. SO-10-14 [Instructions for Completing the Use of Force Incident Report (UFIR: PD Forms 901-e and 901-f)]

6. SOP-16-01 (Handling First Amendment Assemblies and Mass Demonstrations)

B. D.C. Official Code

1. D.C. Official Code, § 5-125 (Limitation on Chokeholds)

Peter Newsham
Chief of Police

PN:KDO:MOC:SMM

Amendment #	*Page #*	*Description of Change*	*Effective Date of Change*	*Name and Title of Authorizing Member*
1	11	Revised Part IV.K.2.outline format to include the previously missing letter “d”.	11/7/2017	Maureen O’Connell, Director, Policy and Standards Branch

Metropolitan Police Department

Decision Making Model

The goal of every encounter is Voluntary Compliance!

Officers must continually

- ***Gather information and assess the threat.***
- ***Consider authority, policy and tactics.***
- ***Identify options and contingencies.***
- ***Develop a strategy.***
- ***Take action and review.***

Threat Assessment Observation should include the subject's:

- ***Emotional state.***
- ***Resistive Tension.***
- ***Early warning signs.***
- ***Pre-attack postures or Gestures.***
- ***Access to a Weapon.***
- ***Apparent willingness to sustain injury.***

GO-RAR-901.07 (Use of Force)
Attachment A - Decision Making Model
November 3, 2017

Metropolitan Police Department

Use of Force Framework

The goal of every encounter is Voluntary Compliance!

Officers must continually

- *Gather information and assess the threat.*
- *Consider authority, policy and tactics.*
- *Identify options and contingencies.*
- *Develop a strategy.*
- *Take action and review.*

Resistance and response are dynamic. The subject's behavior and the use of force to control it may escalate or de-escalate during any given altercation until complete control of the subject is achieved.

Immediately summon emergency medical assistance and render first aid as soon as the scene is safe.

GO-RAR-901.07 (Use of Force)
Attachment B - Use of Force Framework
November 3, 2017