

**Special Investigations and
Prosecutions Unit**

**Report on the Investigation into
The Death of Daniel Prude**



**Letitia James
NYS Attorney General**

EXECUTIVE SUMMARY

On July 8, 2015, Governor Andrew Cuomo signed Executive Order 147, 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 March 30, 2020, Daniel Prude (“Mr. Prude”) died after becoming unresponsive during an incident involving members of the Rochester Police Department (“RPD”). On July 15, 2020, Governor Cuomo issued Executive Order 147.35, expressly conferring jurisdiction on the Office of the Attorney General (“OAG”) to investigate any potential unlawful acts or omissions by law enforcement related to Mr. Prude’s death.

The OAG’s review of the facts and circumstances of this case were exhaustive and culminated in the presentation of this matter to a Monroe County grand jury; the grand jury concluded its business on February 23, 2021. None of the factual information contained in this report was drawn from grand jury testimony or evidence obtained using grand jury subpoenas.

On March 23, 2020, just before 3:00 A.M., Joe Prude, a resident of the City of Rochester, contacted 911 and reported that his brother, Daniel Prude, had run from Joe Prude’s home, wearing only pants and a t-shirt, with no shoes. He also advised that his brother had been taken to Strong Memorial Hospital and released hours earlier and had been suicidal. When members of the RPD arrived at Joe Prude’s house in response to the 911 call, Joe Prude advised that his brother was on “PCP,” which Patrol Officer Mark Vaughn (“PO Vaughn”) broadcasted over the air for responding officers to be aware of in case they encountered Daniel Prude.

Daniel Prude traveled one mile on foot in freezing weather conditions before being intercepted by members of the RPD. Between the time he left his brother’s house and the encounter with RPD, Mr. Prude was captured by a variety of surveillance cameras and his route and activities were later mapped. At one point during the route, he threw a brick through a computer store window and entered the store briefly before exiting, having stolen nothing, and continuing on. RPD officers responded to the store and surmised that the person who had thrown the brick through the window might be the person they were looking for.

In the meantime, Mr. Prude approached a tow truck driver on Jefferson Ave. “screaming” for help before running away after being told that help was coming; the tow truck driver called 911 indicating that a man with “blood all over him” was running down Jefferson Ave. As Mr. Prude ran down the street, a young man, who had seen Mr. Prude engage with the tow truck driver, caught up with and recorded him for the purpose of live streaming the encounter on social media. During Mr. Prude’s recorded interaction with that man, which lasted roughly five minutes, he removed his pants – the last item of clothing he was wearing – and remained naked for the duration of the incident.

The young man’s live stream recording ended when PO Vaughn located Mr. Prude on Jefferson Ave. and directed him to get on the ground and put his hands behind his back; Mr. Prude complied, and PO Vaughn applied handcuffs. Several other RPD officers arrived on scene and they waited for the arrival of an ambulance, which had been dispatched previously. None of the officers made any attempt to connect with Mr. Prude, who grew more agitated. After Mr. Prude began spitting,

the officers placed a spit sock over his head, which seemed to further agitate Mr. Prude. After shouting words to the effect of “Gimme your gun,” but while he remained naked, with his hands cuffed behind his back, Mr. Prude moved in a way that, according to the officers, was leading toward him standing. At that point PO Vaughn, Patrol Officer Troy Taladay (“PO Taladay”), and Patrol Officer Francisco Santiago (“PO Santiago”) forced Mr. Prude to the ground and held him there using a stabilization technique they had been taught at RPD in-service training, called “Segmenting.”

An ambulance, staffed with a paramedic and an emergency medical technician (“EMT”) arrived on scene very shortly after Mr. Prude had been taken to the ground and while he was still very agitated, but their response to the situation appeared to lack urgency. The paramedic told the officers, as they held Mr. Prude against the ground, that she was going to get something to calm Mr. Prude, before circling back to ask questions to enable her to determine which sedative might work best; during this time, the EMT manipulated the gurney and brought it close to Mr. Prude, but did not check on him or interact with him or the officers. In the meantime, Mr. Prude fell silent and vomited.

PO Vaughn noticed that Mr. Prude did not appear to be breathing and the officers rolled him to his side. The EMT joined the officers at that point and checked Mr. Prude for a pulse; not finding one, he called for the paramedic. The paramedic directed that the EMT begin CPR; several minutes later, after the application of medical intervention, Mr. Prude recovered a pulse, but he never regained consciousness. On March 30, 2020, Mr. Prude was removed from life support.

The Monroe County Medical Examiner, Dr. Nadia Granger, performed an autopsy, ultimately deeming the “Manner of Death” a “homicide,” meaning that, for medical purposes, Mr. Prude’s death had occurred at the hands of another. She determined the causes of death to be:

- Complications of asphyxia in the setting of physical restraint;
- Excited delirium; and
- Acute phencyclidine intoxication.

These findings are addressed fully, within the report.

The OAG retained an expert in restraint-related death, Dr. Gary Vilke, to review and, if possible, elaborate on the cause of Mr. Prude’s death. Dr. Vilke, agreed with many of the conclusions reached by Dr. Granger, although he opined that Mr. Prude suffered a cardiac arrest, which then caused a lack of oxygen to his brain, whereas Dr. Granger said she could not know whether Mr. Prude suffered cardiac arrest followed by respiratory arrest or if Mr. Prude’s heart stopped beating after he stopped breathing. Neither physician, however, found any evidence of trauma that might accompany blockage of the windpipe or occlusion of a blood vessel. Dr. Vilke opined that Mr. Prude’s ingestion of PCP precipitated a medical condition that he (and the Medical Examiner and the paramedic) deemed “Excited Delirium.” He noted that people suffering with this medical condition are particularly vulnerable to death by cardiac arrest (as did the Medical Examiner), and he further concluded that it was this – cardiac arrest - that ultimately caused Mr. Prude’s death.

The OAG further retained an expert in police procedures and use of force, Geoffrey Alpert, PhD, to opine as to the officers' conduct in restraining Mr. Prude and the techniques used. His assessment, upon reviewing the evidence in the matter, including the officers' training, was that placing the spit sock over Mr. Prude's head, taking him to the ground, and performing the "segmenting" maneuver, were all within the scope of reasonable (although not necessarily the best) police practices under the circumstances. He did, however, opine that the officers' conduct in not rolling Mr. Prude over from the prone position, particularly after he vomited, was contrary to acceptable police practice.

As noted previously, the OAG placed this matter before a grand jury. This report was prepared before any vote was taken so that, if that no charges were returned against any officer, the public could be provided with details as to what took place in this case. We present a "LEGAL PRINCIPLES" section, to discuss broadly some of the general legal issues presented in this type of case.

* * *

Executive Orders 147 and 147.35 also provide that the OAG may offer "any recommendations for systemic reform arising from this investigation." The OAG recommends that:

- I. Law Enforcement Officers, Emergency Communications Providers (Dispatchers), and Emergency Medical Service Personnel Must be Trained to Recognize the Symptoms of Excited Delirium Syndrome and to Respond to it as a Serious Medical Emergency;
- II. New York Should Mandate De-Escalation Training for all Police Officers, and Police Agencies Should Reflect a Commitment to De-Escalation in their Use of Force Policies;
- III. All Communities Should Assess Models for Responding to Crisis Situations that Minimize or Eliminate Police Responses to Mental Health Calls Whenever Possible; Passing "Daniel's Law" Would Greatly Aid in this Endeavor;
- IV. Law Enforcement Agencies Should Explore the Use of Spit Sock Alternatives;
- V. Data-Driven Analysis Should be Used to Determine the Most Effective Defensive Tactics ("DT") Programs; and
- VI. The City of Rochester should Adopt a Body Worn Camera Release Policy Regarding Critical Incidents.

FACTS

NOTE: Any evidence disclosed in this report was obtained independent of the grand jury process; sources include pre-grand jury interviews as well as material obtained without the use of grand jury subpoenas.

Cheektowaga, New York

On March 21, 2020, 41-year-old Daniel Prude (“Mr. Prude”) boarded an Amtrak train in Chicago, bound for Rochester, New York, in order to visit his brother Joe Prude, with whom he shared a close relationship. At approximately 9:00 A.M., on March 22, 2020,¹ at the Amtrak station just outside of Buffalo, New York, Mr. Prude was asked to disembark because he had been smoking cigarettes onboard; he departed without issue. About 2.5 hours later, at a location three miles away from the train station, Mr. Prude encountered members of the Cheektowaga Police Department (“CPD”).

Much of Mr. Prude’s interaction with CPD officers was captured on body worn cameras (“BWC”), a portion of which is linked [here](#). During his time with the officers, Mr. Prude did not appear agitated and he showed no indication that he failed to accurately perceive reality; he followed the conversation and answered all questions appropriately. It was approximately 35°F in Cheektowaga at the time, and Mr. Prude was dressed in a heavy coat, suitable for the weather conditions. Mr. Prude explained that he was trying to get to his brother’s house in Rochester, New York (located approximately 70 miles east of Cheektowaga) but that his phone had been stolen on the train and he therefore had no way of contacting his brother. The officers asked Mr. Prude if he wanted them to take him to a local shelter and he said that he did. When asked if he was under the influence of anything, Mr. Prude said that he had consumed “a lot of beer” and was drunk. Unprompted, he added, “And I smoke a little PCP and marijuana every now and then.” The officers did not follow up as to when Mr. Prude had last consumed those substances.

The CPD officers took Mr. Prude to the Harbor House homeless shelter in the City of Buffalo. With the assistance of another police agency, CPD was able to locate and contact Mr. Prude’s brother (Joe Prude) in Rochester. Joe Prude then traveled to Buffalo to pick his brother up from the shelter and brought Daniel Prude back to his house located on Child St. in the City of Rochester.

¹ This incident occurred at the very beginning of the Covid-19 pandemic, a fact that loomed large over some aspects of the events that followed.

Rochester, New York

March 22, 2020, The First 911 Call from Joe Prude's Home

At approximately 6:52 P.M. that evening, Joe Prude's wife ("Ms. Prude"), called 911, requesting that a police officer and ambulance respond to her house for a "mental hygiene arrest."² She explained that her brother-in-law (Daniel Prude) had just arrived from Chicago, was "coming off of leaf"³ and hallucinating. According to Ms. Prude, Mr. Prude was not violent but needed to be hospitalized as soon as possible. Mr. Prude, whom Ms. Prude said did not have a mental health history, could be heard speaking incoherently in the background of the [call](#).

In response to the 911 call, four Rochester Police Department ("RPD") officers arrived at Joe Prude's home. Their [BWC footage](#) was synchronized and offers a glimpse into Mr. Prude's mental state before his encounter with different RPD officers several hours later. Mr. Prude's affect was clearly different than it had been earlier in the day in Cheektowaga; he appeared highly agitated and was repeating statements of a paranoid nature. Throughout the incident, Mr. Prude said that people were going to kill him and that he wanted to die, while praying to "Jesus Christ" and "the Lord" throughout. He was never violent, however, and while he appeared to be experiencing a mental health crisis, he complied with all directives and allowed the first officer on-scene to handcuff him without incident. After an emergency medical technician ("EMT") arrived, the officers, the EMT, and Joe Prude led Mr. Prude from the house to the ambulance, again without issue and without the application of force.

Mr. Prude advised the EMT that he had consumed PCP, marijuana, and alcohol. During the nine-minute ride to Strong Memorial Hospital ("Strong Hospital"), Mr. Prude was alert and oriented and knew where he was, but also spoke, unsolicited, about Jesus and wanting to see presumably deceased relatives. He coughed, prompting members of the ambulance crew to place a medical (non-spit) mask over his face to guard against Covid-19. But other than some small abrasions and an elevated heart rate, his physical condition was unremarkable. The EMT noted that the ride was uneventful, and that Mr. Prude appeared to calm down between leaving his brother's house and arriving at Strong Hospital.

RPD Officer John LaClair ("PO LaClair") followed the ambulance to Strong Hospital and processed paperwork for Mr. Prude's Mental Hygiene Arrest ("MHA"). He, like the EMT, advised the OAG that Mr. Prude was far less agitated by the time he arrived at Strong Hospital than he had been when he left his brother's house. PO LaClair left Mr. Prude, who was by then no longer in an agitated state, in the care of Strong Hospital staff.

Strong Memorial Hospital – First Visit (3-22-20)

² Pursuant to New York Mental Hygiene Law § 9.41, "Any ... police officer ... may take into custody any person who appears to be mentally ill and is conducting himself in a manner which is likely to result in serious harm to himself or others. Such officer may [under those circumstances] ... remove [such person] to [a] hospital ..."

³ According to Ms. Prude, the "leaf" that Mr. Prude had consumed was from Chicago and was a type of cigarette dipped in embalming fluid and phencyclidine ("PCP"). The most common vernacular terms for the type of preparation described by Ms. Prude are "fry" and "wet." See, e.g. Gilbert C, Baram M, Cavarocchi N. 2013 "Smoking Wet". Respiratory Failure Related to Smoking Tainted Marijuana Cigarettes. [Tex. Heart Inst. J.] 40(1): 64-67. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3568288/>

As noted above [fn2], New York Mental Hygiene Law (“MHL”) § 9.41 permits a police officer to take an individual into custody if that person is suffering from a mental illness that is likely to result in serious harm to that person or others; PO LaClair took Mr. Prude into custody pursuant to that section of law. From there, MHL §§ 9.45 and 9.39 authorize designated hospitals to assess individuals, such as Mr. Prude, in order to determine whether they have a mental illness which is, again, “likely to result in serious harm to [themselves] or others.” Significantly, MHL § 9.39(a)(2) permits admission of an individual to the hospital *only after* a staff physician has examined that person to confirm that the above prerequisite condition is met. Accordingly, Strong Hospital was authorized to receive Mr. Prude and assess him but was only permitted to admit him to the hospital if, upon assessment, he was at that time found to present a likely risk of serious harm to himself or others.

Mr. Prude’s hospital records are confidential, and we therefore cannot divulge any medical or psychiatric information contained therein. Presumably, hospital staff resolved the question of whether Mr. Prude continued to pose a likely risk of “serious harm to himself or others” in the negative because, at 10:51 P.M., Strong Hospital discharged Mr. Prude back to the Child St. home of his brother, Joe Prude.⁴ According to Joe Prude, at 11:00 P.M. on March 22, 2020, about four hours after his brother had been taken to the hospital in an ambulance, Mr. Prude returned to Joe Prude’s house via medical taxi.

The Incident

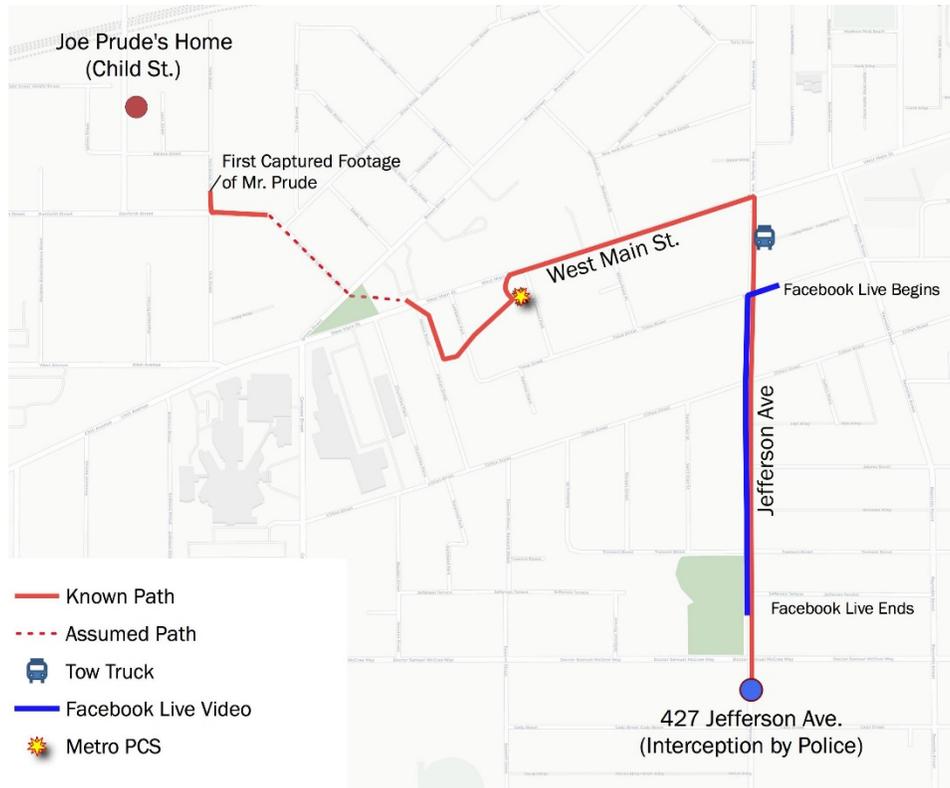
March 22, 2020, The Second 911 Call from Joe Prude’s Home

According to Joe Prude, after Mr. Prude returned from Strong Hospital, the two were sitting at the kitchen table talking for quite some time. At nearly 3:00 A.M., however, Joe Prude said that his brother began acting very strangely and, without warning, ran out of the back door wearing nothing more than a tank top and long-john pajama bottoms. The temperature in Rochester at the time was between 32°F and 33°F.

After he left his brother’s home, footage of Mr. Prude was captured on various city-operated cameras, surveillance cameras, and one civilian’s cellphone; the piecing together of that footage enabled mapping of Mr. Prude’s movements after he left his brother’s house. The map below shows, in the upper left, Joe Prude’s home and, in the lower right, the location where RPD officers intercepted and restrained Mr. Prude. Also displayed are the locations of a Metro PCS store, a tow truck, and the route of a person who recorded Mr. Prude on his cell phone as he livestreamed the

⁴ Without relating any information relative to this case, we learned that Strong Hospital has a standard procedure for assessing individuals brought to the hospital after MHA arrests. This includes a physical examination in the general emergency room before the patient is examined in the Comprehensive Psychiatric Emergency Program (CPEP). Before a patient’s final risk assessment, the patient will have been seen by a CPEP social worker, a nurse(s), and other medical professionals (including resident psychiatric physicians) in CPEP, all of whom must document their interactions with the patient and note the patient’s behavior and demeanor. The social worker will also contact the patient’s family or close contact to ensure that a safety plan is in place before releasing the patient. Additionally, the patient must submit to a drug screen. The drug screen panel in use at Strong Hospital does not include a test for PCP; every RPD officer and medical professional with whom we spoke agreed that PCP is seen very rarely in this geographic area. The assessing psychiatrist is the last person to examine a patient before making the final risk determination pursuant to MHL § 9.39(a)(2), and in addition to the psychiatrist’s own assessment, the doctor will review the complete medical record of the others involved in the process.

footage online; the relevance of each will become clear within this report. The total distance covered by Mr. Prude was approximately one mile and the total amount of time between Mr. Prude leaving his brother’s home and his encounter with the first RPD officer was approximately 20 minutes. The OAG, combining various pieces of media involved (surveillance video, 911 calls, dispatches to law enforcement officers, the civilian witness’s livestream footage, and BWC footage from the involved officers) generated a real-time, synchronized [timeline video](#) displaying the sequence of events beginning at the moment Mr. Prude was first seen on surveillance camera footage and ending when the last portion of BWC footage was captured. [NOTE – Some clips are truncated or minimized when overlay obscures more relevant clips.]



At 2:58:11 A.M., Joe Prude [called 911](#)⁵ and advised that his brother had just run out of his house wearing long johns, a t-shirt, and no shoes. During the call, Joe Prude expressed fear that his brother Daniel might have run in the direction of train tracks and was afraid Daniel might be hit by a train. Joe Prude also advised that Daniel had been released from Strong Hospital two or three hours earlier and that he had been suicidal.

RPD Officers

At 3:00:56 A.M., the first of a series of dispatches was sent out to RPD officers working on the westside of the city - in the Genesee section.⁶ The complete group of dispatches from the relevant

⁵ In Monroe County, 911 call-taking and dispatching out to officers occurs within the City of Rochester’s Emergency Communications Office (“ECO”).

⁶ For purposes of dispatching, Rochester is divided into the eastside and westside and dispatched on two separate channels. The eastside and westside are further divided into “sections;” this incident occurred in the westside Genesee

time period [3:00:56 A.M. to 3:27:37 A.M.] is provided [here](#). Joe Prude's address was in RPD patrol officer Andrew Specksgoor ("PO Specksgoor")'s beat (*see* fn6 for explanation of "beat") and he was directed to respond to the that location for a Black male, "*last seen wearing a white top and long johns and no shoes just ran out of the house.*" The call was immediately updated to advise that, "*the caller's saying that the brother was just released from Strong Hospital two to three hours ago and is suicidal.*" Patrol officer Josiah Harris ("PO Harris"), patrol officer Mark Vaughn ("PO Vaughn"), and patrol officer Paul Ricotta ("PO Ricotta") also responded to assist.

Daniel Prude

As Joe Prude was looking for his brother north of his home in the direction of the train tracks, Daniel Prude was traveling in a southeasterly direction, ultimately reaching West Main St. At 3:02:30 A.M., as Mr. Prude was walking across a parking lot attached to 767 West Main. St. (Metro PCS), he removed his t-shirt; it was later found on the sidewalk, just east of Metro PCS. At 3:03:30 A.M., Mr. Prude threw an object (later determined to be a brick) through the window of the Metro PCS and entered the building; he exited at about 3:04:15 A.M., and, although the store did not have operational interior video surveillance, there is no evidence that Mr. Prude stole anything while inside. Mr. Prude then continued making his way east on West Main St.

Photographs of the broken window at Metro PCs (the brick is visible at bottom right) and the glass underneath the window are displayed below. Individuals who encountered Mr. Prude subsequent to this event noted that he was bleeding.⁷

section. The sections are further broken down into "beats" and officers are assigned to specific beats within each section. The last number of an officer's police vehicle designates the officer's section, while the first numbers designate the officer's beat. Genesee section cars end in the number 3. During this incident the following RPD members were assigned to the corresponding westside Genesee section vehicles: 203 – Paul Ricotta; 213 – Andrew Specksgoor; 223 – Troy Taladay; 233 – Josiah Harris; 253 – Mark Vaughn; and 123 – Michael Magri. ECO dispatchers communicate with the officers by car number, not name.

⁷ A tow truck driver, the RPD officers, ambulance personnel, and the ambulance records all described Mr. Prude as having "blood all over him" or bleeding from various cuts and abrasions on his body. However, in the BWC footage, it is not readily apparent that Mr. Prude was bleeding.



RPD Officers⁸

In the meantime, officers responded to Joe Prude’s home. Although PO Specksgoor was the primary officer on the call, PO Ricotta arrived at the location first, and found Joe Prude in the street, having just returned home from looking for his brother. Joe Prude advised PO Ricotta that his brother was missing, gave a description, and told PO Ricotta that his brother was on PCP.⁹ PO Ricotta left so that he and the other officers could begin searching for Mr. Prude;¹⁰ as he did so, PO Vaughn’s patrol car pulled up next to his and PO Ricotta told PO Vaughn what Joe Prude had just told him about his brother consuming PCP.

At 3:06:52 A.M., after receiving that information from PO Ricotta, PO Vaughn broadcast the following information over the air regarding the call at Child St., “*Just for the officers on this job I guess this guy’s supposed to be on PCP if they run into him.*” When interviewed and asked why he transmitted that information over the air, PO Vaughn said that he did not want individual officers to step out alone with an individual on PCP; he said his previous experience with an individual under the influence of what was reported to be a psychoactive drug, as well as his

⁸ Each officer involved in this incident appeared with his attorney and was interviewed by members of the OAG prior to the grand jury presentation. To the extent that officers also testified before the grand jury, the information released in this report is solely taken from their interviews with members of this office.

⁹ PCP is the more common acronym for phencyclidine, a schedule II hallucinogenic drug known to alter sensory perception, mood, and thought patterns; it can also cause violent, aggressive, and erratic behavior. See e.g., <https://www.medicalnewstoday.com/articles/305328>.

¹⁰ Upon review of the OEC records and dispatch recordings, the call taker who initially spoke with Joe Prude mistakenly believed his name was “Joe Cruz” and that Daniel Prude’s name was “Samuel Cruz.” This mistake was remedied when PO Ricotta and then PO Specksgoor arrived at Child St. and spoke with Joe Prude. We could discern no perceptible effect that mistake had on the outcome of the case.

knowledge of PCP in general, led him to believe that people under the influence of PCP can be very erratic and display extreme strength.¹¹

When Mr. Prude broke the window at Metro PCS, it triggered a silent alarm. The security company tried without success to reach the store owner and then contacted ECO. At 3:09:59 A.M., as PO Specksgoor was at Joe Prude's house obtaining information about Mr. Prude from his brother and the other officers were patrolling the area looking for Mr. Prude, ECO dispatched a request for cars in the area to respond to the alarm at Metro PCS. PO Vaughn answered that he was right around the corner and that he and PO Taladay would respond; PO Ricotta and PO Harris responded as well. PO Vaughn's [BWC footage](#) captures the officers' arrival and their conversation as to what they believe may have occurred. After exiting his vehicle and walking around the building, PO Vaughn said, "I'm just thinking it might be that guy." When interviewed by the OAG, PO Vaughn said that he had been referring to the person who had just run from his brother's house on Child St. Shortly thereafter, PO Vaughn, looking into the Metro PCS, speculated that the person who threw the brick through the window may have been "Mr. PCP."

Daniel Prude

As the officers were assessing the broken window at Metro PCS, surveillance camera footage shows that Mr. Prude had made his way to the intersection of West Main St. and Jefferson Ave., and then jogged south on Jefferson Ave. At 3:08:40 A.M., a tow truck operator hooking up a car on Jefferson Ave., just south of the intersection, [called 911](#). He advised the dispatcher that there was a guy there with "like no clothes on; [with] blood all over him." According to the tow truck operator, the man had appeared out of nowhere and was screaming, "Call 911. I've got coronavirus." During the beginning of the call, Mr. Prude could be heard in the background. According to the tow truck operator, after initially begging him to call 911, when he told Mr. Prude that people were coming to help, Mr. Prude ran away, heading south on Jefferson Ave.

AMR Ambulance

At 3:11:48 A.M., in response to the tow truck driver's call, ECO called the dispatcher at AMR ambulance ("AMR")¹² and requested that an ambulance respond to the area of Jefferson Ave. and West Main St. In turn, the AMR dispatcher radioed Rig-798, advising that there was a psychiatric call at Jefferson Ave. and West Main St., but that the subject was "not violent and doesn't have a weapon." In light of those facts, the dispatcher left the decision of whether to "stage"¹³ in the discretion of the ambulance crew. Rig-798 was staffed with a paramedic ("PA") and an Emergency Medical Technician ("EMT") at that time. The PA advised the dispatcher that they would stage and drove the ambulance to a location on West Main St., just east of the Jefferson Ave. intersection.

¹¹ The fact that Mr. Prude was taking PCP does not render the use of force against him *per se* reasonable. PO Vaughn's act of broadcasting that information over the radio is relevant, however, in that it is evidence of PO Vaughn's state of mind regarding interactions with people using PCP. He advised that in the prior incident he had been involved in, it took numerous officers to restrain an individual who dove head first through an open patrol car window while naked, handcuffed, and on a psychoactive drug. This prior incident is commented upon further in RECOMMENDATION I.

¹² ECO dispatchers do not speak directly with individuals on AMR ambulances. Information that comes into ECO is relayed to an in-house dispatcher at AMR; the AMR dispatcher then contacts the ambulance crew and directs them where to go and for what reason.

¹³ Staging is the practice in which an ambulance is requested to respond to a location near a scene until police can respond and verify that the scene is safe.

Upon arriving at their staging location, the two-person crew continued to receive updated information about the call via mobile monitor. They learned that the subject of the call was reportedly naked and bloody and running south on Jefferson Ave. The PA advised the OAG that, based upon the description of the call, she and the EMT believed the subject might be experiencing what she believed to be “Excited Delirium.”¹⁴

Daniel Prude

A young civilian witness [“CW”] was driving in the area when he witnessed some of Mr. Prude’s interaction with the tow truck driver. He then circled the neighborhood seeking to record Mr. Prude; he proceeded to stream his interaction on a social media platform.¹⁵ At 3:11:12 A.M., as he was trying to catch up to Mr. Prude who was jogging south on Jefferson Ave., CW, talking into his phone, exclaimed that Mr. Prude was about to get hit by a car; surveillance video showed Mr. Prude running into the road and a car swerving to avoid hitting him at the same time. CW then caught up to Mr. Prude and pulled his vehicle alongside him.

Mr. Prude said, “take me take me” and “please” several times, and CW, replying that Mr. Prude should not get too close, pulled his car forward and in front of Mr. Prude. At 3:11:52 A.M., Mr. Prude, who had been jogging behind CW’s vehicle, stopped in the roadway and dropped to his knees. In pre-grand jury interviews, CW indicated that Mr. Prude defecated in the road. At 3:12:02 A.M., Mr. Prude did appear to yell that he needed to defecate and then reached behind himself to the area of his buttocks.¹⁶ After Mr. Prude stood up, he took only a few steps with his long-johns around his ankles before removing them entirely. Mr. Prude remained unclothed from that point forward.

What followed between Mr. Prude and CW essentially consisted of Mr. Prude running after CW’s car as CW offered to call someone for him, while live-streaming the interaction. Mr. Prude would run after the car, drop to his knees in the street, get up and run after the car again. Mr. Prude could be heard at times saying that he wanted CW to call someone, while at other times making nonsensical or inappropriate (as in not appropriate to the situation) statements. CW went around

¹⁴ This subject will be expanded upon in greater detail in subsequent portions of this report; here we only relate the PA’s stated knowledge about the condition she called Excited Delirium. The PA advised that during her paramedic training and in subsequent online training she learned that Excited Delirium is a condition brought about by stimulant drug use or certain psychiatric conditions during which the subject displays agitation and aggression, increased heart rate and respiration, overheating, excessive strength, pain intolerance and incoherent speech. The PA said that she learned that in true Excited Delirium scenarios, rapid sedation is important because the longer a person struggles, the greater the risk that the person will die.

¹⁵ The livestream post was subsequently removed. As noted, CW was young and when interviewed in the aftermath of the incident, he expressed extreme shame and regret about what he had done, noting that he never imagined that the subject of his video might die. A redacted version of this video is presented in the synchronized timeline, but it is not otherwise linked in this report.

¹⁶ This would normally be wholly irrelevant; we reference it, however, because of what transpired shortly thereafter. During the officers’ subsequent interaction with Mr. Prude, he repeatedly said he had “shit” on his fingers and the officers indicated that the statement appeared to be literal. As expanded upon below, this was one of numerous factors that, according to the officers, influenced their interaction with Mr. Prude, including why they did not place him in their patrol vehicle.

the block, caught up with, and passed Mr. Prude for the last time at 03:15:46 A.M.; as before, Mr. Prude appears to have run beside the car before CW's car circles the block again.

RPD Officers

At 3:13:14 A.M., while the officers were still at the Metro PCS, ECO advised that officers in the Genesee section were needed to respond to Jefferson Ave. and West Main St. for the "male at that location with blood all over him [saying] he's sick and not wearing clothes." The dispatcher advised the officers that an ambulance was responding as well. PO Ricotta¹⁷ stayed at the Metro PCS while PO Vaughn, PO Taladay, and PO Harris drove east toward Jefferson Ave.

PO Specksgoor was at Child St. obtaining information from Joe Prude about his brother when ECO sent out the information about the man not wearing clothing in the area of West Main St. and Jefferson Ave. When the dispatcher added that the man was 40 years old, Black, and wearing blue pants and no shirt, Joe correctly surmised that the individual was Daniel Prude. PO Specksgoor then left Joe Prude's house to respond to the call.

PO Vaughn was the first to arrive at Jefferson Ave., and he pulled his vehicle up to the tow truck, just south of the Main St. intersection. The tow truck operator told him that there was a man covered with blood who said he had coronavirus before running down Jefferson Ave. PO Vaughn drove south on Jefferson Ave. several blocks from the intersection, when he said he saw a naked man run into the road, dangerously close to a vehicle.¹⁸ The man, later identified as Mr. Prude, ran from the east side of Jefferson Ave. to the west side, where some garbage totes were located; according to PO Vaughn, the man threw an item into the road and appeared to be biting the garbage receptacles. The item he threw into the road was a chair, which was subsequently located in the middle of Jefferson Ave.

Interception and Restraint of Mr. Prude

NOTE – The BWC footage of every officer present during the restraint was synchronized into one video, so that the officers' actions could be viewed simultaneously. The synchronized video was then added to the synchronized time line video. Every effort was made to synchronize the footage precisely, but microsecond variations may exist. The name of the officer is shown in the upper left of the box corresponding with his footage.

At 3:16:09 A.M., with Mr. Prude in the roadway facing him, PO Vaughn exited his vehicle with his Taser drawn and directed Mr. Prude down to the ground and Mr. Prude complied; PO Taladay arrived immediately after PO Vaughn and approached Mr. Prude as well. PO Vaughn then directed Mr. Prude to put his hands behind his back and not to move as PO Vaughn applied handcuffs; again, Mr. Prude complied. Mr. Prude manifestly understood PO Vaughn's directions at that point

¹⁷ PO Ricotta never interacted with Mr. Prude during the entirety of this incident.

¹⁸ It appears, based on a review of all video footage, that PO Vaughn observed CW's last recorded, livestreamed drive-by of Mr. Prude; none of the officers on scene that night, however, knew about CW or what had transpired between Mr. Prude and him.

in time and he followed them without the application of force. At 3:16:33 A.M., PO Vaughn advised dispatch that he had one male in custody.¹⁹

As he applied handcuffs, PO Vaughn said he noticed that Mr. Prude had blood on him, so he went to his car to apply hand sanitizer,²⁰ leaving Mr. Prude on the ground with PO Taladay. Immediately thereafter, PO Taladay was joined by patrol officer Francisco Santiago (“PO Santiago”), a K-9 officer who had originally been dispatched to check the interior of Metro PCS, before being rerouted to Jefferson Ave. PO Harris also arrived on scene, as did PO Specksgoor, having come from Child St. to determine whether the man called in by the tow truck operator was Joe Prude’s missing brother.

At 3:16:57 A.M., PO Specksgoor approached Mr. Prude and asked if his name was Daniel; Mr. Prude answered, “yes sir.” When PO Specksgoor asked if his full name was Daniel Prude, Mr. Prude did not answer but instead began talking about people and matters unconnected with what was happening in the street at that moment. PO Vaughn, who was walking back from his car after applying hand sanitizer said, “That was easy and fast.” At 3:17:09 A.M., Mr. Prude stated, “Let me eat some shit, there’s shit on my fingers.” The officers later indicated that Mr. Prude did appear to have fecal material on him, which is consistent with CW’s video footage, referenced above (fn16.) Mr. Prude continued to speak in a largely nonsensical manner and the officers maintained a perimeter around him. At 3:17:29 A.M., PO Specksgoor said that he was going to “MHA” Mr. Prude, meaning that he was going to complete the paperwork for a Mental Hygiene arrest, but he made the statement in a questioning tone, to which PO Vaughn replied, “Yeah,” and an officer laughed. PO Specksgoor then left to return to his patrol vehicle.²¹

Despite Mr. Prude being naked and handcuffed in freezing temperatures with snow/rain falling, at no time during this or any other portion of the incident did any of the officers offer Mr. Prude a blanket or ask if he was cold. Although we learned that RPD cars are not equipped with blankets, neither did the officers offer anything to try to cover his genitals or protect him from the elements. Additionally, although the responding ambulance did have blankets, neither member of the crew offered one upon arrival. As the Medical Examiner and Dr, Vilke explained, one of the hallmark characteristics of Excited Delirium Syndrome, the condition they (and the paramedic) opined Mr. Prude was experiencing, is a significantly increased body temperature; the removal of clothing is commonly observed in these situations in an attempt to cool the body (although we note that there is no indication that the responding officers were aware of this fact). We will discuss this condition at length in RECOMMENDATION I, below.

¹⁹ At 3:17:10 A.M., PO Vaughn updated ECO with the specific location of Jefferson Ave. and Cady St. so that the ambulance would know where on Jefferson Ave. to respond.

²⁰ As noted previously [fn1], New York had just begun its Covid-19 lockdown when this incident took place; the virus and its transmission were cited by the officers as looming large over the incident. PO Vaughn said he did not have time to change from the porous and permeable batting-style baseball gloves he normally wore, to latex gloves, and he therefore applied hand sanitizer directly to his gloves more than once during this incident.

²¹ PO Specksgoor was not present during the portion of the incident when officers restrained Mr. Prude and therefore his video footage is not included in the synchronized video. His footage may be [accessed separately](#). Further, PO Specksgoor completed the MHA paperwork inside of his vehicle, which was parked behind several other patrol vehicles. He said he was unaware of what ultimately occurred until he later saw members of the ambulance performing CPR on Mr. Prude; at no time does BWC footage of any officer indicate that he was present during the restraint or any time prior to Mr. Prude being loaded onto the ambulance on a gurney.

Every officer said that at that point, they were waiting for the ambulance to arrive, including the shift supervisor, Sergeant Michael Magri, who was watching from a location outside his patrol vehicle, further away from Mr. Prude than the other officers. At 3:17:41 A.M., Mr. Prude spit for the first time, and as time passed, he began to appear more agitated and his statements seemed to become more disjointed and directed at people who were not present. Other than PO Harris, who told him to “relax dude,” none of the officers attempted to engage Mr. Prude verbally. By 3:18:06 A.M., he had rolled fully over from his stomach to his back, and, at 3:18:24 A.M., in response to a question about whether he had HIV or AIDS, Mr. Prude answered no, before again beginning to yell about matters unrelated to the situation. Seconds later, Mr. Prude appeared to suddenly notice an abandoned building and commented on it, and, instead of making efforts to engage with or assist Mr. Prude, the officers laughed at his non sequitur. At 3:18:40 A.M., Mr. Prude spit again and the officers began to discuss applying a “spit mask.”²² Mr. Prude sat up with his legs straight out in front of him at 3:18:59 A.M., and PO Taladay put a hand on his shoulder and told him to stay down. Mr. Prude remained seated on the ground and spit again at 3:19:06 A.M. and continued talking about things that made no contextual sense.

PO Vaughn placed a spit mask over Mr. Prude’s face at 3:19:21 A.M. After initially saying, “God bless you all,” Mr. Prude became more agitated and rolled onto his back, kicking his legs in the air and again saying words contextually unrelated to the situation, at which an officer or officers laughed. At 3:19:55 A.M., Mr. Prude again sat up, this time facing PO Taladay and asking for his gun and handcuffs; at that point PO Vaughn walked behind Mr. Prude. At 3:20:02 A.M., Mr. Prude spit four times as he was facing PO Taladay, and officers told him to stop spitting. At 3:20:22 A.M., Mr. Prude spit again and then made a movement that the officers said appeared to them to be an attempt to push himself up, while stating, “Gimme that gun.” PO Vaughn told Mr. Prude to stop spitting as he, PO Santiago, and PO Taladay all approached him.

At 3:20:27 A.M., PO Vaughn, PO Taladay and PO Santiago took Mr. Prude to the ground by force, although there was space behind them into which they could have moved. When asked why the officers used force on Mr. Prude rather than move away from him they said that, while infrequent, people in handcuffs do at times escape custody, and that handcuffed subjects can still manage to injure officers and themselves. They also indicated that Mr. Prude appeared to be preparing to stand at the time he was taken to the ground.

PO Santiago almost immediately moved away when PO Vaughn indicated that he did not need to be involved because PO Vaughn was “already in it.” PO Harris did not take part, because, he said, it appeared to him initially that the officers who were involved had the matter under control; later (at 3:22:56 A.M.), PO Harris was dispatched to a different (mental health related) call and left the scene altogether.

Just as Mr. Prude was being taken to the ground, Sgt. Magri turned and began walking north on Jefferson Ave. in order to move PO Harris’ vehicle and make room for the ambulance, which he could see coming down the street. Until he walked away, Sgt. Magri’s BWC offered the best

²² Spit masks are used to prevent the spread of diseases by spitting and biting by blocking saliva; RPD uses the Stearns Wear Spit Hood. See, <https://www.spitsock.com/>. The issue of the spit mask is addressed further, in RECOMMENDATION V, below.

overall view of what was happening, because as the supervisor, he was observing from a distance. Until Sgt. Magri returned from moving PO Harris' vehicle, the perspective of all BWC footage is very close-up and it is impossible to see what type of struggle is occurring at the broad, macro-level.

PO Vaughn said he used the hypoglossal nerve technique in an effort to get Mr. Prude to comply with the officers' request that he stop moving. The hypoglossal nerve technique is a common defensive tactics pain compliance technique taught by the RPD and many other law enforcement agencies.²³ The move involves placing fingers inside of a subject's lower jaw bone and pushing up and across toward the opposite side of the head. PO Vaughn said that when he performed this technique on Mr. Prude, he could hear changes in Mr. Prude's speech, but Mr. Prude did not become immediately and persistently compliant. PO Vaughn's application of the hypoglossal technique generally accompanied PO Vaughn telling Mr. Prude to "calm down" and appeared to cause Mr. Prude's speech to become garbled but seems to have accomplished nothing else.²⁴

In addition to the hypoglossal nerve technique, PO Taladay and PO Vaughn together performed "segmenting" on Mr. Prude. We will address segmenting in more detail below, but for purposes of this portion of the narrative, the segmenting involved PO Vaughn holding Mr. Prude's head to the side and applying downward pressure while PO Taladay placed a knee along Mr. Prude's lower back / belt line.

The ambulance entered the scene at approximately 3:20:56 A.M., 30 seconds after the officers took Mr. Prude down to the ground. Mr. Prude was still very vocal, but as noted previously, none of the BWC footage displays a comprehensive overall view of Mr. Prude or the restraining officers. At 3:21:07 A.M., officers told Mr. Prude to calm down and PO Harris, who was looking down from a standing position, but whose BWC faced forward and did not capture what he was observing, told Mr. Prude to relax or he would "end up getting Tased." At approximately 3:21:14 A.M., PO Taladay's BWC began to capture the most comprehensive view of Mr. Prude on the ground, but only of his upper back.

When interviewed by the OAG, the ambulance paramedic ("PA") said that she suspected "Excited Delirium" based upon the nature of the information available to her and the EMT before entering the scene. She said that she and the EMT discussed their roles on the way to the call and determined that once they arrived on scene she was going to prepare whatever medicine the patient might need, while the EMT was going to safely get Mr. Prude onto the stretcher. By 3:21:23 A.M., the PA had exited the ambulance and come over to observe Mr. Prude; although she is not visible in the BWC footage, she was clearly present, because PO Vaughn said to her, "Can you guys get the gurney out for us please?" and she responded, "We're working on it." She also indicated that

²³ See e.g. [https://www.policemag.com/342012/gaining-compliance-with-targeted-pressure#:~:text=Hypoglossal%20Nerve%20\(under%20the%20jaw,further%20from%20the%20resister's%20mouth.](https://www.policemag.com/342012/gaining-compliance-with-targeted-pressure#:~:text=Hypoglossal%20Nerve%20(under%20the%20jaw,further%20from%20the%20resister's%20mouth.)

²⁴ As will be discussed more fully below, people experiencing the type of agitated or excited state Mr. Prude was experiencing, do not feel pain the way that they normally would. Therefore, the use of pain compliance techniques is generally ineffective and should not have been attempted.

she was going to get Mr. Prude something to calm him down.²⁵ Mr. Prude and the officers are not visible on the BWC footage at that point in time other than at a very close range, but the PA said that her observations upon arrival were that Mr. Prude was agitated, speaking incoherently, moving, and able to lift the officers who were restraining him.

At 3:21:34 A.M., Mr. Prude spit again and PO Vaughn told him to “stop spitting” and then repeated the direction twice more. PO Santiago, who had been standing at Mr. Prude’s feet observing, bent and held Mr. Prude’s legs down at 03:21:36 A.M. As noted previously, there is no BWC footage from this period that provides a distant, comprehensive view of what was transpiring, but PO Santiago said that he took Mr. Prude’s feet because Mr. Prude was kicking his legs and trying to get up. PO Santiago said that he would normally have wrapped his arms around Mr. Prude’s legs to hold them down, but he did not do so in this case, because of concerns about bringing his head close to fecal matter; instead, he said he “stabilized” Mr. Prude’s legs by simply holding them down.

A few seconds later, at 3:22:02 A.M., the PA returned and asked the officers if Mr. Prude felt hot, after which approximately 30 seconds was spent on this subject; from the BWC footage, those 30 seconds appear to be the time during which Mr. Prude changed from vocal and moving to non-vocal and no longer moving. When asked if Mr. Prude felt hot, PO Vaughn told the PA he didn’t know because it was freezing out and Mr. Prude was naked, while PO Taladay said he thought Mr. Prude was cold. The PA said she was asking because it made a difference as to which sedative she should give Mr. Prude. The PA walked back to the ambulance at 3:22:31 A.M., having been advised by the officers that they “couldn’t tell her anything” about Mr. Prude’s temperature.²⁶

In the meantime, Sgt. Magri had returned from moving PO Harris’ vehicle, and walked back to the scene, coming around the back of the ambulance at the same time that the EMT was removing the gurney from the back of the rig. At 3:22:01 A.M., some overall footage was once again captured from Sgt. Magri’s BWC showing PO Vaughn in a modified plank / tripod position with his hands on the side of Mr. Prude’s head; as will be further detailed below, we learned that this position is part of ‘segmenting’ and was taught in defensive tactics training. Ten seconds later, at 3:22:11 A.M., after a brief period during which the gurney obscured Sgt. Magri’s BWC, PO Vaughn still had his hands at Mr. Prude’s head, but his right knee was bent. When we asked PO Vaughn what prompted his change in position, he said that consistent with his training, as Mr. Prude’s resistance decreased, so too did PO Vaughn’s use of force, and at that time he had begun to feel less resistance from Mr. Prude; as noted above, this was the period of time during which

²⁵ Unlike the RPD officers, who, as will be fully detailed below, received deficient training in the constellation of symptoms Mr. Prude was experiencing, the PA was aware of Excited Delirium and the heightened vulnerability of people experiencing it to death by cardiac arrest.

²⁶ The practice at AMR ambulance at the time of this incident was to chemically sedate individuals exhibiting signs of Excited Delirium, using either Ketamine (brand name Ketalar) or Midazolam (brand name Versed), with Ketamine being the stronger of the two. Paramedics on AMR ambulances (including the PA in this case) carried and could administer Midazolam (Versed), but only advanced life support supervisors could administer Ketamine. As will be more fully discussed below, Mr. Prude manifested nearly every sign of Excited Delirium, with the exception of the fact that he was compliant with officers when directed to get on the ground and put his hands behind his back, and that compliance was unknown to the ambulance crew as they proceeded to the scene. The PA indicated that she and the EMT suspected Excited Delirium on the drive to the call; under the circumstances, we can discern no reason why the supervisor wasn’t summoned to the scene along with the PA and EMT. However, we will expand upon this further in Recommendation I, below.

the PA and the officers were engaged in discussing Mr. Prude's temperature and Mr. Prude did appear to become non-vocal and non-resistant during this time. Photos depicting PO Vaughn's position at 3:22:01 A.M. and 3:22:11 A.M. are displayed below.



At 3:22:19 A.M., Mr. Prude made a moaning noise as the PA was still present; if Mr. Prude made further sounds after that, they are not clear on the BWC footage. PO Vaughn removed his hands from Mr. Prude's head at 3:22:34 A.M., and asked, "You good man?" At 3:22:46 A.M., PO Vaughn said, "Uh he's puking. Just straight water. See all that water came out of his mouth?" PO Taladay answered, "I didn't see it, but I see it now." PO Vaughn then moved Mr. Prude's head and said, "My man?" In the BWC footage, Mr. Prude's back appeared to move at 3:23:01 A.M., 3:23:06 A.M., and again at 3:23:21 A.M., but it is difficult to determine from watching the footage whether the movements were actually some form of movement by Mr. Prude, or movements by others that caused Mr. Prude to move. In their interviews with the OAG, both PO Vaughn and PO Taladay indicated that they believed, based upon those movements, that Mr. Prude was breathing.

During that time, the EMT was readying the gurney and walking back and forth to the ambulance but had not taken any steps to engage with the officers or check on Mr. Prude. At 3:23:23 A.M., PO Vaughn said to PO Taladay, "Still moving his arm?" and PO Taladay shook Mr. Prude's arm; Mr. Prude did not respond or move. PO Taladay then checked Mr. Prude's wrist for a pulse. As PO Taladay was checking, PO Vaughn said it did not look like Mr. Prude had "chest compressions"²⁷ and, at 3:23:34 A.M., he directed PO Taladay and PO Santiago to "roll him over on his side." PO Vaughn tried to check Mr. Prude's neck for a pulse at that time. As all of that occurred, the EMT was further manipulating the gurney, but he stopped and began to watch the officers and Mr. Prude as the officers rolled Mr. Prude onto his side.

At 3:23:44 A.M., the EMT walked over and helped the officers roll Mr. Prude onto his back, asking, "Anything?" PO Vaughn told the EMT that Mr. Prude had started throwing up and now it "didn't even look like he has chest compressions." At 3:23:50 A.M., as he was checking Mr. Prude for a pulse, the EMT called to the PA that he needed her. The PA, who was on the phone with a supervisor trying to arrange for someone to bring ketamine to the scene [see above fn26] replied, "Coming." She advised us that while on the phone, she had also been in the process of preparing an injection of Versed to sedate Mr. Prude, in case she needed to use that preparation

²⁷ In his interview with the OAG, PO Vaughn said that by "chest compressions" he said that he meant "chest respirations." Contextually, that makes sense.

instead of Ketamine. When the EMT said he needed her, she said she suspected that Mr. Prude may have gone into cardiac arrest and advised her supervisor of that by saying, at 3:23:58 A.M., that she now had a “Medical 500,” (*i.e.*, the patient was not breathing and had no pulse.)

At 3:24:01 A.M., as the PA was walking over, Sgt. Magri told the officers to uncuff Mr. Prude; the officers began determining whose key to use as the EMT rolled Mr. Prude back onto his stomach. The PA arrived at Mr. Prude’s side and, at 3:24:08 A.M., told the EMT to roll Mr. Prude onto his back as the officers worked on getting cuff keys. At 3:24:20 A.M., the PA asked the EMT if Mr. Prude has a pulse and the EMT advised her that he did not. At 3:24:27 A.M., the PA advised the EMT to begin CPR.²⁸ At 3:25:29 A.M., after approximately one minute of CPR, the EMT and PO Taladay rolled Mr. Prude onto his stomach and PO Taladay removed the handcuffs.

As PO Taladay and the EMT were removing Mr. Prude’s handcuffs, PO Vaughn, who had just returned from applying hand sanitizer, spoke to the PA, telling her, at 3:25:30 A.M. that Mr. Prude had vomited. She answered that PCP can cause “what we call, Excited Delirium.” PO Vaughn answered that he knew what Excited Delirium was. At that time the PA said, “I guarantee you that’s why he coded.” The subject of Excited Delirium will be discussed at greater length below.

The EMT rolled Mr. Prude, now unhandcuffed, onto his back at 3:25:48 A.M., and recommenced CPR as the PA asked the officers to assist in moving Mr. Prude to the gurney, which they did. Once in proper position on the gurney, the PA continued CPR while the EMT pushed the gurney into the ambulance.

Life-Saving Measures

The ambulance crew was joined by advanced life support supervisors and members of the Rochester Fire Department. Together they intubated Mr. Prude, continued CPR, and administered medication. After approximately 18 minutes of intervention, Mr. Prude regained a pulse, but he never resumed spontaneous (unassisted) breathing. He was then transported to Strong Hospital for the second time in less than nine hours.

Over the course of the next week, Mr. Prude remained at Strong Hospital, but his condition never improved. On March 30, 2020, after confirming that Mr. Prude would not recover, he was removed from life support and declared deceased.

²⁸ It appears that PO Taladay had a handcuff key ready to provide to the ambulance crew from approximately 3:24:22 A.M., onward and CPR could have begun without Mr. Prude’s hands restrained behind him. But emblematic of the non-coordinated and haphazard response that plagued this medical emergency, the ambulance crew did not know that PO Taladay had the key, and he appeared hesitant to interrupt them. PO Taladay advised the crew at 3:24:31 A.M., that he had a key and received no response. Then, at 3:24:50 A.M., the PA told him that as soon as the officers could obtain a key she needed Mr. Prude’s handcuffs removed and PO Taladay answered that he had a key for them. At 3:24:59 A.M., the PA said that the cuffs needed to come off and PO Taladay again advised her that he had the key; the PA nevertheless directed the EMT to keep performing CPR.

Summary of Medical Examiner’s Findings

NOTE –The Summary of Final Findings of the Autopsy is attached (Exhibit 2); the full autopsy report is not included. Additionally, the OAG communicated with the Medical Examiner in order to ensure a proper understanding of the findings contained in the autopsy. What is related below has been taken exclusively from the final autopsy report and communications with the Medical Examiner; the OAG did not refer to or utilize any grand jury testimony in generating this or any other portion of the report.

Autopsy Report

On March 31, 2020, the Monroe County Medical Examiner, Dr. Nadia Granger, performed a comprehensive post-mortem examination of Mr. Prude. Before issuing her findings, the Medical Examiner also reviewed records from Strong Hospital, AMR ambulance, and RPD; she also viewed BWC video footage of Mr. Prude’s restraint. On May 5, 2020, the Medical Examiner issued a comprehensive autopsy report ruling Mr. Prude’s Cause of Death as:

- Complications of asphyxia in the setting of physical restraint
- Excited delirium
- Acute phencyclidine intoxication²⁹

and classifying the Manner of Death as “Homicide.”³⁰

In New York, the “Manner of Death” set forth in an autopsy is a medical determination made pursuant to New York State Public Health Law § 4143(3), which directs that medical examiners investigate deaths that occur without medical attendance and, if they are the result of external causes, deem them “accidental, suicidal, or homicidal.” The homicide designation in an autopsy is not a legal culpability determination. The Medical Examiner in this case confirmed that her homicide designation did not mean that a crime *was or was not* committed, but rather, that Mr. Prude’s death occurred “at the hands of another.” In other words, the Medical Examiner designated the manner of death as homicide due to the human involvement of the officers in restraining Mr. Prude; the legal determination of whether or not the medical homicide also constitutes a criminal homicide (*i.e.*, a violation of the New York State Penal Law Article 125) is a distinct determination.³¹

Externally, the Medical Examiner noted that Mr. Prude was 68 1/2” tall, weighed 186 pounds, and that his body appeared to be consistent and compatible with his reported age of 41 years. The Medical Examiner also noted evidence of recent organ and tissue donation,³² as well as evidence

²⁹ In the Autopsy report and Certificate of Death, the Medical Examiner listed the cause of death as Complications of asphyxia in the setting of physical restraint due to Excited Delirium due to Acute phencyclidine intoxication.

³⁰ Cause of death is the specific disease or injury that leads to death; manner of death is the determination of how that disease or injury occurred.

³¹ To illustrate this point, in a case where a person is charged with murder, but claims that the act was one of self-defense, if a trial ends in an acquittal, the Medical Examiner does not change the manner of death in the autopsy - it remains a medical homicide whether it is criminal or not.

³² Mr. Prude was, commendably, a registered organ donor, and underwent a kidney and liver procurement procedure at Strong Hospital following cardiac death on March 30, 2020.

of recent medical and surgical intervention consistent with the on-scene emergency ambulance care and subsequent medical care at Strong Hospital. She also found numerous superficial abrasions on Mr. Prude's body, none of which was found to have independently or collectively caused or contributed to Mr. Prude's death.

Internally, the Medical Examiner found evidence of a "profound global hypoxic ischemic injury" – an injury to the brain caused by lack of oxygen. However, as further expanded upon below, the autopsy report revealed no evidence that would be expected to accompany the blockage or obstruction of blood circulation (such as petechial hemorrhages of the eye)³³ or blockage or obstruction of Mr. Prude's airway (such as abnormalities in the soft tissues of the neck). Further, total body x-rays revealed no evidence that Mr. Prude had suffered any recent fractures.

Microscopic examination of the tissues taken from the major organs revealed pneumonia in Mr. Prude's lungs and evidence of inflammation (myocarditis) in his heart. The Medical Examiner opined that these injuries were likely not preexisting conditions but had instead most likely developed during the period of hospitalization preceding Mr. Prude's death.

The toxicology report, reflecting blood drawn from Mr. Prude at 4:01 A.M. on March 23, 2020 – at or near the time of his admission to Strong Hospital – revealed the presence of caffeine; cotinine (a nicotine metabolite); phencyclidine (in an amount of 18 ng/mL); as well as an active component and inactive metabolite of marijuana.

OAG Interviews

As noted above, in addition to reviewing the autopsy and toxicology reports, members of the OAG communicated with the Medical Examiner, in order to ensure that we properly understood her findings and to seek clarification of certain points.

The Medical Examiner explained that her use of the word "asphyxia" in the autopsy meant a condition resulting from a decrease or deprivation of oxygen in the body (and specifically, the brain), without reference to how that condition came about. According to the Medical Examiner, asphyxia can result when blood flow through a vessel or vessels is restricted or stopped, thereby preventing oxygen from reaching the brain and other organs; asphyxia could also result when the lungs or airways are blocked, obstructed or constricted, thereby preventing the intake of sufficient oxygen from the air.³⁴ However, she also explained that her use of the term asphyxia does not imply asphyxia by mechanical means, such as strangulation (blocking a major vessel) or choking (blocking the windpipe). According to the Medical Examiner, regardless of the reason, a deprivation of oxygen to the brain, which can lead to serious injury or death, constitutes asphyxia.

³³ Petechial hemorrhages are caused by bleeding from 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 from asphyxia, head injury, and central nervous system disorders." Rao VJ, Wetli CV. The forensic significance of conjunctival petechiae. *Am J Forensic Med Pathol.* 1988 Mar; 9(1):32-4.

³⁴ There are several other ways that death by asphyxia can occur. The classification of asphyxial deaths appears to be an area where medical examiners do not always use the same terminology. *See e.g.*, Sauvageau A, Boghossian E. Classification of asphyxia: the need for standardization. *J Forensic Sci.* 2010 Sep;55(5):1259-67. (Authors noting, "At this point in time, there is so much variation in the classification and definitions of terms [regarding asphyxia] that research and practice are inevitably tinted by confusion.")

According to the Medical Examiner, Excited Delirium,³⁵ is a condition brought about by psychiatric illness or illicit drug use that causes certain physiological changes in the body. Those changes include but are not limited to, rapid breathing, increased heart rate, increased body temperature, and an increased demand for oxygen. The Medical Examiner advised that individuals experiencing Excited Delirium can sometimes manifest bizarre, paranoid, aggressive and violent behavior, and, because of the neurochemical changes occurring in the brain, will often display a reduced sensitivity to pain and a reduction in fatigue. She noted that because of the collective physiological changes occurring in the body, including the increased heartrate, increased respiration, and enhanced demand for oxygen, an individual experiencing Excited Delirium is more vulnerable to sudden cardiac or respiratory arrest than that person would be otherwise.

Significantly, the Medical Examiner explained that not every person who consumes illicit drugs or has a psychiatric illness develops Excited Delirium and, in fact, the condition is quite rare. She further noted, however, that PCP is among the class of drugs found to induce Excited Delirium in some people.

The Medical Examiner viewed BWC footage of the encounter between RPD officers and Mr. Prude after her post-mortem examination, but before reaching any conclusions as to the cause and manner of death. Regarding her review of the footage, she noted that Mr. Prude exhibited clear signs of Excited Delirium, including an altered mental state, lack of coherence, paranoia and being inappropriately attired for the weather (indicating that his body temperature was elevated.)

Regarding the restraint of Mr. Prude, the Medical Examiner specifically discussed the officer restraining Mr. Prude's head and the officer restraining his torso. She noted that during the restraint, the action of the officer at the head likely added to Mr. Prude's paranoia, agitation and stress, thereby further increasing his heart rate and need for oxygen. The Medical Examiner further noted that the actions of the officer at Mr. Prude's torso would have interfered with his ability to fully expand and contract his lungs to accommodate his increased need for oxygen.

Regarding the cause of death, the Medical Examiner opined that Mr. Prude died from a combination of the Excited Delirium and the restraint, which combined to result in asphyxia (*i.e.*, deficient oxygen delivery to Mr. Prude's brain). However, the Medical Examiner acknowledged that she could not determine the specific mechanism of death (*i.e.*, the specific reason why there was insufficient oxygen delivery to brain). Moreover, as noted above, she did not see evidence during the post-mortem examination or on the BWC video indicating that Mr. Prude's airway or blood flow had been restricted by the officers.

According to the Medical Examiner, the onset of Excited Delirium was precipitated by Mr. Prude's consumption of PCP. As such, Mr. Prude was already experiencing increased body temperature, increased respirations, and an increased heartrate; all resulting in an increased demand for oxygen that made him vulnerable to sudden cardiac or respiratory arrest. The Medical Examiner made clear, however, that this heightened vulnerability did not make cardiac or

³⁵ We will address the issue of Excited Delirium much more extensively below, in RECOMMENDATION I. For this portion of the report, we will only offer what the Medical Examiner told us about her knowledge of Excited Delirium, in the same manner that we previously related the Paramedic's knowledge of Excited Delirium (see fn14).

respiratory arrest preordained. Mr. Prude did not die solely as a result of Excited Delirium; he did not die solely as a result of PCP intoxication; and he did not die solely as a result of the police restraint. According to the Medical Examiner, it was the combination of the restraint and the effects of Excited Delirium, brought on by the PCP intoxication, that caused Mr. Prude's death, and they could not be independently teased apart.

The Medical Examiner could not reach a conclusion as to whether Mr. Prude suffered cardiac arrest (*i.e.*, a heart attack) first, which led him to stop breathing or, alternatively, whether he first suffered from respiratory failure (*i.e.*, stopped breathing), which then caused his heart to stop beating. According to the Medical Examiner, the ischemic, hypoxic brain injuries, observed at autopsy, were consistent with changes normally associated with a lack of blood flow to the brain and the resulting deprivation of oxygen. This lack of oxygen in the brain formed the basis for the determination that Mr. Prude's death was caused by complications from asphyxia.

Finally, as part of this investigation, we requested that the Medical Examiner review, not only the BWC footage, but CW's live stream social media video depicting Mr. Prude in the street immediately prior to his interaction with RPD officers. The Medical Examiner opined that the activity depicted in the footage, which showed Mr. Prude intermittently running down the street while yelling at CW for several city blocks over the course of several minutes, would have increased Mr. Prude's heart rate, respirations, and need for oxygen beyond that which they already were; this would have further contributed to Mr. Prude's physical vulnerability.

RPD TRAINING – Defensive Tactics, Segmenting, De-escalation, and Excited Delirium

The goal of Defensive Tactics ("DT"), in the context of law enforcement, is obtaining and maintaining custody and control of individuals. DT techniques are the maneuvers taught to and used by law enforcement officers in order to achieve the goals of custody and control.

At the basic police academy level, the curriculum and minimum standards for DT instruction, and in fact all instruction, are approved of and overseen by the Municipal Police Training Council ("MPTC") and the Division of Criminal Justice Services ("DCJS");³⁶ this includes the instruction of DT to police academy recruits. According to individuals certified by DCSJ to teach DT throughout the state, the curriculum was updated in 2017 for the first time in several years. By all accounts the update was needed; DT had been instructed the same way for many years and the methods and protocols were premised on pain compliance. Recruits were taught a vast number of specific techniques designed for use in specific circumstances, each designed to cause some amount of pain. But the techniques were difficult to remember, and pain appeared to be a poor motivator of human behavior. After a period of study, a new curriculum was developed and rolled out in 2017. The new program was a concept-based program designed to promote stabilization and control of a subject's body rather than the application of pain compliance techniques.

One of the DT techniques taught in the new curriculum is segmenting, which involves dividing a subject's body into segments – the head; lower back / hips; and legs. With a subject in a prone

³⁶ See, New York State General Municipal Law (GML) §209-q (1)(a); <https://www.criminaljustice.ny.gov/ops/training/bcpo/bcpo01.htm>. Police training in general will be expanded upon in RECOMMENDATION II, below.

position on the ground, and the subject's head facing to either side, an officer places hands on the subject's head, on either side of the upward facing ear and applies pressure (*i.e.*, the thumb and pointer fingers of each hand will frame the ear). While maintaining pressure, the officer assumes a plank or tripod position. The officers are taught that as a subject offers less resistance, the pressure on the head should be lessened, by modifying the plank position or dropping a knee. The instructors advised that the human head can withstand a large amount of weight.³⁷ They further explained that maintaining this position on the head ensures that airways remain open and no pressure is placed on the subject's neck.

If two officers are present and available, as one officer segments the head, the other officer can segment the middle, by taking a 'knee on top position,' placing a shin across the subject's beltline, and avoiding the upper back. Alternatively, the second officer (or a third officer if needed and available) can segment at the bottom by wrapping arms around the subject's legs and using body weight to hold the legs down. However, the leg segmenting position is disfavored in circumstances where a subject is not entirely clothed, and an officer's head could come in close proximity to bodily waste.

PO Vaughn segmented at Mr. Prude's head. PO Taladay segmented at Mr. Prude's lower back. PO Santiago ultimately grabbed and held Mr. Prude's legs down. No other officer restrained Mr. Prude. The officers who restrained Mr. Prude had been trained in the new DT techniques (including segmenting) as follows:

- *PO Vaughn* – August 13, 2019 (SWAT in-service training); February 10, 2020, (RPD in-service training);
- *PO Taladay* – 2018 (Basic police academy DT training); January 22, 2020 (RPD in-service training);
- *PO Santiago* – January 22, 2020 (RPD in-service training).³⁸

In each training session, certified instructors memorialized that the officer performed the maneuvers, including segmenting, acceptably. Further, upon review of the video of Mr. Prude's restraint, the instructors advised that each officer performed the segmenting technique in a manner consistent with their training.

When asked whether officers are trained not to perform segmenting on handcuffed subjects, the instructors indicated that officers are not trained that segmenting, or any other technique, is not to be used on a handcuffed subject. Every DT instructor interviewed said that handcuffs do not necessarily mean that a subject is controlled; that determination, they said, is fluid and officers are trained to assess the totality of the circumstances. Nearly every officer interviewed spoke of having personal experience with or knowing of incidents where handcuffed individuals escaped from

³⁷ See - e.g. <https://www.reference.com/science/much-pressure-can-human-skull-withstand-1bcef73aaa0018cb#:~:text=An%20average%20human%20skull%20can,unless%20using%20a%20heavy%20object>

³⁸ Every officer involved at the scene of Mr. Prude's restraint had been trained in the new techniques; because he was a member of the SWAT team, as was PO Vaughn, Sgt. Magri was trained in the new techniques twice.

officers, harmed officers, or harmed themselves. The officers involved in restraining Mr. Prude advised that they believed restraint was necessary because of Mr. Prude's increasingly agitated behavior and their fear that he would get up.³⁹

The basic recruit academy in Monroe County⁴⁰ is 26 weeks (six months) long. Of that time, three full weeks (120 hours) are dedicated to defensive tactics, three times more than the DCJS's mandated minimum. No time is dedicated to stand alone, communications-based de-escalation training, although 20 hours is dedicated to "Fundamentals of Crisis Intervention Skills," of which communication is a part. We will discuss this more fully below, in RECOMMENDATION II, below.

Relative to the risk of restraint-related death or "positional asphyxia," RPD academy recruits receive instruction in that topic during their instruction about "Aerosol Subject Restraint." Aerosol Restraint is more commonly known as gaining custody and control of a subject using Oleoresin Capsicum ("OC") or "pepper spray."⁴¹ When asked why this topic is not taught as a stand-alone subject or during general defensive tactics, rather than as a part of Aerosol Restraint training,⁴² academy instructors advised that the basic course and training materials are approved by DCJS.

In addition to the above-referenced slides presented during recruit training, on January 21, 2015, the RPD issued a Training Bulletin entitled, "Legal Issues – Non-Traditional Deadly Physical Force." The bulletin listed eight ways in which (non-firearm) techniques or police responses could result in unintended death or serious physical injury; the first of the eight was "Body positions" and contained following description:

Positional asphyxia may occur when the position of a person's body interferes with respiration, resulting in serious injury or death. Prolonged restraint and struggling, particularly when the lungs are being squeezed while empty, can result in exhaustion. This can occur without the subject being aware of it and can lead to sudden death. The risk of positional asphyxia can increase when a person is restrained in the prone position. Current training dictates that once a member

³⁹ Whether or not their subjective beliefs were objectively reasonable under the circumstances is a separate matter and is discussed more fully below in LEGAL PRINCIPLES section, below.

⁴⁰ RPD is not the only agency to attend the basic academy in Monroe County; all local police agency recruits attend the academy together before beginning field training with their respective departments, including the Monroe County Sheriff's Office, Greece PD, Brighton PD, etc.

⁴¹ Although taught briefly, during the module, understanding restraint related asphyxia is not one of the five objectives of the Subject Aerosol Restraint Training. Nevertheless, four out of 84 slides contain "Advisements" about restraint-related asphyxia. The content of the slides is reproduced *verbatim*: [SLIDE 1] *The people who are at particular risk for sudden death, with or without OC exposure. They can exhibit some or all of the following features: •Male gender, generally in their 30's •Obesity •Large size [SLIDE 2] •Bizarre behavior due to psychotic illusional agitated or stimulant drug induced mental states •Drug or alcohol involvement •Chronic heart disease or pulmonary disease •Fail to be subdued by OC •Are or have been engaged in struggle or are involved in violent activity [SLIDE 3] •Have been placed in restraints in positions of possible respiratory compromise such as prone position, "hog tied" or tightly strapped •Do not place anyone under arrest in these positions if they have unusually bizarre behavior or fail to be subdued by OC [SLIDE 4] Danger signs during transport: •Cessation of conversation •Change in breathing •Cessation of movement.*

⁴² Learning about the subject of restraint related death during the aerosol restraint portion of the academy, might lead individuals to believe they should be vigilant about this issue when using aerosol sprays, but not at other times; Mr. Prude was never subjected to any form of aerosol spray.

believes the scene is safe, the member would remove a subject from the prone position by placing them on their side, in a seated position on their buttocks, or in a standing position. Other risk factors that could increase the risk of positional asphyxia include, but are not limited to: obesity, prior cardiac or respiratory problems, and the use of drugs.

As of the date of Daniel Prude's death, there was no mechanism in place to ensure that members actually read and reviewed released bulletins.

Finally, relative to Excited Delirium, out of the six-month academy, RPD recruits receive two lectures where the term "Excited Delirium" is used – and in each lecture, the reference to Excited Delirium is in one slide only. The first slide (reproduced below at left) is part of the recruit class training on "Causes of Emotional Distress." The second (reproduced below at right) is part of the recruit class training on "Psychiatric Emergencies" and the slide pertaining to Excited Delirium is between a slide about Post Traumatic Stress Disorder and a slide about Co-occurring Disorders.

Excited Delirium

"A state of extreme mental and physiological excitement, characterized by extreme agitation, hyperthermia, hostility, exceptional strength and endurance without fatigue"

Many similarities to an emotionally distressed person

The significant difference is that they may be under the influence of an unknown substance or synthetic drug

Excited Delirium

- True emergency leading to death.
- Body core is overheating.
- Very agitated.
- Extreme strength.
- Patient will be removing clothing.
- Diaphoretic.
- Need for police intervention.
- Patient will need to be restrained.
- Needs body core cooling and oxygen.
- Rapid Transport

Experts

NOTE - In light of the significant and complex issues involved in this case, the OAG consulted with two experts - Geoffrey Alpert, PhD, an expert in police practices, and Dr. Gary Vilke, a medical doctor and expert in restraint related death. As with the Medical Examiner's section of this report, if either of these individuals testified before the grand jury investigating the matter, the OAG did not refer to or utilize their grand jury testimony in generating this or any other portion of the report.

Geoffrey Alpert, PhD

Dr. Alpert is a Professor of Criminology and Criminal Justice at the University of South Carolina, and a nationally renowned expert in police training and practices. His experience is deep and includes many awards, fellowships, appointments, as well as 225 publications and 25 book chapters and monographs regarding police work, police practices, and police use of force. Dr. Alpert's Curriculum Vitae is attached. (Exhibit 3)

Before making any assessments, Dr. Alpert reviewed all relevant police reports, use of force reports, witness statements, 911 calls, police dispatch and police radio communications, all police

BWC video footage of the incident, CW's livestream video, as well the OAG's interviews with all involved officers. Because he was not asked to render a medical opinion, Dr. Alpert was not provided with any medical records – with the exception of the ambulance patient care report – and he was not provided with a copy of the autopsy report.⁴³ Dr. Alpert also reviewed certain RPD training materials related to the defensive tactics' instruction received by the involved officers prior to the incident.

Upon reviewing the materials, Dr. Alpert concluded that, while Daniel Prude was clearly a person in crisis who needed help (based on the fact that he was naked, as well as his erratic comments and threats), he had also been involved in criminal activity (the brick thrown through the Metro PCS window), a fact known to the officers when they ultimately encountered Mr. Prude.

Regarding the actions of the involved RPD officers, Dr. Alpert concluded that the act of taking Mr. Prude to the ground – a tactic referred to as “ground stabilization” by the officers – was reasonable and consistent with accepted police procedures. Dr. Alpert noted that while the takedown of a suspect “never looks good,” police officers are trained to use the ground to help take control of subjects. Dr. Alpert also noted that the police properly called for emergency medical services and kept Mr. Prude on the ground while waiting for the ambulance to arrive.

Dr. Alpert further concluded that the use of the spit sock on Mr. Prude was proper and an acceptable police procedure. He noted that the spit sock was placed on Mr. Prude's head to reduce the likelihood he would spit on anyone, which was of particular concern because this incident occurred at the onset of the Covid-19 pandemic, especially in light of Mr. Prude's earlier statement that he had coronavirus. Dr. Alpert also noted that Mr. Prude was observed spitting in the BWC footage, prior to the placement of the spit sock over his head; although it was not clear to Dr. Alpert that Mr. Prude was trying to spit “on” the officers, he did appear to be spitting in their direction.

According to Dr. Alpert, the use of the technique known as “head segmenting” and the hypoglossal maneuver by the officer at Mr. Prude's head (PO Vaughn) were also reasonable. Dr. Alpert noted that these tactics, while not extremely well known nationally in the field of criminology, are used by law enforcement to control a subject's head so that the subject cannot turn it to spit (or bite) and are also used to control the subject's movements. Dr. Alpert further noted that the pressure on the subject's head should vary with resistance, which it reportedly was in this case (according to the officer). Finally, Dr. Alpert noted that, while placing pressure person's head on freezing pavement would be painful, the technique was not designed and is not intended to injure a subject.

Dr. Alpert did conclude, however, that keeping Mr. Prude on his stomach for three minutes, including nearly one minute after Mr. Prude appeared to have vomited, was unnecessary, unreasonable, and against accepted police practice. In Dr. Alpert's view, Mr. Prude should have been turned from his stomach as soon as possible, since he was handcuffed, controlled, and no longer a threat to the officers. According to Dr. Alpert, the officers knew – or should have known

⁴³ As it relates to cause of death, Dr. Alpert was informed only that the ME had ruled that Mr. Prude's death was caused by “complications of asphyxia in the setting of physical restraint due to Excited delirium due to Acute phencyclidine intoxication.”

– that Mr. Prude’s breathing was compromised and that he should have been rolled over on his side as soon as possible. In drawing this conclusion, Dr. Alpert opined that the delay in rolling Mr. Prude over caused his death.⁴⁴ [Neither the ME nor Dr. Vilke (the expert in restraint related death), concluded that the delay in rolling Mr. Prude over from his stomach to his back after he vomited was a proximate cause of his death.]

Dr. Gary Vilke

Dr. Vilke is a board-certified, practicing emergency department physician with substantial experience in cardiac arrest and sudden death in the setting of restraint. He is also an independent researcher on the physiological effects of restraint, body position, and the use of force on in-custody death. Dr. Vilke is a professor of Clinical Emergency Medicine at the University of California at San Diego and has published in excess of 275 articles as well as 70 book chapters on a variety of medical topics, primarily restraint-related physiological issues. Dr. Vilke’s Curriculum Vitae is attached. (Exhibit 4)

Before making his assessment, Dr. Vilke reviewed an extensive amount of material relevant to the case including the medical reports, ambulance reports, Medical Examiner’s report, the BWC video footage, surveillance video, and CW’s livestream video footage, as well as relevant police reports and OAG interviews with the involved officers. Based upon his comprehensive review, Dr. Vilke opined that Mr. Prude was exhibiting signs and symptoms consistent with Excited Delirium Syndrome, and that Excited Delirium, brought about by the ingestion of PCP, caused Mr. Prude to suffer cardiac arrest, which ultimately led to his death.⁴⁵

Like the medical examiner, Dr. Vilke described the classic symptoms of Excited Delirium syndrome – delusional behavior that often includes hallucinations and/or paranoia, hyperactivity, fighting despite threats or overwhelming force, elevated temperature often leading to inappropriate dress for the weather conditions in order to cool the body, intolerance to pain, and rapid breathing. And, like the Medical Examiner, Dr. Vilke noted that Mr. Prude displayed many symptoms consistent with Excited Delirium – he was agitated and delusional, intermittently not following commands given by the officers, demonstrated near constant physical activity (lack of fatigue) which included traveling one mile in 33°F weather conditions without shoes, appeared to be impervious to the pain of being cut by glass, and most notably, Mr. Prude was naked in near freezing weather conditions, indicating that his body temperature was elevated.

Dr. Vilke also noted that when the emergency medical workers identified Mr. Prude’s first cardiac rhythm, it was pulseless electrical activity (“PEA”), a common presenting rhythm following cardiac arrest in people exhibiting signs and symptoms of Excited Delirium. Dr. Vilke observed that Mr. Prude appeared to become less physically active and lose consciousness around the time he vomited. He opined that the cardiac arrest likely occurred at that time - just prior to the vomiting, since vomiting is an involuntary event that sometimes occurs when an individual goes into cardiac arrest.

⁴⁴ Dr. Alpert was asked to review and assess the police actions and conduct in this case. Inasmuch as he is not a medical expert, he was not asked to provide medical opinions or opine as to the cause of Mr. Prude’s death.

⁴⁵ The Medical Examiner indicated that she could not opine as to whether Mr. Prude suffered cardiac arrest, which caused him to stop breathing, or whether Mr. Prude stopped breathing, which eventually caused his heart to stop.

Regarding the force used to restrain Mr. Prude, Dr. Vilke noted that the weight-force applied was not in such an amount or placed on Mr. Prude in such a manner that it would have created the potential to meaningfully limit his ventilation. He noted research revealing that a significant amount of weight (400 pounds) placed squarely on the upper back (across from the lungs) for a prolonged period of time does not cause asphyxiation. Dr. Vilke also noted that if the weight force applied by the officers had impacted Mr. Prude's ability to ventilate to the point of generating a cardiac arrest, the process would have taken much longer than the time involved here. Based on modeling and other types of asphyxiation, Dr. Vilke noted that it typically takes about five minutes of *total* airway obstruction or cessation of breathing to cause cardiac arrest from lack of oxygen; and prior to losing consciousness, Mr. Prude showed signs that were inconsistent with total airway obstruction.

Finally, Dr. Vilke noted that patients experiencing signs and symptoms of Excited Delirium Syndrome have gone into cardiac arrest in the backs of ambulances, in the backs of police cars and in within emergency departments, including the emergency department where he continues to work. He said that individuals suffering from Excited Delirium Syndrome have gone into cardiac arrest while in the prone position and the supine position, with and without weight being placed upon them.

LEGAL PRINCIPLES

The OAG presented this matter to a Monroe County Grand Jury. After hearing the evidence and receiving instruction on the applicable law, the grand jury in this case determined that no criminal charge(s) 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.⁴⁶

While we cannot, in accordance with state law, discuss what specific evidence and charge or charges were submitted to the grand jury, the law applicable to the events at issue here would require determination of two difficult factual issues: (1) whether the conduct⁴⁷ of any officer (or officers) actually caused Mr. Prude's death and, if so, (2) whether, at the time of such conduct, any officer (or officers) had the requisite culpable mental state.⁴⁸

Causation

Under New York State law, a person “causes the death” of another when that person’s conduct is a sufficiently direct cause of the death of another (*see generally People v Matos*, 83 NY2d 509 [1994]). Sufficiently direct causation is established by satisfaction of a two-pronged standard: (1) that defendant’s actions were “an actual contributory cause of (the) death, in the sense that they ‘forged a link in the chain of causes which actually brought about the death’ ” (*Matter of Anthony M.*, 63 NY2d 270, 280 [1984], quoting *People v Stewart*, 40 NY2d 692, 697 [1976]); and (2) “that the fatal result was reasonably foreseeable” (*People v Davis*, 28 NY3d 294, 299 [2016]) quoting *People v Hernandez*, 82 NY2d 309, 314 [1993]).

With respect to one’s actions being an actual contributory cause of another person’s death, so long as “the necessary causative link is established, other causes, such as a victim’s preexisting condition, will not relieve the defendant of responsibility for homicide” (*see Anthony M.*, 63 NY2d at 280). However, the evidence must be “sufficient to prove that defendant’s conduct ‘set in motion and legally caused the death’ of” the victim (*People v DaCosta*, 6 NY3d 181, 185 [2006], quoting *Matos*, 83 NY2d at 511), because an obscure or merely probable connection between the conduct and the death will not suffice (New York Criminal Jury Instructions: Causation—Cause of Death). Said another way, if a person’s conduct is an actual contributory cause of the death of another, then it does not matter that such conduct was not the sole cause of the death, or that a pre-existing medical condition also contributed to the death, or that the death did not immediately follow the injury.

⁴⁶ “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” (CPL 190.25(4); *see also* Penal Law § 215.70 (“A person is guilty of unlawful grand jury disclosure when...he intentionally discloses to another the nature or substance of any grand jury testimony, or any decision, result or other matter attending a grand jury proceeding which is required by law to be kept secret, except in the proper discharge of his official duties or upon written order of the court.”)).

⁴⁷ Penal Law § 15.00(4) defines “conduct” as “an act or omission and its accompanying mental state.”

⁴⁸ Culpable mental state means “intentionally”, “knowingly”, “recklessly” or with “criminal negligence” (*see* Penal Law § 15.00(6)). These terms are defined in Penal Law § 15.05.

With respect to foreseeability of the death, as noted above, in order to establish that one's conduct caused another's death, it must be proven "that the ultimate harm is something which should have been foreseen as being reasonably related to the acts of the accused" (*People v Kibbe*, 35 NY2d 407, 412 [1974], citing 1 Wharton, Criminal Law Procedure Section 169). Death is a reasonably foreseeable result of a person's conduct when the death should have been foreseen as being reasonably related to the actor's conduct. It is not required that the death was the inevitable, or even the most likely, result (New York Criminal Jury Instructions: Causation—Cause of Death).

Courts have cautioned, however, that not every act which results in death necessarily constitutes a crime, and criminal liability "should not be imposed unless the inadvertent risk created by the conduct would be apparent to anyone who shares the community's general sense of right and wrong"; in the end, the finder of fact must evaluate the actor's failure of perception and determine whether "it was serious enough to be condemned" (*People v Ricardo B.*, 73 NY2d 228, 235-36 [1989]; *see also People v Haney*, 30 NY2d 328, 335 [1972]).

Intent or Mental State

In order for a person to be criminally responsible for the death of a person, it must be proven that the person had a specific intent or state of mind at the time the actor caused the harm.⁴⁹ Under New York law, culpable mental states that could be applicable to the facts of this incident include intentionally, recklessly, and criminally negligent.

A person acts intentionally with respect to a result "when his conscious objective is to cause such result or to engage in such conduct" (Penal Law § 15.05[1]).

A person acts recklessly with respect to a result "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" (Penal Law § 15.05[3]).

A person acts with criminal negligence with respect to a result "when he fails to perceive 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 the failure to perceive it constitutes a gross deviation from the standard of care that a reasonable person would observe in the situation" (Penal Law § 15.05[4]).

With the foregoing in mind, a person acts intentionally with respect to a death when that person's conscious objective or purpose is to cause the death of another (New York Criminal Jury Instructions: Penal Law § 125).

A person acts recklessly with respect to a death when that person engages in conduct which creates or contributes to a substantial and unjustifiable risk that another person's death will occur, and when he or she is aware of and consciously disregards that risk, and when that risk is of such nature and degree that disregard of it constitutes a gross deviation from the standard of conduct

⁴⁹ See generally Penal Law § 125.00.

that a reasonable person would observe in the situation (New York Criminal Jury Instructions: Penal Law § 125.15[1]).

A person acts with criminal negligence with respect to a death when that person engages in blameworthy conduct so serious that it creates or contributes to a substantial and unjustifiable risk that another person's death will occur, and when he or she fails to perceive that risk, and when the risk is of such nature and degree that failure to perceive it constitutes a gross deviation from the standard of care that a reasonable person would observe in the situation (New York Criminal Jury Instructions: Penal Law § 125.10).

The question of what was in a person's mind and what he intended when he performed the actions he did 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. Direct or dispositive evidence of a person's state of mind is rare. In determining whether or not a person had the required intent for the commission of a crime, 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.⁵⁰ 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.⁵¹

Justification

Under New York law, certain conduct which would otherwise constitute a criminal offense is deemed "justifiable" and therefore not criminal in certain situations, including the use of physical force by a police officer to effect an arrest or prevent escape. Specifically, Penal Law § 35.30(1) provides, in pertinent part, that a police officer, "in the course of effecting or attempting to effect an arrest, or of preventing or attempting to prevent the escape from custody, of a person whom he or she reasonably believes to have committed an offense, may use physical force when and to the extent he or she reasonably believes such to be necessary to effect the arrest, or to prevent the escape from custody." A police officer is only allowed to use deadly physical force (defined as "physical force, which under the circumstances it is used, is readily capable of causing death or other serious physical injury") in certain limited circumstances, including when he or she reasonably believes that it is necessary to defend himself or herself, or another person, from what

⁵⁰ See New York Criminal Jury Instructions: Culpable Mental States—Intent; New York Criminal Jury Instructions: Evidentiary Inferences; see also *People v Green*, 56 NY2d 427, 432 (1982) (stating that "the various degrees of culpability specified in subdivision 6 of section 15.00 of the Penal Law and defined in section 15.05...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'"), citing *People v Stanfield*, 36 NY2d 467, 473 (1975).

⁵¹ "It is the jury's function to resolve issues of credibility and to accept or reject all or part of the testimony" (*People v Ward*, 282 AD2d 819, 820 [3d Dept 2001]).

the officer reasonably believes to be the use or imminent use of deadly physical force (Penal Law § 35.30[3][a]).

It follows therefore, that, in order for criminal liability to attach to conduct related to Mr. Prude's death, a fact-finder would ultimately have to resolve the issue of whether an officer (or officers) was justified in his or her actions. In resolving that issue, a fact-finder would have to determine whether the officer (or officers) used physical force or deadly physical force. Should the fact-finders determine that the officer (or officers) used only physical force, they would then need to resolve the issue of whether or not that use of force to effect Mr. Prude's arrest pursuant to Mental Health Law Section 9.41 was reasonable in light of all the facts and circumstances. On the other hand, if the fact-finders determined that the officer (or officers) used deadly physical force against Mr. Prude, they would again need to resolve the issue of whether or not the officer's (or officers') beliefs and conduct were reasonable in light of all the facts and circumstances.

In sum, if a fact-finder determined that an officer (or officers) caused Mr. Prude's death and had the requisite culpable mental state, there would nevertheless be no criminal liability for that conduct if the fact-finder also determined that the officer (or officers) was justified in his or her use of force.

RECOMMENDATIONS

I. Law Enforcement Officers, Emergency Communications Providers (Dispatchers), and Emergency Medical Service Personnel Must be Trained to Recognize the Symptoms of Excited Delirium Syndrome and to Respond to it as a Serious Medical Emergency.

In this case, the responding paramedic, the medical examiner, and the restraint expert all concluded that Mr. Prude had been experiencing Excited Delirium Syndrome (“ExDS”), a rare medical condition that can render a person vulnerable to cardiopulmonary arrest and sudden death, especially when restrained. As discussed below, people experiencing this condition generally display some relatively classic symptoms and Mr. Prude presented with nearly every one of them.⁵² The RPD officers who restrained Mr. Prude were largely unfamiliar with ExDS, its most salient features, and how to best handle this specific type of medical emergency. Since 2015, when Ex. Order 147 conferred jurisdiction to this office over all police-involved unarmed civilian deaths, we have seen similar scenarios repeat themselves across the state, with devastating and fatal consequences. This compels us to recommend that law enforcement, dispatchers, and emergency medical service (“EMS”) personnel be trained about ExDS and how best to manage a safe and coordinated response to this serious medical condition.

This topic can be controversial and for good reason. Some of the more commonly cited symptoms of an ExDS event include reduced sensitivity to pain, aggression, and extreme strength, features that overlap with racist stereotypes of Black men. And these stereotypes continue to put Black people in danger, including in the context of medical treatment and how they are viewed and treated by police.⁵³ It is hardly surprising then, that some would look upon the existence of ExDS with extreme skepticism and concern.⁵⁴

Moreover, some argue that ExDS is a post-hoc diagnosis meant to shield police from brutality claims.⁵⁵ Yet while the majority of reported deaths have happened in the context of law enforcement, individuals have died as a consequence of ExDS events in the absence of police

⁵² The only classic symptom of ExDS that Mr. Prude did not display was that he was initially compliant with PO Vaughn’s directives, indicating that he was amenable to de-escalation. We address this more fully below (RECOMMENDATION II).

⁵³ See e.g. Sabin, Janice A. “How We Fail Black Patients in Pain.” *AAMC*, 6 Jan. 2020, www.aamc.org/news-insights/how-we-fail-black-patients-pain, (racial bias in the medical profession and its effect on the manner in which Black people and white people are treated for pain); Wilson, J. P., Hugenberg, K., & Rule, N. O. (2017). Racial bias in judgments of physical size and formidability: From size to threat. *Journal of Personality and Social Psychology*, 113(1), 59–80, (study revealing that people perceive young Black men as bigger and more physically threatening than equally sized young white men).

⁵⁴ Here we note that only recently has the American Medical Society recognized the threat to public health caused by systemic racism and vowed to take steps to combat it. See, <https://www.ama-assn.org/press-center/ama-statements/ama-board-trustees-pledges-action-against-racism-police-brutality> (June 7, 2020); <https://www.ama-assn.org/delivering-care/health-equity/ama-racism-threat-public-health> (November 16, 2020).

⁵⁵ https://www.washingtonpost.com/outlook/chokehold-police-excited-delirium/2020/07/17/fe907ec8-c6bc-11ea-b037-f9711f89ee46_story.html

involvement.⁵⁶ Further, while we regularly contend with the realities of police brutality and excessive force, we are unaware of any scientific studies in peer reviewed literature endorsing the notion that ExDS is a concocted, false finding that was generated to shield police misconduct. In other words, we have identified numerous studies (only a fraction of which are cited in this Recommendation) acknowledging the condition known as ExDS and could find no scientific literature disproving those studies or the existence of ExDS.⁵⁷ Put simply, we believe, based on the literature, that a revised response to individuals with ExDS symptoms can and will save lives.

In 2008, the American College of Emergency Physicians convened a panel of experts to examine whether or not “the entity commonly referred to as ‘Excited Delirium’ exists” and if so, whether or not it could be better defined, identified, and treated.⁵⁸ The unanimous conclusion of the panel members was that ExDS did exist and could be identified “by the presence of a distinctive group of clinical and behavioral characteristics.”⁵⁹ The panel further noted that in some cases, ExDS “may be amenable to early therapeutic intervention.”⁶⁰

Emergency physicians are not the only category of physicians to recognize ExDS as a syndrome with unique, identifiable features. In 2017 the National Association of Medical Examiners published a position paper within which the organization also recognized ExDS.⁶¹ Notably, emergency care physicians and medical examiners are the two types of doctors who actually see and examine individuals who are experiencing or have experienced ExDS – one in the

⁵⁶ See e.g., <https://www.floridatoday.com/in-depth/news/2019/10/24/excited-delirium-custody-deaths-gregory-edwards-melbourne-taser/2374304001/> - Story revealing that of the 85 deaths attributed to “Excited Delirium Syndrome” in Florida between 2009 and 2019, at least 22% did not involve law enforcement.

⁵⁷ Perhaps the closest any scientific literature comes to challenging ExDS is, Strommer EM, Leith W, Zeegers MP, Freeman MD. The role of restraint in fatal excited delirium: a research synthesis and pooled analysis. *Forensic Sci Med Pathol*. 2020 Dec; 16(4) 680-692, accessible online at: <https://pubmed.ncbi.nlm.nih.gov/32827300/>. Yet the authors do not dispute that ExDS exists; rather they argue that ExDS should be classified consistently as Agitated Delirium Syndrome, whether death results or not. They also assert that there is “no evidence to support ExDS as a cause of death in the absence of restraint.” That assertion stands in contrast to other scholarly work (See, e.g. Karch, S.B. (2005). ‘Autopsy, Findings / Drug Deaths’ in Payne-James J. (ed.) *Encyclopedia of Forensic and Legal Medicine*. Elsevier Ltd. 198-203. “[D]ecedents are often to be found in the shower, with cold water running, or surrounded by wet towels and ice cube trays.”) as well as otherwise newsworthy stories (Roach B, Echols K, Burnett A. Excited Delirium and the Dual Response. Preventing In-Custody Deaths. FBI Law Enforcement Bulletin July 8, 2014. <https://leb.fbi.gov/articles/featured-articles/excited-delirium-and-the-dual-response-preventing-in-custody-deaths>. “[For instance], a case occurred involving an Anderson University basketball player. An Anderson County, Indiana, coroner “said [the man] had complained of cramps and vision problems just before he collapsed on a campus basketball court September 30 and had an ‘extremely elevated body temperature’ when he was rushed to the emergency room ... The man’s death days later was caused by ‘acute drug toxicity with ExDS that led to multiple organ failure.’”)

⁵⁸ ACEP Excited Delirium Task Force. *White Paper Report on Excited delirium Syndrome*. 2009. Accessible online at: https://www.prisonlegalnews.org/media/publications/acep_report_on_excited_delirium_syndrome_sept_2009.pdf.

⁵⁹ *Id.*

⁶⁰ *Id.*

⁶¹ Mitchell RA Jr, Diaz F, Goldfogel GA, et al. National Association of Medical Examiners Position Paper: Recommendations for the Definition, Investigation, Postmortem Examination, and Reporting of Deaths in Custody. *Acad Forensic Pathol*. 2017;7(4):604-618. Accessible online at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6474445/>

acute setting of the emergency department and the other after death, during the autopsy. Accordingly, the two branches of the medical field that deal directly with this condition both recognize it.

Some argue that ExDS has not been formally recognized by the American Medical Association (AMA),⁶² and while that assertion is technically true, it is also incomplete. The AMA has never formally taken up the subject of whether ExDS is real, but the organization *has* endorsed its existence in a resolution addressing the separate subject of Taser use by law enforcement. Specifically, in a 2009 resolution, the AMA noted:

*Excited delirium is a widely accepted entity in forensic pathology and is cited by medical examiners to explain the sudden in-custody deaths of individuals who are combative and in a highly agitated state. Excited delirium is broadly defined as a state of agitation, excitability, paranoia, aggression, and apparent immunity to pain, often associated with stimulant use and certain psychiatric disorders.”*⁶³

In sum, it appears that every panel or working group to have addressed the issue of whether or not ExDS exists has concluded that it does, that it is characterized by identifiable features, and that it renders individuals vulnerable to sudden death.⁶⁴

To be sure, much remains ill-defined about why ExDS occurs in some individuals and not others, but genetic factors appear to play a role.⁶⁵ And while the precise pathophysiology of ExDS has not been fully elucidated, the scientific literature points to elevated dopamine levels generating a neurological cascade that can ultimately culminate in sudden death.⁶⁶ But significantly, ExDS, a

⁶² See above at fn55.

⁶³ American Medical Association. Use of TASERS by Law Enforcement Agencies (Resolution 401, A-08). Resolutions of the 2009 AMA National Convention. 2009. Accessible online at: <https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/about-ama/councils/Council%20Reports/council-on-science-public-health/a09-csaph-tasers.pdf>

⁶⁴ See above at fn56, fn59, and fn61. See also e.g., Special Panel Review of Excited Delirium. Less-Lethal Devices Technology Working Group. National Institute of Justice Weapons and Protective Systems Technologies Center (2011) (“[T]he consensus of this panel is that [Ex DS] certainly exists as a syndrome.”). https://www.prisonlegalnews.org/media/publications/wpstc_special_panel_review_excited_delirium_dec_2011.pdf; Report of the Tucson Sentinel Event Review Board (SERB) on the Deaths in Custody of Mr. Damien Alvarado and Mr. Carlos Adrian Ingram-Lopez. 2020. (“[T]he existence of excited delirium is supported in the medical literature and the medical professionals participating in the [panel] were unanimous in their belief that the risk factors indicating a higher risk of death are accurate and real.”). <https://bloximages.chicago2.vip.townnews.com/tucson.com/content/tncms/assets/v3/editorial/b/a1/ba1a6be6-a50b-5384-9e42-5f7d27d3fcb0/5f656840a85d2.pdf.pdf>.

⁶⁵ Mash D. Excited Delirium and Sudden Death: A Syndromal Disorder at the Extreme End of the Neuropsychiatric Continuum. *Front. Physiol.* 13 October 2016. <https://www.frontiersin.org/articles/10.3389/fphys.2016.00435/full#B81>

⁶⁶ See e.g., Wesley K. Excited Delirium Strikes without Warning. *J. Emerg. Med.* 2.1.2011. <https://www.jems.com/administration-and-leadership/excited-delirium-strikes-witho/>; Takeuchi A, Ahern TL, Henderson SO. Excited Delirium. *West. J. Emerg.* 2011 Feb; 12(1): 77-83. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3088378/>.

rare condition in and of itself, does not always portend a fatal outcome and appropriate intervention can reduce the possibility of death.⁶⁷

Since Executive Order 147 was issued on July 8, 2015, all restraint-related deaths in New York (with or without additional force beyond the restraint itself) have been conveyed to a single office for review – the OAG. If those deaths had instead remained with local prosecutors, a comprehensive, aggregate view of this issue, which is what compelled and guides this recommendation, would not have been possible; this is particularly true in light of the variation among Medical Examiners as to how they classify the cause and manner of restraint-related deaths.⁶⁸ The OAG has, in turn, repeatedly observed cases throughout the state with strikingly similar factual characteristics and we cannot ignore this. If ExDS is accepted as a medical emergency requiring an immediate and coordinated response, lives might be saved.⁶⁹ Stated differently, “[t]he current debate surrounding whether or not ExDS exists limits first responders and emergency physicians in their ability to increase awareness, improve training and interventions, and design appropriate policy and response protocols to reduce arrest related deaths.”⁷⁰

The term ‘Excited Delirium’ has “generally been used to describe patients displaying altered mental status with severe agitation and combative or assaultive behavior that has eluded a unifying, prospective clinical definition.”⁷¹ Further, ExDS presents with rapid onset and is generally characterized by the following additional salient features: bizarre behavior, shouting, paranoia, panic, unexpected physical strength, and hyperthermia (above normal body temperature).⁷² Stimulant and hallucinogenic drugs can trigger ExDS - chief among them cocaine, methamphetamine, PCP, and LSD.⁷³

RPD’s current training regarding restraint-related death is very general and essentially amounts to warnings that any person could potentially die if restrained and not removed from the prone position as soon as possible, especially people on drugs. Instructing for broad awareness is better

⁶⁷ See e.g., Vilke GM, Payne-James J, Karch SB. Excited delirium syndrome: Redefining an old diagnosis. *J. Forensic Leg. Med.* 2012; 19(1): 7-11. Not available online.

⁶⁸ In many of our cases, medical examiners do not expressly reference ExDS as a cause of death, instead describing it in terms such as, ‘sudden death during prolonged physical altercation,’ ‘cardiac arrest during an excited state,’ or ‘mixed drug toxicity with agitated behavior.’ We have also observed wide variation in the way the manner of death is expressed - some medical examiners describe the manner of death in these cases as ‘homicide’ (with or without a qualification that the homicide designation is a medical, not legal, determination), some deem the manner of death ‘accident’ and others find it ‘undetermined.’ In referencing the cases we have observed across the state, we use the guideline of characteristics presented in the Excited Delirium White Paper, referenced in fn58 above.

⁶⁹ See e.g., Bornstein K, Montrieff T, Parris MA. Excited Delirium: Acute Management in the ED Setting. *EM Resident* 4/8/2019. <https://www.emra.org/emresident/article/excited-delirium/>.

⁷⁰ Baldwin S, Hall C, Bennell C, Blaskovits B, Lawrence C. Distinguishing features of Excited Delirium Syndrome in non-fatal use of force encounters. *J Forensic Leg Med.* 2016 Jul; 41:21-7. <https://pubmed.ncbi.nlm.nih.gov/27107564/>.

⁷¹ Vilke GM, DeBard ML, Chan TC, Czarnecki F, Heck J, Boxeman WP. Excited Delirium Syndrome (ExDS): Defining Based on a Review of the Literature. *J. Emerg. Med.* 2012 Nov 1; 43(5), 897-905, 898.

⁷² Takeuchi A, Ahern TL, Henderson SO. Excited Delirium. *West. J. Emerg.* 2011 Feb; 12(1): 77-83. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3088378/>.

⁷³ Ordoobadi A, Kivlehan S. CE Article: Excited Delirium. *EMS World.* May 2017. <https://www.emsworld.com/216063/ce-article-excited-delirium>.

than not instructing at all, but with an issue like ExDS, specific training is necessary. Broad warnings can numb a receiver to the message – especially when some officers encounter people on drugs regularly but may only encounter a person exhibiting the signs of ExDS once, if at all, during their career.

RPD’s specific instruction on ExDS consists of two slides presented during the police academy, which are reproduced below.

Excited Delirium

“A state of extreme mental and physiological excitement, characterized by extreme agitation, hyperthermia, hostility, exceptional strength and endurance without fatigue”

Many similarities to an emotionally distressed person

The significant difference is that they may be under the influence of an unknown substance or synthetic drug

Excited Delirium

- True emergency leading to death.
- Body core is overheating.
- Very agitated.
- Extreme strength.
- Patient will be removing clothing.
- Diaphoretic.
- Need for police intervention.
- Patient will need to be restrained.
- Needs body core cooling and oxygen.
- Rapid Transport

There is no information whatsoever presented about *how* death in these circumstances comes about, or *when* (i.e. usually during the restraint), or *what* the best practice is for police to follow when dealing with individuals manifesting these symptoms.⁷⁴ The slides call for restraint without noting that struggle and restraint can be fatal and without providing any techniques to reduce the risk of death. The slides give officers notice of the term ExDS, indicate that drugs may be involved, and provide some of the symptoms, without sufficient useful or practical information.

When the paramedic advised PO Vaughn that Mr. Prude was experiencing ExDS, PO Vaughn replied, “Yeah, I know what excited delirium is.” During his interview with the OAG, PO Vaughn said that he had heard of ExDS and believed it to be a psychiatric condition with drug involvement but had never been trained to know what it looked like or how to respond to it. While we cannot know for certain what he (or any of the other officers) knew about ExDS, the training they received in the police academy supports his assertion in this regard – they appear to have learned just enough to have heard of ExDS, but nothing useful beyond that.

While we cannot know if the ultimate outcome of this case would have been different if the officers had been properly trained regarding this medical condition, we know that the response could have been different. Mr. Prude consumed PCP - one of the substances known to sometimes cause ExDS. PO Vaughn felt that the PCP consumption was significant enough that he broadcasted it to his fellow officers, explaining that he was concerned for officer safety. What was completely missing from the equation, however, was how dangerous the officers’ restraint of Mr. Prude, who was exhibiting nearly every sign of ExDS, was to Mr. Prude’s safety.

⁷⁴ There is a 40-hour Crisis Intervention Tactics (CIT) training offered to RPD officers who wish to take it and are approved to do so. During that training, an entire presentation on ExDS is provided. None of the officers involved in this matter had taken the training. We discuss this CIT training more fully, below, in RECOMMENDATION III.

Every officer at the scene outlined the reasons why he felt it was important that Mr. Prude be taken to the ground when he was: Mr. Prude could have run away and escaped from them if allowed to get up; Mr. Prude could have fallen and harmed himself if allowed to get up; Mr. Prude could have attacked them and potentially taken a weapon if allowed to get up.⁷⁵ Whether those reasons are sufficient to call for restraint would shift once officers are placed on meaningful notice that a person exhibiting the distinct combination of symptoms that Mr. Prude displayed is at a heightened risk of cardiorespiratory arrest and could die if restrained - especially if the person is restrained without a plan and vigilant monitoring. In other words, when properly trained, the analysis becomes - is the risk that Mr. Prude might run away, attack us, or take our weapons outweighed by the risk that if we restrain Mr. Prude he might die? Unlike many individuals exhibiting signs of ExDS, Mr. Prude showed early signs that he was amenable to de-escalation. Well-trained, the officers may have decided against stabilizing Mr. Prude on the ground when they did, and if not, that would have weighed into the determination of whether or not their actions were reasonable.

For these reasons, some law enforcement agencies have begun to proactively train officers to recognize the features of ExDS and issue policies describing a safer, appropriate and effective coordinated response.⁷⁶ Generally these policies contain the following guiding principles:

- (1) Recognize ExDS's characteristic features;
- (2) De-escalate *if at all possible* until EMS arrives on scene;
- (3) Restrain quickly (and when at all possible only after EMS is at the ready);
- (4) Assist EMS with whatever is needed to address the medical emergency.⁷⁷

We recommend that the Division of Criminal Justice Services incorporate the expanded training on ExDS referenced above (fn74) into the basic police academy curriculum, so that recruits are provided with the full spectrum of information as early as possible. But we believe this training should go beyond the academy.

⁷⁵ We feel compelled to point out that emerging data show what many have long known to be the case - Black people are disproportionately subjected to uses of force when compared to white people. *See generally*, Peeples, Lynne. "What the Data Say about Police Brutality and Racial Bias – and Which Reforms Might Work." *Nature News*, Nature Publishing Group, 19 June 2020. (available online at <https://www.nature.com/articles/d41586-020-01846-z>). *And see*, Spencer K, Charbonneau A, Glaser J. Implicit Bias and Policing. *Social and Personality Psychology*. 2016, October 1: 50-63. We hope that many aspects of this tragic case can lead to meaningful change, including an uncomfortable but necessary conversation about whether Mr. Prude would have been taken to the ground when he was, or if at all, had he had been white.

⁷⁶ *See e.g.*, Sonoma County Sheriff's Department – Law Enforcement Division 309 – Excited Delirium <https://sonomacounty.ca.gov/WorkArea/DownloadAsset.aspx?id=2147539234>; International Association of Chiefs of Police – Model Policy -Excited delirium (April 2017) – <https://www.theiacp.org/resources/policy-center-resource/excited-delirium> (members only); Dallas Police Department 905.00 Drug Induced Psychosis / Excited delirium - <https://dallaspolice.net/resources/Shared%20Documents/General-Orders.pdf>; Seattle Police Department 16.135 – POL - <https://www.seattle.gov/police-manual/title-16---patrol-operations/16135---excited-delirium>.

⁷⁷ The American College of Medical Toxicology (ACMT) supports the use of sedatives such as ketamine in the pre-hospital care setting for the express purpose of reducing the threat of death to a person experiencing ExDS. However, the ACMT *does not* support the use of sedatives at the simple behest of law enforcement officers in order to help officers control an uncooperative subject. *See*, https://www.acmt.net/cgi/page.cgi/zine.html/The_ACMT_-_Connection/Statement_on_Ketamine_Sedation_and_Law_Enforcement.

This is not only a law enforcement issue. Therefore, responding to an ExDS event must involve “a coordinated response by dispatchers, law enforcement, paramedics, and emergency department medical staff.”⁷⁸ For instance, dispatchers should be trained that certain 911 calls (such as calls indicating that a person is naked or inappropriately clothed and acting in a bizarre manner) signal a potential ExDS situation and they should dispatch an ambulance to stage in the area immediately. Law enforcement officers must attempt to de-escalate for as long as at all possible, while awaiting the arrival of EMS.⁷⁹ In turn, EMS should respond to these calls with the full knowledge that ExDS may be involved and have a planned response ready to execute swiftly.⁸⁰ Law enforcement and EMS should work together in a coordinated manner, and since these are *medical* emergencies, once EMS is present, their assessment of how to treat the patient should govern. Likewise, hospital personnel should know in advance that a person being transported to their facility, whether conscious or not, appears to be experiencing ExDS. Since all of this requires a coordinated response, we highly recommend that each of the stakeholders mentioned above (dispatchers, law enforcement, EMS, and emergency department personnel) work together to develop a community-wide response policy, disseminate it to their respective organizations, and conduct trainings together.

There was *no* coordinated response whatsoever in this case. And perhaps the most stunning aspect of the lack of coordination is that the Rochester area stakeholders actually had coordinated on training about the best way to respond to ExDS situations. In 2013, the Monroe County EMS Medical Director (an emergency department physician at Strong Hospital) worked with members of local law enforcement agencies to produce a training video for local EMS providers and law enforcement officers.⁸¹ In fact, the paramedic who responded to this incident had watched the video; but the RPD (despite some of its members taking part in the video’s production) never made watching the video a part of its in-service trainings.

Eight years have passed since the video was produced, and knowledge about ExDS as well as the body of scientific literature has certainly expanded, but the information provided in that video remains highly relevant and foretold what happened in this case. For instance, the following information is provided approximately four minutes in, “*So what is the classic case of arrest related deaths? Generally, it’s a middle-aged male, who is agitated and belligerent. Police are summoned because of this behavior. He is then apprehended by police where he is eventually subdued and restrained. Shortly thereafter he goes into cardiac arrest and dies.*” The video goes

⁷⁸ Special Panel Review of Excited Delirium. Less-Lethal Devices Technology Working Group. National Institute of Justice Weapons and Protective Systems Technologies Center (2011).

https://www.prisonlegalnews.org/media/publications/wpstc_special_panel_review_excited_delirium_dec_2011.pdf

⁷⁹ We discuss de-escalation more fully below, RECOMMENDATION II and while we recognize that people experiencing an excited delirium event may not always be amenable to de-escalation techniques, Mr. Prude displayed that he, at least partially, was.

⁸⁰ Roach B, Echols K, Burnett A. Excited Delirium and the Dual Response. Preventing In-Custody Deaths. FBI Law Enforcement Bulletin July 8, 2014. Accessible online at: <https://leb.fbi.gov/articles/featured-articles/excited-delirium-and-the-dual-response-preventing-in-custody-deaths>.

⁸¹ The video is online at https://www.mlrems.org/VodCastPlayer/player.html?video=HYPe_BPu6FI&format=w (at the end an actual ExDS situation in Appleton WI is highlighted; the responding officer demonstrated knowledge of the condition and provided a calming presence which was followed by a well-coordinated, team response.)

on to describe how officers can recognize the signs of ExDS, including the fact that, “oftentimes, the subject will take off their clothes in public, regardless of the outside temperature.” It also makes clear that ExDS is a medical issue, that coordination between law enforcement and EMS is a key to minimizing the risk of death; and recommends restraint techniques for use in these situations.⁸²

RPD had at the ready the type of local training we encourage every agency to implement, yet its members were not required to watch it. Again, we cannot know whether the outcome of this case would have been different if the officers on scene *had* been required to see the training video, but the marker against which their actions were judged certainly would have been.⁸³

In recommending that agencies develop protocols and adhere to best practices regarding ExDS, we acknowledge that restraint can contribute to the deaths of individuals suffering from this condition. In fact, individuals exhibiting the hallmark symptoms of ExDS such as tachycardia (elevated heart rate), hyperthermia (increased body temperature), tachypnea (rapid breathing) and extreme agitation, are particularly vulnerable to the stress and rigor of restraint; this is particularly problematic when the person struggling against the restraint is largely impervious to pain and does not fatigue normally.⁸⁴ The confluence of these dynamics means that, “[t]he patient with excited delirium [often] continues to fight the restraint until cardiac arrest occurs.”⁸⁵

Of course, the challenge lies in the fact that people experiencing an ExDS event need medical intervention, and restraint will generally be necessary to provide that intervention. It stands to reason that law enforcement officers, who will invariably be called upon to respond to, interact with, and likely restrain individuals in these unique circumstances, should be trained to recognize ExDS and the safest way to manage these medical emergencies.

⁸² We recommend updating the video to include the newest information about ExDS, the role of dispatchers in a coordinated response and the dangers of racial stereotypes and bias.

⁸³ As noted during the factual portion of this report, as soon as the paramedic heard that a naked man was running in the street in freezing weather acting irrationally, she surmised (accurately) that ExDS was involved. We cannot understand why the ALS supervisor was not also paged to stage as a precautionary measure. We also note that the paramedic and the EMT appeared to display no sense of urgency whatsoever during this call, despite the fact that the paramedic was familiar with ExDS, had seen the training video, and knew that the longer someone struggled against restraint, the greater the likelihood of death. When asked about their response, the paramedic and EMT both indicated that they are trained not to rush because when they rush mistakes are made. We understand that, and we also understand that their conduct, and the conduct of the police officers and the civilian witness who recorded Mr. Prude, is being viewed with the benefit of hindsight. However, we hope that in addition to law enforcement, EMS personnel will use this incident to improve their responses going forward. In the factual portion of this report (fn11), we indicated that PO Vaugh spoke of a prior incident involving a naked man on a hallucinogenic drug who dove head first out of an open patrol car window. We reviewed that incident and found that getting that man onto the gurney and into the ambulance was a more coordinated and swiftly executed effort, and that man lived. We also note that the subject in that incident was a white college student.

⁸⁴ See e.g., Wilson, M & Vilke G. (2013). The patient with excited delirium in the emergency department. In L. Chepenik & M. Mallory (Authors) & L. Zun (Ed.), *Behavioral Emergencies for the Emergency Physician* (pp. 125-131). Cambridge University Press. https://www.researchgate.net/publication/283743169_The-patient-with-excited-delirium-in-the-emergency-department.

⁸⁵ Wesley K. Excited Delirium Strikes without Warning. *J. Emerg. Med.* 2.1.2011. <https://www.jems.com/administration-and-leadership/excited-delirium-strikes-witho/>.

Finally, we note that not only can ExDS policies and training potentially save lives, they can also promote police accountability. When an officer is properly trained, and does not act in accordance with that training, that failure weighs into the determination of whether the officer's conduct was "objectively reasonable."⁸⁶ And as noted above (LEGAL PRINCIPLES) the risk of death inherent in this (or any) situation, as well as the officer's knowledge of that risk, is an element of potential homicide charges that must ultimately be proven beyond a reasonable doubt.

We therefore recommend that RPD and all police organizations work with their local communications / 911 offices, EMS partners, and medical facilities to learn about ExDS and proactively implement policies for how best to respond to these critical, medical incidents. Specifically, officers should be trained, consistent with best standards, on how to reduce the likelihood of death in these situations, including when and how to restrain people with ExDS in order to minimize harm to themselves or others. Training on this subject must be done in a culturally competent manner and should explicitly address how racial stereotypes and bias can impact the police response and the perception of a person's symptoms, both of which lead to restraint.

⁸⁶ *Graham v. Connor*, 490 US 386 (1989). See also Michael L. Storey. Explaining the Unexplainable: Excited delirium Syndrome and its Impact on the Objective Reasonableness Standard for Allegations of Excessive Force. St. Louis University Law Journal Vol 56 Number 2 (2012).
<https://scholarship.law.slu.edu/cgi/viewcontent.cgi?article=1379&context=lj>

II. New York Should Mandate De-Escalation Training for all Police Officers and Agencies Should Reflect a Commitment to De-Escalation in their Use of Force Policies.⁸⁷

When last examined comprehensively (December 2017), twenty-one states had acted to require that police officers receive de-escalation training;⁸⁸ New York was not one of those states and that has not changed. We have made a similar recommendation [previously](#), noting at the time that de-escalation techniques carry the potential to save lives in situations that might otherwise evolve into tragic uses of force.⁸⁹ In the previous case, a subject was shot and killed by an officer who did not attempt any de-escalation whatsoever. In this case, the lack of any effort to de-escalate, when confronting a man in a crisis situation, who had shown himself amenable to de-escalation early on, compels us to issue this recommendation yet again. Even as data emerge establishing that de-escalation techniques significantly reduce uses of force and injuries to officers and citizens alike,⁹⁰ even as courts urge the use of de-escalation in their decisions,⁹¹ and even as other states act to require de-escalation training, New York has taken no action in this regard. We therefore again recommend that the state legislature require that all law enforcement officers receive training in how to defuse incidents, using communications-based de-escalation, as a condition of their continued employment.⁹²

Further we encourage agencies to embrace a commitment to de-escalation by updating their Use of Force policies to reflect that commitment. In particular, agencies should emphasize that the sanctity of life, both civilian and officer, is paramount; when a situation can be resolved without

⁸⁷ We recognize that the term ‘de-escalation’ can carry different meanings. For purposes of this recommendation, we use the Department of Justice definition, specifically “the strategic slowing down of an incident in a manner that allows officers more time, distance, space and tactical flexibility during dynamic situations ...”. <https://www.justice.gov/opa/pr/justice-department-applauds-adoption-police-department-wide-tactical-de-escalation-training>.

⁸⁸ <https://www.apmreports.org/story/2017/12/20/more-states-training-police-to-use-words-not-guns>; <http://govred.com/blog/deescalation-training-state-requirements/>.

⁸⁹ See e.g. <https://theintercept.com/2017/11/09/baltimore-police-deescalation-video/> (detailing an encounter between a Baltimore Police Officer trained in de-escalation and a male with a knife; includes video); see also e.g., <https://sanfrancisco.cbslocal.com/2018/10/31/san-francisco-police-credit-de-escalation-training-for-fewer-use-of-force-incidents/>; <https://www.bloomberg.com/news/articles/2020-06-04/how-camden-new-jersey-reformed-its-police-department>; <https://www.fox6now.com/news/nj-police-department-didnt-fire-single-shot-in-2020-thanks-to-de-esclation-program>.

⁹⁰ Engel R., Corsaro N., Isaza G., McManus H. Examining the Impact of *Integrating Communications, Assessment, and Tactics (ICAT)* De-escalation Training for the Louisville Metro Police Department: Initial Findings. October 30, 2020. (Accessible online at: https://www.theiacp.org/sites/default/files/Research%20Center/LMPD_ICAT%20Evaluation%20Initial%20Findings%20Report_FINAL_10.30.20%20Update.pdf).

⁹¹ See, e.g., *Elizondo v. Green*, 671 F. 3d 506, 511-512 (5th Cir. 2012)(DeMoss, concurring)(“Either law enforcement procedures or our law must evolve if we are to ensure that more avoidable deaths do not occur at the hands of those called to ‘protect and serve.’ Saving lives remains job number one for every law enforcement agency, and it is imperative that they have better procedures in place to deal with those persons who are young, intoxicated, mentally ill, or otherwise likely to react poorly in already volatile situations.”)

⁹² These techniques are tools. We do not imply that de-escalation will be appropriate in all circumstances; nor do we suggest that de-escalation training will obviate every use of force. We seek to ensure that law enforcement officers in this state possess the tools and training they need to resolve as many incidents as possible without force while recognizing that sometimes that will not be possible.

the use of force, it should be, regardless of whether force is technically permissible.

Before discussing this recommendation, we take this opportunity to outline broadly the requirements for police training in New York. In doing so, we recognize that many agencies in this state train their members to a level that far exceeds what is required by law, including the RPD. However, Executive Order 147 requires that we provide recommendations for “systemic reform arising from [our investigations]” and accordingly, this recommendation will address the issue of training statewide.

In New York, all individuals hired by municipal police agencies to become police officers must, within one year of appointment, successfully complete an approved Basic Course for Police Officers (“basic course”) administered by the New York State Division of Criminal Justice Services (“DCJS”).⁹³ Once an officer completes the basic course (informally known as the police academy) and is certified by DCJS, the state of New York does not require any further in-service training as a condition of that officer’s continued employment, unless and until the officer is promoted to a first-line supervisory position.⁹⁴

DCJS offers a voluntary accreditation process that constitutes a “progressive and contemporary way of helping police agencies evaluate and improve their overall performance.”⁹⁵ Accreditation requires that an agency achieve and maintain various standards, including the provision of 21 hours of yearly in-service training to its members.⁹⁶ However, the accreditation process is voluntary and of the 514 law enforcement agencies in New York, fewer than 1/3 are accredited.⁹⁷ Moreover, while 21 hours of annual training is required in order to maintain accreditation, there is no requirement that any part of that training cover de-escalation skills.⁹⁸

In 2018, DCJS increased the minimum number hours dedicated to instruction on mental illness in the basic course from 14 to 20 hours, implemented through a training module entitled, “Fundamentals of Crisis Intervention for Law Enforcement.” During that training, recruit officers learn information about mental illness and attain some valuable crisis intervention skills. Upon leaving the academy, however, RPD officers (until recently) received no additional training in communicating with people in crisis unless they chose to enroll in an expanded, 40-hour Crisis Intervention training, offered once each year. On January 19, 2021, in the wake of this tragic case,

⁹³ See, New York State General Municipal Law (GML) §209-q (1)(a); *and see*, <https://www.criminaljustice.ny.gov/ops/training/bcpo/bcpo01.htm>.

⁹⁴In that case, the officer must complete an approved course in police supervision. See New York State General Municipal Law §209-q (1-a).

⁹⁵ <http://www.criminaljustice.ny.gov/ops/accred/>.

⁹⁶ The OAG has previously recommended that police agencies seek and obtain DCJS accreditation: <https://ag.ny.gov/sites/default/files/oagreport-andrewkearse.pdf>, https://ag.ny.gov/sites/default/files/oag_report_-_wardel_davis_iii.pdf.

⁹⁷ <https://www.bjs.gov/content/pub/pdf/csllea08.pdf> ; <https://www.criminaljustice.ny.gov/ops/accred/accredited-agencies.htm>.

⁹⁸ https://www.criminaljustice.ny.gov/ops/docs/accred/standards_compliance_verification_manual.pdf. The required areas are firearms training, legal updates, a review of the use of force, and the use of deadly force. We understand that de-escalation may be woven into use of force or other trainings, but it is not required as a stand-alone block of training.

all law enforcement agencies in Monroe County, including the RPD, announced their intention to require that all officers receive the expanded 40-hour training,⁹⁹ and we commend this.

Nonetheless, we recommend that police agencies implement a generalized, communications-based de-escalation program that provides officers with tools they can use across a host of scenarios. The Integrating Communications, Assessment, and Tactics [“ICAT”] training program, developed by the Police Executive Research Forum [“PERF”],¹⁰⁰ is the type of general de-escalation training program we encourage agencies to implement.¹⁰¹ ICAT’s mission is to teach officers to “safely and professionally resolve critical incidents involving subjects who may pose a danger to themselves or others but who are not [known to be] armed with firearms”.¹⁰² Programs like ICAT use scenario-based training to teach officers a number of de-escalation strategies that can be employed in a variety of circumstances. Further, as noted above (fn90), ICAT has been studied and shown to actually reduce uses of force.

We reviewed RPD’s in-service training records for the ten years prior to this incident. In order to maintain its DCJS accreditation, RPD is required to provide yearly training in firearms, legal updates, and the use of force (see fn98) and this was reflected in the records. But not once during that ten-year period did RPD provide its officers with communications-based de-escalation instruction – or indeed, communications training of *any* sort - and this is typical of law enforcement agencies across the state. This disparity between firearms training and communications training appears especially illogical when considering the fact that most officers complete their careers without ever firing their service weapon, but (presumably) communicate with people during each of their shifts.¹⁰³

As noted in the factual portion of this report, Mr. Prude initially complied with PO Vaughn’s directions. When PO Specksgoor arrived on scene, Mr. Prude acknowledged that his name was Daniel, further indicating that he understood what people were saying.¹⁰⁴ And yet, upon hearing Mr. Prude’s name, not a single officer tried to use his name to speak with him; no officer tried to connect with him, distract him from rising, or simply advise him that they were there to help him.

⁹⁹ See, <https://www.whec.com/rochester-new-york-news/monroe-county-to-have-all-law-enforcement-officers-complete-crisis-intervention-team-training-this-year/5983642/>.

¹⁰⁰ <https://www.policeforum.org/about>. “The Police Executive Research Forum (PERF) is an independent research organization that focuses on critical issues in policing. Since its founding in 1976, PERF has identified best practices for fundamental issues such as reducing police use of force; developing community policing and problem-oriented policing; using technologies to deliver police services to the community; and evaluating crime reduction strategies.” And see <https://www.policeforum.org/about-icat>

¹⁰¹ The OAG cites ICAT as the *type* of program we recommend; the OAG is not expressly endorsing ICAT over any other training program, but rather, is recommending that officers be trained in the types of scenario-based techniques that the ICAT program covers extensively.

¹⁰² <https://www.policeforum.org/icat-mission-statement> [“Reducing the need to use deadly force, upholding the sanctity of life, building community trust, and protecting officers from physical, emotional, and legal harm are the cornerstones of ICAT.”]

¹⁰³ We are not suggesting that firearms training is not important; rather we are pointing out that communication skills are critical.

¹⁰⁴ As we have noted, PCP is widely known to cause erratic, often violent behavior, and we do not minimize that; but in light of Mr. Prude’s initially compliant behavior and his (at least partial) understanding of reality, including the fact that he knew the people standing around him were police officers, there was simply no reason not to try to engage with him.

There was simply no effort whatsoever to empathize with Mr. Prude, and as soon as he moved in a way that indicated he might try to rise, he was taken to the ground; the officers all said this was because if Mr. Prude rose, it could be dangerous – for Mr. Prude and for them. Not attempting to de-escalate in a situation like that - where a person was restrained, naked, unarmed, and at least partially amenable to de-escalation - reflects police training and culture.¹⁰⁵ Like so many police officers, the RPD officers involved in this case displayed a mentality that prioritized their safety to the exclusion of all else.

This mentality is reflected in RPD’s current Use of Force Policy, which, at a very practical level, does little more than restate the language of *Graham v Connor*, 490 US 386 (1989), with no meaningful attempt to prioritize a respect for the sanctity of *all* life. Many agencies across the nation are embracing the fact that *Graham* sets a floor relative to police conduct - minimum expectations that agencies are free to exceed.¹⁰⁶ Those agencies have chosen to adopt policies that set expectations well above that. We suggest that RPD adopt a policy that includes core principles such as an affirmative duty to de-escalate whenever safe and feasible, a requirement that force be used only when necessary, and a requirement that any force employed be proportional to the threat, with an ongoing duty to modulate force.

As noted above, implementing de-escalation training has been shown to *reduce* uses of force and prevent injuries to citizens and officers alike.¹⁰⁷ Therefore, pursuant to Executive Order 147’s directive that we make recommendations aimed at “systemic reform,” we recommend that the legislature act to require that police officers in New York be trained in de-escalation techniques as a condition of their continued employment; we further recommend that agencies across the state demonstrate their commitment to de-escalation principles by updating their Use of Force policies accordingly.

¹⁰⁵ See, Stoughton, Seth W. “How Police Training Contributes to Avoidable Deaths.” *The Atlantic*, Atlantic Media Company, 12 Dec. 2014, <https://www.theatlantic.com/national/archive/2014/12/police-gun-shooting-training-ferguson/383681/>

¹⁰⁶ See, <https://www.policeforum.org/assets/30%20guiding%20principles.pdf> [Principles 1-4]

¹⁰⁷ See above, [fn90].

III. All Communities Should Assess Models for Responding to Crisis Situations that Minimize or Eliminate Police Responses to Mental Health Calls Whenever Possible; Passing “Daniel’s Law” will Greatly Aid in this Endeavor.

People with an untreated mental illness are sixteen (16) times more likely to die during an interaction with police than other civilians.¹⁰⁸ And as noted previously, (fn75) Black people are disproportionately subjected to uses of force when compared to their white counterparts. Those sobering facts converged in Mr. Prude’s case. We recommend that communities do everything they can to invest in mental health responses that avoid law enforcement officers acting as first-responders whenever possible.

Although we understand that the traditional paradigm involves a police response whenever criminal behavior is suspected, the circumstances of this case demonstrate why that is not always in the public interest. This case evolved as follows:

- The incident began with a 911 call followed by a search for a suicidal, missing man;
- Shortly after the initial call, it was reported that Mr. Prude was on PCP. As noted previously, PCP is a drug not often seen in this geographic area, but known to cause highly erratic and at times violent behavior;
- The call next took on the suggestion of criminal activity when the officers were dispatched to the window break at Metro PCS (where no individuals were harmed), and began to suspect that the person they were searching for was the same person who threw the brick through the window;
- As the officers were at Metro PCS, they learned that a bleeding, naked man was running down Jefferson Ave. and responded, suspecting that the same person was involved.

By that point, the incident was (i) a search for a missing person, (ii) who was on a dangerous substance, (iii) who had potentially committed a crime but had not caused physical harm to any one, and (iv) was now bleeding and running down Jefferson Ave. Even assuming that that the City of Rochester had in place a fully operating Mental Health Response Team that could have responded at 3:30 A.M., which it did not, it is not clear that that under those circumstances there would have been no police response at all.¹⁰⁹

Our previous recommendation (mandatory de-escalation training) acknowledges that police will sometimes need to interact with people experiencing mental health issues and that the nature and quality of those interactions must change. But against the backdrop of the public awareness generated by this case, we strongly urge adoption of the best crisis response models possible. Our hope is that in the future, a case such as this will be handled by mental health providers.

¹⁰⁸ Treatment Advocacy Center. (2015). *Overlooked in the Undercounted: The Role of Mental Illness in Fatal Law Enforcement Encounters*. <https://www.treatmentadvocacycenter.org/overlooked-in-the-undercounted>

¹⁰⁹ As noted above [fn13] the ambulance crew, upon hearing only that the matter was a psychiatric call and the person involved was unarmed and reportedly not violent, still chose to stage, rather than report to the scene - until the police could confirm that it was safe for them to enter.

In response to New York State Executive Order 203, which directed every local municipality with a police force in the state to adopt a policing reform plan, the City of Rochester released its reform proposal on February 4, 2021.¹¹⁰ In its plan, the city noted, “Due to recent events, the role of police officers in responding to psychiatric calls has been in question.” It then outlined a new Person in Crisis (“PIC”) team pilot program. The PIC team would constitute a “law enforcement alternative response to mental health, domestic violence and other identified crisis calls” and would send trained social workers to calls, completely independent of police.

We believe *any* efforts to identify mental illness calls and divert them away from a law enforcement response and toward mental health specialists are highly worthwhile efforts, and PIC sounds capable of doing that. But at a press conference announcing PIC’s rollout, the city noted that, “As long as there are no weapons or injuries, or no crime has been committed” the PIC team will be dispatched to the scene. Mr. Prude was injured and had reportedly committed a crime and so his case was outside the purview of a PIC response, as the model is presently constructed.

Instead, we recommend that the City consider a tiered approach in situations where a person is in emotional distress. In instances where no crime or only a minor crime has been alleged and there is no indication of violence or other safety concerns, a trained mental health responder should be afforded first contact with the person in emotional distress. If the dispatch indicates a potential but inactive safety concern the police could be simultaneously dispatched, along with the mental health responder who would respond first. Police could set up at a staged location nearby as a precautionary measure. In that model, the dual public interests in providing necessary and effective assistance to individuals in emotional distress and ensuring that the greater community is safe are both addressed. If greater criminal conduct or safety issues are reported and the police are dispatched, it should be a joint response with mental health professionals, and it is critical that those officers have the necessary training to effectively interact with the emotionally distressed individual (*see* RECOMMENDATION II, above).¹¹¹

There are precedents for this type of model. The Vera Institute for Justice’s “Behavioral Health Crisis Alternatives, Shifting from Police to Community Responses”¹¹² provides an overview of the variety of crisis response models currently in use throughout the nation, highlighting three that have been very successfully implemented in their communities. A high degree of collaboration - from dispatchers, EMS, and law enforcement to private entities, service providers, and community leaders - is key to any alternative response model.

The City of Rochester was once at the statewide forefront of crisis intervention for people suffering from mental illness; in 2004 RPD became the first police department in the state to implement a Crisis Intervention Team.¹¹³ Our hope is that the City of Rochester working

¹¹⁰ See - <https://www.cityofrochester.gov/executiveorder203/>

¹¹¹ Rochester’s over-reliance on having its police officers respond to mental health issues was highlighted by the fact that PO Harris left the scene at Jefferson Ave. to take a separate call for “Somebody ... screaming. Possible drugs involved. *With Mental Health history.*”

¹¹² See - <https://www.vera.org/behavioral-health-crisis-alternatives>

¹¹³ See - <https://13wham.com/news/local/crisis-intervention-team-helps-those-dealing-with-mental-illness>

collaboratively with Monroe County, can work toward finding solutions that will allow “law enforcement to return to policing and ... mental health professionals to assume the role of crisis [responders.]”¹¹⁴

In the spirit of this sentiment, the OAG strongly recommends that New York State pass “Daniel’s Law.”¹¹⁵ The proposed legislation, named in honor of Daniel Prude, would make significant changes to the mental health response landscape in New York. Among its features, the law would establish mental health response units specifically trained and equipped to de-escalate mental health crises – including those involving, or precipitated by, substance abuse. Regional mental health councils would provide structure and oversight while developing appropriate response protocols. Further, the law would require training for 911 dispatchers, which, as we have noted (*see* RECOMMENDATION I, above) is crucial for ensuring the appropriate response to cases that potentially involve ExDS.

Making “Daniel’s Law” the law of New York brings with it the real potential to assist people struggling with mental illness and to allocate resources in such a way that people in need of mental health assistance receive help rather than being funneled into the criminal justice system; it will also, undoubtedly, save lives. “Daniel’s Law” represents a positive outcome arising from an otherwise tragic case and the OAG strongly recommends that it become law.

¹¹⁴ *See* – Substance Abuse and Mental Health Services Administration, “Executive Order *Safe Policing for Safe Communities: Addressing Mental Health, Homelessness, and Addiction Report*.” (October 17, 2020). Accessible online at - <https://www.samhsa.gov/sites/default/files/safe-policing-safe-communities-report.pdf>

¹¹⁵ <https://www.nysenate.gov/newsroom/press-releases/samra-g-brouk/senator-samra-brouk-chair-senate-mental-health-committee>

IV. Law Enforcement Agencies Should Explore the Use of Spit Sock Alternatives.

Spit socks are widely used by members of law enforcement, EMS providers and hospital workers in order to restrict the flow of saliva from one individual to another and thereby reduce the spread of disease. The type of spit sock in use at RPD is called the “Spit Sock Hood,”¹¹⁶ is made of mesh, and fits loosely around an individual’s head. A photograph from the manufacturer’s website of an individual wearing a Spit Sock Hood is reproduced below.



In this case, there was no evidence that the spit sock placed over Mr. Prude’s head *directly* contributed to his death. By this we mean that there was no evidence that the spit sock impeded Mr. Prude’s airflow or impaired his circulation. Further, the two (small scale) studies of the physiological effects of spit socks performed to date,¹¹⁷ each involving a different type of spit sock device, revealed that they do not impact breathing. However, both studies were performed on healthy subjects.

When the RPD officers encountered Mr. Prude, he was agitated. Placement of the spit sock over Mr. Prude’s head clearly added to his stress and agitation; we cannot know whether that further contributed to his death, but it certainly did nothing to calm him. In light of this, we recommend that agencies investigate whether alternatives to traditional spit socks, such as plastic face coverings worn by officers or regular medical masks, might be a better alternative in different situations.¹¹⁸

¹¹⁶ See, <https://www.spitsock.com/>

¹¹⁷ Lutz, M., Sloane, C. M., Castillo, E. M., Brennen, J. J., Coyne, C. J., Swift, S. L., & Vilke, G. M. (2019). Physiological effects of a spit sock. *The American journal of emergency medicine*, 37(2), 291-293; Marigold O, Castillo EM, Sloane C, Brennan J, Coyne CJ, Swift S, Vilke GM. Further study on the physiological effects of an alternative spit mask. *J Forensic Leg Med*. 2020 May;72:101945.

¹¹⁸ We are not the first to recommend this. See, https://tucson.com/news/local/tucson-police-changing-restraint-techniques-eliminating-use-of-spit-socks-on-combative-suspects/article_e99849c5-b299-50db-85c8-8f4072b3221c.html.

V. Data-Driven Analysis Should be Used to Determine the Most Effective Defensive Tactics (“DT”) Programs.

At the outset, we again note (*see* RECOMMENDATION II, above) that de-escalating a tense or volatile interaction, whenever feasible, should be the default police response. In situations where de-escalation is impossible or ineffective, and the officer goes “hands on,” the goal should be to gain custody and control over the subject as quickly as possible, in a manner that minimizes the risk of pain or injury to the subject.

As noted above during the factual portion of this report, DCJS updated its curriculum with respect to the way defensive tactics (“DT”) was taught to new recruits (and eventually sworn police officers) in 2017, shifting the focus from pain compliance techniques to a concept-based program designed to promote body stabilization. This shift in the way DT was taught was, by all accounts, a necessary and welcome change. The previous program emphasized techniques such as strikes, blows, batons, wristlocks and pressure points, with the goal of inflicting pain in order to gain subject compliance; the new, concepts-based approach focuses on maintaining mobility, creating angles, engaging and disengaging at the right times, and transitioning between tactics and weapons, with the goal of stabilizing the subject in order to gain compliance.¹¹⁹

The segmenting and “knee on top” position techniques utilized by officers involved in the restraint of Mr. Prude were included in the new curriculum and taught to the involved officers. While the new DT program appears broadly preferable to the application of pain compliance techniques (when force is necessary at all) and was designed to minimize the risk of injury to the subject, OAG is aware of no large-scale studies comparing the correlation between use of force-related injuries and deaths and the employment of different DT programs.

In order to provide a better understanding of what techniques are most effective to enable officers to gain custody and control over an individual in a manner least likely to cause injury or death, as well as better inform the development of new training policies, procedures and curriculum, we encourage data-driven analysis aimed at developing the most effective DT program available.

¹¹⁹ Jay Young, *City Officer Lays Groundwork For New Defensive Tactic Standards*, The Post-Standard (Nov. 13, 2017) (Available online at: <https://www.post-journal.com/news/page-one/2017/11/city-officer-lays-groundwork-for-new-defensive-tactic-standards/>). The shift from pain compliance to stabilization techniques did appear to reduce injuries when implemented at the Jamestown Police Department; we encourage a broader analysis.

VI. The City of Rochester should Adopt a Body Worn Camera Release Policy Regarding Critical Incidents.

It goes without saying that the manner in which the BWC was released in this case created community outrage. We have previously [recommended](#) that agencies develop policies relative to what information it will release to the public following police involved uses of force and when; and we do so again here. As of this writing, the RPD has no written, publicly available policy governing the release of video in critical incidents. For some time, law enforcement agencies have been encouraged to develop “[c]lear and concise policies and procedures relating to ... [among other issues] video evidence” in officer-involved incidents.¹²⁰ Many agencies have embraced this recommendation, generated policies, and made them available to the public; this obviously serves the dual purpose of establishing expectations and promoting consistency.

Among the most significant issues covered by critical incident video release policies are:¹²¹

- The scope of incidents to which the policy applies;
- A default number of days by which material will be released;
- The manner in which the material will be disseminated;
- A process to define when and under what circumstances release of video may be delayed; and
- A process to notify persons or entities affected or impacted by the video’s release and allow them to be heard.

The OAG recommends that minimally, any video release policy include guidance relative to these issues.

In the absence of a policy providing direction as to when, how, and under what circumstances video will be released, law enforcement agencies invite criticism for releasing video that appears to enhance the public’s perception of officers’ actions, while withholding videos that cast officers’ actions in a negative light. We therefore recommend that the RPD adopt a policy governing release of body worn camera evidence following critical incidents.

¹²⁰ Officer Involved Shootings: A Guide for Law Enforcement Leaders (2016) Office of Community Oriented Policing Services (COPS Office), U.S. Department of Justice (https://www.theiacp.org/sites/default/files/2018-08/e051602754_Officer_Involved_v8.pdf).

See also generally, BJA, CONSIDERATIONS AND RECOMMENDATIONS REGARDING STATE AND LOCAL OFFICER-INVOLVED USE OF FORCE INVESTIGATIONS, August, 2017 (http://it.ojp.gov/GIST/1202/File/Considerations%20and%20Recommendations%20Regarding%20State%20and%20Local%20Officer%20Involved%20Use%20of%20Force%20Investigations_Report%2008170.pdf);

Kuhns, Joseph B., Josie F. Cambareri, Shannon Messer, and Darrel Stephens. 2018. *Independent Investigation of Officer-Involved Shootings: Current Practices and Recommendations from Law Leaders in the United States and Canada*. Washington, DC: Major Cities Chiefs Association.

(https://www.majorcitieschiefs.com/pdf/news/ois_final_report_9_27_18.pdf)

¹²¹ The OAG examined at length the New York Police Department (NYPD) Public Release of Body-Worn Camera (BWC) Footage of Critical Incidents Policy

(https://www1.nyc.gov/assets/nypd/downloads/pdf/public_information/bwc-release-oo-54-20.pdf),

the Los Angeles Police Department (LAPD) Critical Incident Video Release Policy

(<http://assets.lapdonline.org/assets/pdf/Administrative%20Order%20No.%206.pdf>), and the Chicago Police

Department (CPD) Video Release Policy

(https://www.chicago.gov/city/en/depts/cpd/supp_info/video_release_policy.html), since those are the largest police agencies in the nation.

EXHIBIT 1



State of New York

Executive Chamber

No. 147.35

EXECUTIVE ORDER

In view of the request of Attorney General Letitia James, my order and requirement, embodied in Executive Order Number one hundred and forty-seven, dated July 8, 2015, is hereby amended to include an additional paragraph to the penultimate paragraph as amended by Executive Order Numbers 147.1 - 147.34 to read as follows:

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

(ii) of any and all unlawful acts or omissions or alleged unlawful acts or omissions by any law enforcement officer, as listed in subdivision 34 of section 1.20 of the Criminal Procedure Law, arising out of, relating to, or in any other way connected with the death of Daniel Prude on March 30, 2020, in Monroe County.



GIVEN under my hand and the Privy Seal of the
State in the City of Albany this
fifteenth day of July in the year two
thousand twenty.

BY THE GOVERNOR


Secretary to the Governor



EXHIBIT 2



CASE SUMMARY
REPORT

Case Number: 20-00902
Pathologist: Nadia A. Granger, MD
Pronounced: Mar 30 2020 8:22PM
ME Case
County/Origin: Monroe Co.

Name: Daniel T. Prude

Date of Birth: 09/20/1978

Manner of Death: Homicide

Age: 41 Years

Cause of Death: Complications of asphyxia in the setting of physical restraint
Excited delirium
Acute phencyclidine intoxication

FINAL FINDINGS

- I. Complications of asphyxia in the setting of physical restraint:
 - a. Bilateral organizing bronchopulmonary pneumonia.
 - b. Acute myocarditis.
 - c. Severe respiratory acidosis (clinical history).
 - d. Profound global hypoxic ischemic injury (clinical history).
 - i. Cerebral edema.
 - ii. Subfalcine and transtentorial herniation.
 - e. History of physical restraint in prone position (incident report).
- II. Excited delirium:
 - a. Suicidal ideation and possible auditory hallucinations and paranoia (clinical history).
 - b. Agitation and combative behavior (clinical history).
- III. Acute phencyclidine intoxication (toxicology studies).
- IV. Status post donor after cardiac death organ (liver and left kidney) procurement.

State of New York
County of Monroe ss.

Nadia A. Granger MD
Nadia A. Granger, M.D. 03/22/2020
Medical Examiner

On the 5 day of May in the year 2020
I, the undersigned, a Notary Public in and for the said
County of Monroe, personally appeared Nadia A. Granger
known to me whose name is subscribed to the within instrument
and he / she acknowledged to me that he / she executed the same in his / her
individual capacity and the terms / her signature on the instrument, the
individual executed the instrument.

Julie Ann Luedke
Signature of Notary

Number of Pages

Pursuant to CPL Sections 120.60-8 and 190.30-2
I certify that this is a true copy of an examination
performed by me.

Nadia A. Granger MD
(signature)
Nadia A. Granger
(Title)

JULIE ANN LUEDKE
Notary Public, State of New York
License No. 4848301
Qualified in Monroe County
My Commission Expires Mar. 30, 2023

8/12/23

EXHIBIT 3

Geoffrey P. Alpert

CURRICULUM VITAE
November 2020

NAME: Geoffrey P. Alpert

ADDRESS: Department of Criminology and Criminal Justice
1305 Greene St.
University of South Carolina
Columbia, SC 29208

Phone: [REDACTED]
e-mail: [REDACTED]

EDUCATION:

Ph.D.	Washington State University	1975
	University of Oregon Law School	1974-1975
M.A.	University of Oregon	1970
B.A.	University of Oregon	1969

AWARDS, FELLOWSHIPS & APPOINTMENTS:

Affiliate Professor, South Carolina School of Law. 2020 - Present

University of South Carolina President's Award for Excellence. July 2020.

Lifetime Achievement Award, Brentwood College. 2019.

Core Faculty, Rule of Law Collaborative. University of South Carolina. 2019.

University of South Carolina Russell Research Award for Outstanding Research and Scholarship. 2012.

Academy of Criminal Justice Sciences, Bruce Smith Award for Outstanding Contributions to Criminal Justice. 2009.

University of South Carolina Alpha Chapter of Mortar Board, Excellence in Teaching. 2006-2007.

University of South Carolina Alpha Chapter of Mortar Board, Excellence in Teaching. 2000-2001.

University of South Carolina Educational Foundation Research Award for Outstanding Research and Scholarship. 1995.

Police Development and Training Fellowship, German Marshall Fund, Republic of Germany. 1992.

Senior Research Scholar, Bureau of Justice Statistics, Washington, DC. 1991.

Directeur d'Etudes Associe, Maison des Sciences de L'Homme, Paris, France. 1985-1987

ADMINISTRATIVE EXPERIENCE:

Chair, Department of Criminology and Criminal Justice. University of South Carolina. Columbia. South Carolina. 2002-2007.

Director of Research, College of Criminal Justice. University of South Carolina. Columbia, South Carolina. 1988-2002.

Director, Criminal Justice Program, Department of Sociology. University of Miami. Coral Gables, Florida. 1985-1988.

Director, Center for Study of Law and Society. University of Miami. Coral Gables, Florida. 1981-1988.

Legal Ombudsman, Lane County District Attorney's Office. Eugene, Oregon. 1978-1981.

Coordinator, Victim/Witness Bureau. El Paso County District Attorney's Office. Colorado Springs, Colorado. 1979.

Director of Research, Georgia Department of Corrections. Atlanta, Georgia. 1971-1972.

TEACHING EXPERIENCE:

Professor, Department of Criminology and Criminal Justice, College of Criminal Justice, University of South Carolina. Columbia, South Carolina. August 1988-present.

Professor of Sociology, University of Miami. Coral Gables, Florida. 1985-1988.

Associate Professor of Sociology, University of Miami. Coral Gables, Florida. 1981-1985.

Assistant Professor of Sociology and Public Administration, University of Colorado. Colorado Springs, Colorado. 1978-1979.

Assistant Professor of Sociology and Political Economy, School of Social Sciences, The University of Texas at Dallas. Richardson, Texas. 1975-1977.

Teaching Assistant, Department of Sociology, Washington State University. Pullman, Washington. 1972-1976.

Instructor, Department of Sociology, Georgia State University. Atlanta, Georgia. 1971-1972.

RESEARCH EXPERIENCE:

Co-Principal Investigator, Assessment of Cognitive Performance-Based Training to Improve Police Decision-Making. National Institute of Justice. 2019-present.

Officer Involved Shootings in Phoenix. Phoenix Police Department/Police Foundation. 2019.

Member, Professional Development Committee, Major County Sheriffs of America. 2018-2020.

Chief Research Advisor, National Institute of Justice. 2017-2020.

Member, Policy Center Advisory Group. International Association of Chiefs of Police. 2017-2020.

Member, Research Advisory Board. Police Executive Research Board. 2017- present.

Principal Investigator, An Evaluation of a Social Interaction Training Program to Reduce the Use of Force and Build Legitimacy. National Institute of Justice. 2017-2020.

Member, Compliance Officer and Community Liaison Team to Implement Settlement Agreement, Portland Police Bureau. Portland, Oregon. 2015-present.

Monitor, Office of the Consent Decree Monitor for the New Orleans Police Department. New Orleans, Louisiana. 2014-present.

Co-Principal Investigator, Officer-Involved Collisions. National Institute of Justice and Center for Disease Control. 2013-2017.

Principal Investigator, Evidence Based Solutions to Reduce Law Enforcement Officer Vehicular Crashes. Bureau of Justice Assistance. 2012-2016.

Co-Principal Investigator, Evidence Reducing Police Officer Crashes. National Institute of Justice. 2011-2017.

Co-Principal Investigator, Promoting Officer Integrity through Early Engagements and Procedural Justice. National Institute of Justice. 2011-2014.

Adjunct Professor, Centre for the Excellence in Policing and Security, Griffith University. Brisbane, Australia. 2011-2014.

Member, International Association of Chiefs of Police, Research Advisory Committee. 2010-2020.

Professor, Department of Criminology and Criminal Justice and Griffith Criminology Institute, Griffith University. Brisbane, Australia. 2010-present.

Geoffrey P. Alpert

Principal Investigator, Building Bridges between Police Researchers and Practitioners: Agents of Change in a Complex World. National Institute of Justice. 2009-2013.

Principal Investigator, Perceptions of the Organization and Violence of Gangs. Bureau of Justice Assistance. 2008-2011.

Principal Investigator, A Multi-Method Evaluation of Police Use of Force Outcomes. National Institute of Justice. 2005-2009.

Academic Affiliate, The Analysis Group. Development of a Methodology for Analysis of Los Angeles Police Department Pedestrian and Motor Vehicle Stop Data. Los Angeles, California. 2004-2007.

Principal Investigator, Assessing Police Officers' Decision Making and Discretion. National Institute of Justice. 2002-2005.

Principal Investigator, Investigating Racial Profiling in the Miami-Dade Police Department. Miami-Dade County, Florida. 2000-2005.

Associate Project Director, Promoting Police Accountability. Office of Community Oriented Policing Services. 2000-2003.

Principal Investigator, The Lexington County Domestic Violence Court: A Partnership and Evaluation. National Institute of Justice. 2000-2003.

Co-Principal Investigator, The Effect of Community Policing on Urban Violence. American Statistical Association and Bureau of Justice Statistics. 2000-2002.

Principal Investigator, An Analysis of the Force Factor: Measuring Police Use of Force Relative to Suspect Resistance. National Institute of Justice. 1998-2001.

Member, Olympic Research Group. Atlanta Committee for the Olympic Games. 1996.

Principal Investigator, Facilitating Organizational Change: Shaping Philosophies Through Individual and Organizational Evaluations. National Institute of Justice. 1996-1999.

Principal Investigator, An Analysis of Police Use-of-Force Data. National Institute of Justice. 1996-1998.

Principal Investigator, Evaluation of Hi-Risk Police Activities. Insurance Reserve Fund. State of South Carolina. 1995.

Principal Investigator, Police Pursuit Driving and Use of Excessive Force. National Institute of Justice. 1994-1997.

Geoffrey P. Alpert

Principal Investigator, Firearm Use and Analysis. Metro-Dade Police Department, Florida. 1994-1995.

Principal Consultant, State Evaluation Capacity Building Program. National Institute of Justice. 1992-1996.

Member, Study Group on Criminal Justice Research and Outcome Measures. Princeton University/Bureau of Justice Statistics. 1992-1994.

Co-Principal Investigator, Evaluation of Tactical Narcotics Team. Metro-Dade Police Department, Florida. 1991-1993.

Research Professor, Institute of Public Affairs, University of South Carolina. 1989-1996.

Principal Investigator, Police Officer Task Analysis, City of Columbia. South Carolina. 1989-1990.

Principal Investigator, National Survey of Security Needs. American Society of Industrial Security, 1989-1990.

Principal Investigator, Firearm Use and Analysis. Metro-Dade Police Department, Florida. 1988-1989.

Principal Investigator, Police Pursuit Project. U. S. Department of Transportation. 1987-1988.

Director, Review of Deadly Force Training and Policies, Dallas Police Department. Texas. 1986-1987.

Co-Director of Research, School Dropout Prevention Center, University of Miami. Florida. 1985-1986.

Research Director, Police Pursuit Project, Dade Association of Chiefs of Police. Dade County, Florida. 1985-1988.

Principal Investigator, Impact of Police Behavior in a Multi-Ethnic Setting. Metro-Dade Police Department, Florida. 1985-1986.

Research Director, Use of Deadly Force Project, Dade Association of Chiefs of Police. Dade County, Florida. 1983.

Consultant, Deadly Force Project. Police Foundation. Washington, D.C. 1983-1984.

Research Associate, Graduate School of Education, Harvard University. Cambridge, Massachusetts. 1977.

Research Associate, Southeastern Correctional and Criminological Research Center. Florida State University. Tallahassee, Florida. 1971.

PUBLICATIONS:

Books and Monographs:

Dunham, R. and G. Alpert (eds.). Critical Issues in Policing: Contemporary Readings. 8th edition. Prospect Heights, IL: Waveland Press (2021).

Ready, Justin, Louise Porter, Geoffrey Alpert, Mark Wheatley, Katelyn Jansen and Tiahna Mulholland. 2020. International Review of Command and Control for New Zealand Police. Griffith University: Brisbane, Australia.

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Rojek, J., J. Nix, S. Wolfe, G. Alpert, J. Burch, J. Grieco, and T. Robbins. Analysis of 2018 Use of Deadly Force by the Phoenix Police Department. National Police Foundation: Washington, DC (2019). www.policefoundation.org/publication/analysis-of-2018-use-of-deadly-force-by-the-phoenix-police-department/

Rojek, J., P. Martin, and G. Alpert. Developing and Maintaining Police-Researcher Partnerships to Facilitate Research Use: A Comparative Analysis. New York: Springer (2015).

Alpert, G., R. Dunham, and M. Stroshine. Policing: Continuity and Change. 2nd edition. Prospect Heights, IL: Waveland Press (2015).

Alpert, G. and C. Lum. Police Pursuit Driving: Policy and Research. New York: Springer (2014).

Noble, J. and G. Alpert. Managing Accountability Systems for Police Conduct: Internal Affairs and External Oversight. Prospect Heights, IL: Waveland Press (2009).

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Smith, W. and G. Alpert. Management of Emergency Vehicle Operational Risks. Evanston, IL: Northwestern University Center for Public Safety (2003).

Alpert, G. and J. MacDonald. Understanding Social Science Research: Applications in Criminology and Criminal Justice. Prospect Heights, IL: Waveland Press (2001).

Alpert, G., D. Kenney, R. Dunham, and W. Smith. Police Pursuits: What We Know. Washington, DC: Police Executive Research Forum (2000).

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Kappeler, V., R. Sluder, and G. Alpert. Forces of Deviance: The Dark Side of Policing. Prospect Heights, IL: Waveland Press (1994). *Second Edition* (1998).

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Hawkins, R. and G. Alpert. Adult Correctional Systems. Englewood Cliffs, NJ: Prentice-Hall (1989).

Alpert, G. and R. Dunham. Policing Multi-Ethnic Neighborhoods. Westport, CT: Greenwood Press (1988).

Alpert, G. and R. Dunham. Policing Urban America. Prospect Heights, IL: Waveland Press (1988). *Second Edition* (1992), *Third Edition* (1997).

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Alpert, G. The American System of Criminal Justice. Beverly Hills, CA: Sage Publications (1985).

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McLean, Kyle., Wolfe, Scott, Rojek, Jeff, Alpert, Geoffrey. & Smith, Michael (2020). A Randomized Controlled Trial of Social Interaction Police Training. *Criminology and Public Policy* 19: 805 – 832. doi:10.1111/1745-9133.12506

Lawson, Spencer, Jeff Rojek, Scott Wolfe and Geoffrey Alpert. 2020. Predicting Police Officer Seat Belt Use: Evidence-Based Solutions to Improve Officer Driving Safety. *Police Quarterly* 23:472-499. doi.org/10.1177/1098611120923159

McCarthy, Molly, Louise Porter, Michael Townsley and Geoffrey Alpert. 2020 (forthcoming). The Role of Social Distance in The Relationship Between Police-Community Engagement and Police Coercion. *Policing and Society*. doi.org/10.1080/10439463.2020.1749274.

Pfeiffer, Michael and Geoffrey Alpert. 2020. Developing Methodology for Finding Ghosted Police Vehicle Pursuits. *Translational Criminology* (Spring, 2020): 17 - 19.

Aronie, Jonathan and Geoffrey Alpert. 2020. 16 to a dealer's 10: Could blackjack odds help inform police pursuit policies? *PoliceOne*. March 2. <https://policeone.webstage.lexipol.com/police-products/pursuit-management-technology/articles/16-to-a-dealers-10-could-blackjack-odds-help-inform-police-pursuit-policies-Y9x2Avr8SWzJG1c4/>

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2020 National Institute of Occupational Safety and Health (NIOSH) Alice Hamilton Award for Excellence in Occupational Safety and Health

Rojek, J., J. Sharbuck, A. Hansen, and G. Alpert. 2019. Present but not Prevalent: Identifying the Organizational Correlates of Researcher-Practitioner Partnerships in U.S. Law Enforcement. *Police*

Practice and Research. DOI: 10.1080/15614263.2019.1657626

Nix, J., J. Pickett, H. Baek, and G. Alpert. 2019. Police Research, Officer Surveys, and Response Rates. *Policing & Society: An International Journal of Research and Policy* 29: 530-550. doi: [10.1080/10439463.2017.1394300](https://doi.org/10.1080/10439463.2017.1394300)

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McLean, K., G. Alpert, C. Naoroz, and A. Alikhan. February 2019. Toward a Threat Analysis Model (TAM) of Force. *The Police Chief (Research-in-Brief)*. www.policechiefmagazine.org/research-in-brief-toward-a-threat-analysis-model-tam-of-force/

Tregle, B., J. Nix, and G. Alpert. 2019. Disparity does not mean bias: making sense of observed racial disparities in fatal officer-involved shootings with multiple benchmarks. *Journal of Crime and Justice* 42: 18-31. doi: [10.1080/0735648X.2018.1547269](https://doi.org/10.1080/0735648X.2018.1547269)
Outstanding Paper Award in 2019 for the Journal of Crime & Justice
Reprinted: Pp. 18-31 in R. Moule and B. Fox (Eds.). Contemporary Issues in American Policing. 2021. New York: Routledge.

McCarthy, M., L. Porter, M. Townsley, and G. Alpert. 2018. Influence of Community Characteristics on Serious Police Use of Force Events in an Australian Policing Jurisdiction: A Test of Minority Threat, Social Disorganisation and Ecological Contamination Theories. *Policing and Society: An International Journal of Research and Policy*. doi: [10.1080/10439463.2018.1493109](https://doi.org/10.1080/10439463.2018.1493109)

Hine, K., L. Porter, N. Westera, A. Allen, and G. Alpert. 2018. Exploring Police Use of Force Decision-Making Processes and Impairments Using a Naturalistic Decision-Making Approach. *Criminal Justice and Behavior*. doi: [10.1177/0093854818789726](https://doi.org/10.1177/0093854818789726)

Alpert, G., P. Martin, and J. Rojek. 2018. Rewarding Operationally-Relevant Research: A Critical Role for the University. *Police Science* 3: 46-47. [ANZSEBP Summer18](https://www.anzsebp.org.au/summer18)

Porter, L., J. Ready, and G. Alpert. 2018. Officer Involved Shootings: Testing the Effect of Question Timing on Memory Accuracy for Stressful Events. *Journal of Experimental Criminology* 15: 1– 28 (2019). [Springer link 10.1007/s11292-018-9348-0](https://doi.org/10.1007/s11292-018-9348-0)

Alpert, G. and K. McClean. 2018. Where is the Goal Line?: A Critical Look at Police Body-Worn Camera Programs. *Criminology and Public Policy* 17:679-688. doi: [10.1111/1745-9133.12374](https://doi.org/10.1111/1745-9133.12374).

Cordner, G. and G. Alpert. 2018. Striking a Balance: Research, Science, and Policing. *The Police Chief* 85: www.policechiefmagazine.org/rib-striking-a-balance/

Hine, K., L. Porter, N. Westera, and G. Alpert. 2018. Too much or too little? Individual and Situational Predictors of Police Force Relative to Suspect Resistance. *Policing and Society: An International Journal of Research and Policy* 28: 587-604. [doi: 10.1080/10439463.2016.1232257](https://doi.org/10.1080/10439463.2016.1232257)

Nix, J. and G. Alpert. 2018. Officer-Involved Shootings: Context Means Everything. *The Police Chief* 85: 18-19. www.policechiefmagazine.org/rib-ois-context-means-everything/

Hine, K., L. Porter, N. Westera, and G. Alpert. 2018. The Understated Ugly Side of Police-Citizen Encounters: Situation, Suspect, Officer, Decision-Making and Force Predictors of Officer Injuries. *Policing and Society: An International Journal of Research and Policy* 28: 665-683. [doi: 10.1080/10439463.2016.1251430](https://doi.org/10.1080/10439463.2016.1251430)

Alpert, G. and J. Nix. February 22, 2018. See Something, Say Something, Do Nothing? There is a Solution. *The Hill*. thehill.com/opinion/education/374556-see-something-say-something-do-nothing-there-is-a-solution.

Alpert, G. and J. Nix. January 24, 2018. Police Fatal Force: What's Behind the Curtain? *The Hill*. thehill.com/opinion/criminal-justice/370328-police-fatal-force-whats-behind-the-curtain.

Pickett, J., F. Cullen, S. Bushway, T. Chiricos, and G. Alpert. 2018. The Response Rate Test: Nonresponse Bias and the Future of Survey Research in Criminology and Criminal Justice. *The Criminologist* 43: 7-11. [doi: 10.2139/ssrn.3103018](https://doi.org/10.2139/ssrn.3103018)

Owens, E., D. Weisburd, K. Amendola, and G. Alpert. 2018. Can You Build a Better Cop? Experimental Evidence on Supervision, Training, and Policing in the Community. *Criminology and Public Policy* 17: 41-87. [doi: 10.1111/1745-9133.12337](https://doi.org/10.1111/1745-9133.12337)

Porter, L. and G. Alpert. 2017. Understanding Police Recruits' Attitudes Towards Public Interactions: An Australian Example. *Police Quarterly* 20: 449-480. [doi: 10.1177/1098611117723567](https://doi.org/10.1177/1098611117723567)

Alpert, G., K. McLean, and S. Wolfe. 2017. Consent Decrees: An Approach to Police Accountability and Reform. *Police Quarterly* 20: 239-249. [doi: 10.1177/1098611117709591](https://doi.org/10.1177/1098611117709591)

Owens, E., D. Weisburd, K. Amendola, and G. Alpert. 2017. Passing it Forward: Modeling Procedural Justice in the Workplace to Improve Public-Police Interactions. *The Police Chief* 84: 14-15. www.policechiefmagazine.org/research-brief-passing-forward-modeling-procedural-justice-workplace-improve-public-police-interactions/

Nix, J., B. Campbell, E. Byers, and G. Alpert. 2017. A bird's eye view of civilians killed by police in 2015: Further evidence of implicit bias. *Criminology and Public Policy* 16: 309-340. [doi: 10.1111/1745-9133.12269](https://doi.org/10.1111/1745-9133.12269)

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- Nix, J., B. Campbell, and G. Alpert. 2016. Fatal shootings by US police officers in 2015: A bird's eye view. *The Police Chief* 83: 48-52. www.policechiefmagazine.org/fatal-shootings-by-u-s-police-officers-in-2015-a-birds-eye-view/
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- Hickman, M., L. Atherley, P. Lowery, and G. Alpert. 2015. Reliability of the Force Factor Method in Police Use-of-Force Research. *Police Quarterly* 18: 368-396. [doi: 10.1177/1098611115586175](https://doi.org/10.1177/1098611115586175)
- Hansen, A., J. Rojek, S. Wolfe, and G. Alpert. 2015. The Influence of Department Policy and Accountability on Officer-Involved Collisions. *Policing: An International Journal of Police Strategies & Management* 38: 578-594. [doi: 10.1108/PIJPSM-03-2015-0042](https://doi.org/10.1108/PIJPSM-03-2015-0042)
- Wolfe, S., J. Rojek, G. Alpert, H. Tiesman, and S. James. 2015. Characteristics of officer-involved vehicle collisions in California. *Policing: An International Journal of Police Strategies & Management* 38: 458-477. [doi: 10.1108/PIJPSM-03-2015-0029](https://doi.org/10.1108/PIJPSM-03-2015-0029)
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Mentally Ill Criminals in Dade County. Citizens' Crime Commission. Miami, Florida. 1985.

Youth Gangs in Dade County. Final Report of the Grand Jury. Dade County, Florida. Fall 1984.

Police Use of Deadly Force in Dallas, Texas: 1980-1983. Dallas Police Department. Dallas, Texas. 1984.

School Dropouts in Dade County. Final Report of the Grand Jury. Dade County, Florida. Spring 1984.

Final Report, Overtown Blue Ribbon Committee. Miami, Florida. 1983.

Police Use of Deadly Force. Final Report of the Grand Jury. Dade County, Florida. Spring 1983.

Legal Rights of Correctional Officers. Florida Department of Corrections. October 1982.

The Grand Jury Looks at Itself: A Follow-Up Study. Final Report of the Grand Jury. Dade County, Florida. Fall 1982.

The Impact of Mariels and other Entrants on South Florida. Final Report of the Grand Jury. Dade County, Florida. Spring 1982.

BOOK REVIEWS:

American Journal of Police
Contemporary Sociology
Criminal Justice Review
Criminology
Journal of Criminal Law and Criminology
Sociology: Reviews of New Books

EDITORIAL EXPERIENCE:

Issue Editor	2015
Issue Editor, Police Practice and Research	2011
Editorial Board, <u>Encyclopedia of Law Enforcement</u>	2004-2005
Executive Board, <u>Crime and Delinquency</u>	2000-present
Series Editor, Wadsworth Publishing	2000-2007
Associate Editor, <u>Justice Research and Policy</u>	1998-2001
Editor, <u>Policing: An International Journal of Police Strategies & Management</u>	1997-1999
Associate Editor, <u>Justice Quarterly</u>	1995-1998
Editor, <u>American Journal of Police</u>	1995-1997
Editorial Board, <u>The Justice System Journal</u>	1994-1998
Associate Editorial Consultant, <u>Journal of Criminal Law and Criminology</u>	1990-1998
Editorial Board, <u>American Journal of Criminal Justice</u>	1989-1998
Advisory Board, <u>Police Liability Review</u>	1989-1998
Advisory Board, <u>Annual Editions: Criminal Justice</u> (Dushkin)	1988-1994
Board of Editors, <u>Sociological Inquiry</u>	1987-1998
Contributing Editor, <u>Criminal Law Bulletin</u>	1987-1995
Associate Editor, <u>Criminology</u>	1980-1984
Editor, <u>Georgia Journal of Corrections</u>	1971-1972

Special Reader:

<u>American Journal of Criminal Justice</u>	<u>Crime and Public Policy</u>
<u>American Journal of Police</u>	<u>Criminal Justice and Behavior</u>
<u>American Journal of Sociology</u>	<u>Criminology & Public Policy</u>
<u>American Sociological Review</u>	<u>Criminology: An International Journal</u>
<u>Australia – New Zealand Journal of Criminology</u>	<u>Journal of Crime and Delinquency</u>
Cambridge University Press	<u>Journal of Criminal Justice</u>

Geoffrey P. Alpert

<u>Journal of Justice Issues</u>	<u>Police Quarterly</u>
<u>Journal of Quantitative Criminology</u>	Praeger Press
<u>Journal of Research in Crime and Delinquency</u>	Sage Publications
<u>Judicature</u>	<u>Social Problems</u>
<u>Justice Quarterly</u>	<u>Social Science Quarterly</u>
<u>Justice System Journal</u>	<u>Sociological Focus</u>
<u>Law and Human Behavior</u>	<u>Sociological Inquiry</u>
<u>Law and Society Review</u>	Wadsworth Publishing
McGraw Hill Publishing Company	West Publications

SELECTED PROFESSIONAL ACTIVITIES:

Participant, Equity Summit, Policing and Bodies. University of South Carolina. November 2020.

Reviewer, Chicago Police Department Use of Force Lesson Plan and Training Curriculum. October 2020.

Presenter, California Community College Chancellor's Office and Cal POST Forum, Evidence-Based Policing: Fundamentals and Concepts. September 2020.

Member, Charlotte City Council Safe Communities Committee 2020.

Invited Participant, Law Enforcement Academy Symposium, July 2020.

Invited Testimony, President's Commission on Law Enforcement and the Administration of Justice. June 2020.

Panelist, Charleston Forum. Charleston, SC. June 2020.

Consultant, Charleston Branch NAACP. Denzel Curnell Officer-Involved Shooting. 2020.

Instructor, FBI National Academy. FBI Academy, Quantico, Virginia. February 2020-2006.

Member, FBI National Academy Advisory Board Meeting. Quantico. July 2019.

Invited Participant, 2020 Vision for Law Enforcement and Behavioral Health Partnerships. Bureau of Justice Assistance. Washington, DC. August 2019.

Presenter, Crowdsourced Police Shooting Data: What We Know and What We're Missing. Annual Meeting of the American Sociological Association. New York. August 2019.

Presenter, A New Approach to the Use of Force: Threat and Resistance. Tasmanian Police Executive Team. Hobart, Australia. July 2019.

Presenter, Police Activities: Influences from Multiple Disciplines. Victoria Police Master Class. Melbourne, Australia. July 2019.

Geoffrey P. Alpert

Presenter, Fatal Police Shootings. A Conference for Producing a Volume of the Annals of the AAAPSS. University of Pennsylvania. February 2019.

Invited Participant, LAPD, PERF Less-Lethal Force Options Symposium. Los Angeles, California. January 2019.

Invited Participant, U.S. Council of Mayors. Washington, DC. January 2019.

Presenter, LaGrange Police Department Annual Supervisor Retreat, LaGrange, Georgia. October 2018.

Geoffrey P. Alpert

Invited Participant, US Conference of Mayors Fall Leadership Meeting. Columbia, South Carolina. September 2018.

Member, FBI National Academy Law Enforcement External Training Review Board. Charlottesville, Virginia. September 2018.

Presenter, Officer-Involved Shootings: Confronting the Crisis in America. Major Cities Chiefs Association, Police Executive Research Forum. FBI National Executive Institute Associates Conference. Nashville, Tennessee. June 2018.

Member, International Association of Chiefs of Police Vehicular Pursuit Working Group. 2018-present.

Presenter. Body-Worn Camera Research Convening. Los Angeles Police Department. September 2017.

Presenter, Police Misconduct and Civil Rights Section. The American Association for Justice. Boston. July 2017.

Instructor, Implementing a Use of Force Review Board. Chicago Police Department. Chicago. June-July 2017.

Faculty, Police Executive Research Forum, Senior Management Institute for Police (SMIP). Boston. June-July 2017.

Presenter, Officer Involved Shootings: Understanding Officer Memory. Major City Chiefs Association. Las Vegas, June 2017, Charlotte-Mecklenburg Police Department, July 2017.

Presenter, American Society of Evidence-Based Policing Conference. Phoenix, Arizona. May 2017.

Presenter, Keeping Officers Safe and Well. CNA. Washington, DC. February 2017.

Invited Participant, Implementation of Police Department Consent Decrees. Texas A & M School of Law. Ft. Worth, Texas. November 2006.

Invited Participant, Trending Issues in Policing. Federal Law Enforcement Training Center. Glynco, Georgia. September 2016.

Presenter, Finding Common Ground: Policing in the 21st Century. University of South Carolina. August 2016.

Presenter, The Ferguson Effect and the Dallas Effect on Policing. Queensland Police Service, Executive Leadership Committee and Police Academy. July 2016.

Presenter, Committee on Proactive Policing – Effects on Crime, Communities, and Civil Rights. National Academy of Sciences. Washington, DC. April. 2016.

Geoffrey P. Alpert

Invited Participant, National Officer Safety and Wellness Group. COPS and Bureau of Justice Assistance. Washington, DC. March 2016.

Presenter, Social Science, Evidence – Based Policing, and Judicial Rulemaking, South Carolina. South Carolina Circuit Court Judges' Association. January 2016.

Invited Participant, Use of Force: Taking Policing to a Higher Standard. Police Executive Research Forum. Washington, DC. January 2016.

Presenter, Annual Meeting, South Carolina Chapter of the National Association of Blacks in Criminal Justice. Columbia, South Carolina. December 2015.

Presenter, Managing Use of Force: Reporting, Investigating and Reviewing the Use of Force. Virgin Islands Police Department (Consent Decree). St. Thomas and St. Croix. November 2015.

Presenter, Securing G20: Strategies, Planning and Operations. Presented at the Annual Meeting of The International Association of Chiefs of Police. Orlando, Florida. October 2015.

Presenter, Symposium on the Future of Police. Griffith University and Queensland Police Service. Brisbane, Australia. September 2015.

Presenter, Trends in Use of Force Training. Federal Law Enforcement Training Center, Office of the Inspector General. Largo, Maryland. August 2015.

Presenter, Center for Evidence-Based Crime Policy Symposium. George Mason University and the Police Foundation. Arlington, Virginia. August 2015.

Presenter, The National Association of Women Law Enforcement Executives (NAWLEE) Annual Meeting. Hartford, Connecticut. August 2015

Participant, FBI's Uniform Crime Reporting Program. Development of a new data collection system on officer-involved shootings. June-September 2015.

Faculty, Police Executive Research Forum, Senior Management Institute for Police (SMIP). Boston. June-August 2015.

Invited Testimony, U.S. Commission of Civil Rights. March 2015.

Presenter, Cuyahoga County (Ohio) Prosecutor's Office, Forum on Police Use of Deadly Force. March 2015.

Invited Testimony, President's Task Force on 21st Century Policing. January 2015.

Presenter, Innovation in American Policing and Public Safety. MacArthur Foundation. Chicago. November 2014.

Geoffrey P. Alpert

Presenter, StarChase: A Pursuit Avoidance Technology. Presented at the Annual Meeting of The International Association of Chiefs of Police. Orlando, Florida. October 2014.

Presenter, Australian, New Zealand Association of Criminology (ANZSOC). Sydney, Australia. October 2014.

Presenter, Contemporary Leadership in Policing for Indian Police Service. Queensland Police Service, Brisbane, Australia. October 2014.

Invited Speaker, Symposium on the Future of Police. Griffith University and Queensland Police Service. Brisbane, Australia. September 2014.

Subject Matter Expert and Testifying Expert, Police Use of Deadly Force, Travis County, Texas Grand Jury. Austin, Texas. March 2014.

Presenter, Research Evidence for Supervisors: Use of Force and Police Pursuits. Evidence-Based Policing Leadership Training for First and Second Line Supervisors. George Mason University. Arlington, Virginia. January 2014.

Member, Richland County Sheriff's Office Citizens' Advisory Council. Columbia, South Carolina. 2014-present.

Subject Matter Expert, United States District Court of Northern California. Consent Decree, Oakland Police Department. December 2013.

Presenter, Internal Affairs Units and Early Intervention Systems. Seminar on Internal Affairs and Police Accountability. Federal Police of Mexico. Mexico City. December 2013.

Keynote Speaker, Traffic Safety, Officer Safety and Crime Control. Road to Zero: Strategies to Enhance Road Policing. Victoria Police. Melbourne, Australia. November 2013.

Presenter, Use-of-Force Decision Making. Use of Force Workshop. Centre of Excellence in Policing and Security. Griffith University. Brisbane, Australia. November 2013.

Presenter, Police-Researcher Partnerships. Policing and Security in Practice: Then, Now and into the Future. Charles Sturt University. Sydney, Australia. November 2013.

Invited Participant, White House Law Enforcement Officer Safety Datajam. Washington, DC. September 2013.

Presenter, Practitioner-Researcher Partnerships and Relations. Criminology in Practice. University of Pennsylvania. September 2013.

Presenter, Early Warning Systems: Data-Driven Decisions. American Psychological Association. Honolulu, Hawaii. July 2013.

Geoffrey P. Alpert

Presenter, Maryland State Summit: Reducing Deaths, Disabilities, and Injuries to Maryland Law Enforcement Officers Engaged in Traffic-Related Activities. Johns Hopkins University. Baltimore, Maryland. June 2013.

Invited Participant, Experiments in Policing Masterclass. University of Queensland. Brisbane, Australia. April 2013.

Presenter, Naturalistic Decision Making: The Explanatory Value of Human Factors in Police Use of Force. Victoria Police Service. Melbourne, Australia. April 2013.

Presenter, Controlling Violent Suspects: A Necessary and Dangerous Part of Police Work. Human Rights and Policing Conference. Centre of Excellence in Policing and Security. Canberra, Australia. April 2013.

Reviewer, The Health Effects of Conducted Energy Weapons. The Council of Canadian Academies & The Canadian Academy of Health Sciences. Ottawa, Canada. 2013.

Invited Participant, Civil Rights Investigations of Local Police. PERF. Washington, DC. October 2012.

Presenter, Consortium for Police Leadership in Equity/Department of Justice Conference: A Measure of Justice. Washington, DC. August 2012.

Presenter, Conducted Electronic Weapons, Car Crashes, and Pursuits. Australian Institute of Criminology. Canberra, Australia. July 2012.

Presenter, Distortions in Memory after Police Shootings and other Critical Incidents. Australian Research Council, Centre for Excellence in Policing and Security. Brisbane, Australia. July 2012.

Keynote Speaker, Police Integrity Forum, Crime and Misconduct Commission, Queensland State Government. Brisbane, Australia. June 2012.

Presenter, Contemporary Issues in American Policing, and Developing Researcher-Practitioner Relationships, Senior Staff, Queensland Police Service. Brisbane, Australia. June 2012

Presenter, Use of Force Research and American Policing. Management and Staff, Ethical Standards Command, Queensland Police Service. Brisbane, Australia. May 2012.

Presenter, California POST Officer Crash Reduction Initiative. National Officer Safety and Wellness Group. Washington, DC. April 2012.

Keynote Speaker, 2012 Civil Rights Conference. United States Attorney's Office Northern District of Ohio and Cleveland FBI. Understanding Police Use of Force. Cleveland, Ohio. April 2012.

Subject Matter Expert and Testifying Expert, Police Use of Deadly Force, Travis County, Texas Grand Jury. Austin, Texas. February 2012.

Geoffrey P. Alpert

Presenter, Defense Research Institute, Civil Rights and Governmental Tort Liability Seminar. Miami, Florida. February 2012.

Invited Participant, Symposium on Police Use of Force. International Association of Chiefs of Police. Alexandria, Virginia. May 2011.

Presenter, Gang Affiliation and the Student Athlete. Senior Leadership Group, National Collegiate Athletic Association (NCAA). Indianapolis, Indiana. April 2011.

Panelist, Criminal Justice Research and Policing Strategies for Safer Communities. Congressional Briefing. March 24, 2011.

Advisor, Symposium on Police use of Force. International Association of Chiefs of Police and Office of Community Oriented Policing Services. Washington, DC. January 2011.

Advisor, Queensland Police Service Project on Risk Assessment and Decision Making. Australian Research Council (ARC) Centre of Excellence in Policing and Security (CEPS). Griffith University. Brisbane, Australia. December 2010.

Keynote Speaker. Police Use of Force Conference. Institute for Law Enforcement Administration, The Center for American and International Law. Plano, Texas. September 2010.

Invited Participant, Conducted Energy Devices: Guidelines for Policy and Practice. Police Executive Research Forum. Philadelphia, Pennsylvania. August 2010.

Presenter, International Police Executive Symposium. Developing and Managing Communication Systems for Major Special Events: An American Nightmare. Malta. March 2010.

Presenter, Shelby County (Tennessee) Sheriff's Office. Managing Officer's Behavior: Early Identification Systems and Beyond. December 2009.

Presenter, Caruth Police Institute, Dallas Police Department, Managing Officer's Actions and Behavior: Policies and Liability. December 2009.

Invited Participant, Annual Meeting of the Police Executive Research Forum. Washington, DC. March 2009.

Advisor, New York State Police-on-Police Shootings Task Force. New York. 2009- 2010.

Invited Participant, Linking Local Law Enforcement Internal Affairs Practices and Community Trust Building: City Managers/Mayors Roundtable. International Association of Chiefs of Police. October 2008.

Presenter, Suing and Defending the Police. Annual Meeting of the Police Executive Research Forum. Miami, Florida. April 2008.

Geoffrey P. Alpert

Keynote Speaker, Seattle Police Department. Investigating and Evaluating a Police Pursuit: Reducing Exposure and Liability. Seattle, Washington. February 2008.

Keynote Speaker, Washington State Criminal Justice Training Commission. Offender Pursuit Seminar. Bothell, Washington. February 2008.

Presenter, Charleston Police Department. Seminar for Pursuit Management. Charleston, South Carolina. February 2008.

Member, California POST California Vehicle Operations Training Advisory Council. 2008-present.

Member, International Association of Chiefs of Police, Committee on Use of Force. 2008-2009.

Presenter, The Charleston Area Crime Summit. North Charleston, South Carolina. November 2007.

Presenter, To Protect and to Serve ... Police and Policing in an Age of Terrorism and Beyond. Ministry of Public Security and National Institute of Justice. Jerusalem, Israel. October 2007.

Presenter, Police Driver Trainers' Seminar. Peel Regional Police, Brampton, Ontario Canada. August 2007.

Presenter, Major Cities Chiefs of Police Task Force on Internal Affairs. Dallas, Texas. May 2007.

Presenter, Scott v Harris: The Supreme Court revisits police use of deadly force. Annual Meeting of the Police Executive Research Forum. Chicago. April 2007.

Consultant, Advisory Committee on Police Standards (Racial Profiling). State of New Jersey. January, 2007.

Member, Research Advisory Committee, Police Foundation. Washington, DC. 2007-2010.

Invited Participant, Workshop on Policing Research. National Institute of Justice. Washington, DC. November 2006.

Presenter, New Developments in Criminal Justice and Crime Prevention Conference, University of Shanghai. Shanghai, China. October, 2006.

Instructor, Early Identification Systems. International Association of Chiefs of Police. Maple Grove, Minnesota. September 2006.

Instructor, Police Use of Force and Pursuits. Pharr, Texas. Police Department. June, 2006.

Instructor, National Summit on Police Use of Force. Institute for Law Enforcement Administration. Plano, Texas. January 2006.

Invited Participant, Strategies for Resolving Conflict and Minimizing the Use of Force. PERF, San Diego, California. December 2005.

Geoffrey P. Alpert

Invited Participant, Symposium on Conducted Electronic Devices. PERF, Houston, Texas. October 2005.

Guest Editor, Police Quarterly. Vol. 8 Number 3. September 2005.

Invited Participant, 14th World Congress of Criminology. University of Pennsylvania. August 2005.

Invited Participant, Less-Lethal Technology Symposium. U.S. Department of Justice. Washington, DC. April 2005.

Invited Participant, Best Practices in Managing Police Use of Force. Los Angeles Police Department. Los Angeles, California. March 2005.

Senior Advisor, Major Cities Chiefs of Police Task Force on Internal Affairs. Los Angeles, California. 2005-2008.

Member, South Carolina Law Enforcement Training Advisory Council. Department of Public Safety. Columbia, South Carolina. 2005-2006.

Presenter, Early Identification Systems: A Changing Paradigm. Internal Affairs. Institute for Law Enforcement Administration. Plano, Texas. November 2004.

Presenter, By the Numbers: How to Analyze Race Data from Vehicle Stops. Kansas City, Police Executive Research Forum. August 2004.

Presenter, The Annual Conference on Criminal Justice Research and Evaluation. Washington, DC. July 2004.

Presenter, Pursuit Driving, Executive Management Program. Northwestern University Center for Public Safety. May 2004.

Presenter, Western Regional Racially Biased Policing Summit. Sacramento Police Department. Sacramento, California. February 2004.

Consultant, Coroner's Office. Inquest on Police Pursuit Driving. Quebec, Canada. 2004.

Consultant, Citizen Advisory Panel on Pursuit Policy. Orlando Police Department. Orlando, Florida. December 2003.

Presenter, Enrichment Retreat. Royal Bahamas Police Force. Nassau. November 2003.

Presenter, The Annual Conference on Racial Profiling. Northwestern University. Chicago. November 2003.

Presenter, The Annual Conference on Criminal Justice Research and Evaluation. Washington, DC. July 2003.

Geoffrey P. Alpert

Invited Participant, Minority Trust and Confidence in the Police. National Institute of Justice. Washington, DC. July 2003.

Presenter, Community Oriented Police Services Annual Meeting. Washington, DC. June 2003.

Presenter, Promoting Cooperative Strategies to Prevent Racial Profiling. Sacramento Police Department. Sacramento, California. June 2003.

Presenter, Confronting Racial Profiling in the 21st Century: New Challenges and Implications for Racial Justice. Northeastern University. Boston. March 2003.

Moderator and Panel Member, Racial Profiling Conference, The Foley Institute for Public Policy and Public Service. Washington State University. February 2003.

Presenter, Pursuit Driving. Rocky Mountain Criminal Justice Conference. Gatlinburg, Tennessee. November 2002.

Invited Participant, Minority Trust and Confidence in the Police. National Institute of Justice. Washington, DC. October 2002.

Panelist, Racial Profiling. Smith College. Northampton, Massachusetts. September 2002.

Presenter, State Bar of Texas Suing and Defending Governmental Entities Course. Galveston, Texas. August 2002.

Panelist, Excessive Force Demonstration. State Bar of Texas Suing and Defending Governmental Entities Course. Galveston, Texas. August 2002.

Presenter, Annual Convention of the Association of Trial Lawyers of America. Atlanta, Georgia. August 2002.

Presenter, Committee to Review Research on Police Policy and Practices. National Research Council. Washington, DC. April 2002.

Panelist, Pursuit Driving Training Symposium. Federal Law Enforcement Training Center. Glynco, Georgia. (Sites throughout the United States) 2002-2004.

Presenter, Racial Profiling: Setting the Research Agenda. Center for Studies in Criminology and Law. University of Florida. October 2001.

Presenter, Racial Profiling, Bureau of Justice Statistics/Justice Research & Statistics Association Annual Meeting. New Orleans, Louisiana. October 2001.

Presenter, Early Warning Systems and the Police. Pasadena, California Police Department. October 2001.

Geoffrey P. Alpert

Presenter, "Pursuit Driving – Dynamics and Liability." High Liability Trainers' Conference. Florida Department of Law Enforcement. Orlando, Florida. August 2001.

Presenter, The Annual Conference on Criminal Justice Research and Evaluation. National Institute of Justice. Washington, D.C. July 2001.

Invited Participant, Ethics and Integrity Curriculum Development. Office of Community Oriented Policing Services. Washington, DC. May 2001.

Presenter, Early Warning Systems and the Police. School of Professional Studies. Johns Hopkins University. Baltimore, Maryland. April 2001.

Panelist, Pursuit Driver Training Symposium. Federal Law Enforcement Training Center. Glynco, Georgia. March 2001.

Presenter, Speed Enforcement/Aggressive Driving Conference. Institute of Police Technology and Management. Orlando, Florida. March 2001.

Invited Participant: Early Warning System Curricula Development Meeting. Regional Community Policing Institute for New England. Boston Police Department. Boston. January 2001.

Academic Community Liaison, National Commission on Law Enforcement Integrity. 2001-2005.

Presenter, Working Session on Police Practices. Department of Justice. Washington, DC: November 2000.

Presenter, The Annual Conference on Criminal Justice Research and Evaluation. National Institute of Justice. July 2000.

Invited Participant, Police Pursuit Issues for Managers and Supervisors: Curriculum Development Conference. Federal Law Enforcement Training Center. Glynco, Georgia. May 2000.

Presenter, Police Use of Force in Miami-Dade County, Florida. Miami-Dade County Criminal Justice Council. Miami, Florida. November 1999.

Presenter and Moderator, Building Accountability into Police Operations. Department of Justice. Washington, DC. November 1999.

Presenter, The Annual Conference on Criminal Justice Research and Evaluation. National Institute of Justice. July 1999.

Invited Participant, Homicide Clearance Rate Project. Implementation Group Meeting. Justice Research and Statistics Association. Washington, DC. May 1999.

Presenter, Less than Lethal Force: A Safe and Reasonable Response to Suspect Resistance, Law Enforcement Applications of Non-Lethal Weapons. Quantico, Virginia. May 1999.

Geoffrey P. Alpert

Presenter, Measuring Police Use of Force Relative to Suspect Resistance. International Association of Chiefs of Police Annual Conference. Salt Lake City, Utah. October 1998.

Presenter, The Annual Conference on Criminal Justice Research and Evaluation. National Institute of Justice. July 1998.

Keynote Speaker, Seminar on Risk Management: Police Use of Deadly Force and Pursuit Driving. Southwestern Law Enforcement Institute. Dallas, Texas. November 1995, May 1996, May 1998.

Presenter, Locally Initiated Research Partnership Program Conference. National Institute of Justice. February 1998.

Presenter, Pursuit Policy and Practice. International Association of Women Police Conference. Dallas, Texas. November 1997.

Presenter, Meeting the Challenges of Crime and Justice: The Annual Conference on Criminal Justice Research and Evaluation. Office of Justice Programs, Department of Justice. Washington, DC. July 1997.

Presenter, Locally Initiated Research Partnership Program Conference. National Institute of Justice. January 1997.

Faculty, Southwestern Law Enforcement Institute Management College. Dallas, Texas. January 1977.

Presenter, State and Local Partnership Training for Criminal Justice. Bureau of Justice Assistance. January 1997.

Presenter, Lessons Learned from the 1996 Olympic Games. Special Events Planning and Management Symposium. Metro-Dade Police Department, Florida. September 1996.

Presenter, and Workshop Director, Building a Safer Society: The Annual Conference on Criminal Justice Research and Evaluation. Office of Justice Programs, Department of Justice. Washington, DC. August 1996.

Presenter, Police in Pursuit: Policy and Practice. Research in Progress Series (Video). National Institute of Justice. July 1996.

Presenter, Use-of-Force Cluster Conference. National Institute of Justice. Washington, DC. April 1996.

Member, National Criminal Justice Network Consumer Advisory Network. 1996.

Discussant, Measuring What Matters, National Institute of Justice. Washington, DC. May 1996.

Geoffrey P. Alpert

Presenter, Police Pursuits and the Use of Force: Recognizing and Managing “the Pucker Factor.” The Annual Conference on Criminal Justice Research and Evaluation. National Institute of Justice. Washington, DC. July 1995.

Invited Participant, Police Use of Force Focus Group. National Institute of Justice/Bureau of Justice Statistics. Washington, DC. May 1995.

Presenter, Hi-Risk Police Activities and Managing Their Risks. South Carolina Sheriff’s Association. May 1995.

Presenter, Police Pursuits. Making Policy Decisions. Transportation Research Board. Washington, DC. January 1995.

Invited Participant, Strategic Planning Workshop: Developing a Police Research and Evaluation Agenda. National Institute of Justice. December 1994.

Presenter, Special Events Planning and Management Symposium. Metropolitan Police Institute. Miami, Florida. October 1994.

Invited Participant, Justice Research & Statistics Association Annual Meeting. Atlanta, Georgia. October 1994.

Pursuit Driving and Risk Assessment Seminar. Indiana Police Chiefs Association. Anderson, Indiana. September 1994.

Presenter, Use of Force and Pursuit Risks, Southeastern Campus Safety Institute. Long Beach, Mississippi. August 1994.

Invited Participant, Focus Groups Sessions on Community Policing and the Crime Bill. National Institute of Justice. Washington, DC. July-August 1994.

Invited Speaker, South Carolina City and County Management Association Annual Meeting. Hilton Head, South Carolina. July 1994.

Facilitator, Pursuit Policy Workshop. Criminal Justice Institute, St. Petersburg Community College. February 1994.

Presenter, Frontiers of Legal Thought Conference. Duke Law School. Durham, North Carolina. January 1994.

Member, Pursuit Guidelines Development Advisory Committee, California Peace Officer Standards and Training, 1994.

Keynote Speaker, Seminar on Risk Management: Police Use of Deadly Force and Pursuit Driving. Southwestern Law Enforcement Institute. Dallas, Texas. May 1993.

Geoffrey P. Alpert

Keynote Address, Police Vehicle Pursuits: Policy Implications and Liability. Illinois State University and the Traffic Institute, Northwestern University. Normal, Illinois. April 1993.

Invited Lecturer, Institute of Criminology, Cambridge University. Cambridge, England. March 1993.

Presenter, Reducing the Risk of Emergency Vehicle Operations, Risk Management Services, South Carolina Budget and Control Board. Columbia, South Carolina. December 1992.

Invited Participant, Bureau of Justice Statistics/Justice Research and Statistics Association 1992 Annual Conference. New Orleans, Louisiana. September 1992.

Testimony on police pursuit to United States House of Representatives, Committee on Government Operations Sub-Committee on Government Information Justice and Agriculture. July 1992.

Faculty, Graduate Course on Victimology. The Free University. Amsterdam, Netherlands. July 1992.

Invited Participant, Annual Conference on Evaluating Drug Initiatives. Washington, DC. July 1992.

Testimony on police pursuit to the House Safety Committee, State of Massachusetts. March. 1992.

Presenter, Developing a Decentralized Police Department from a National Police Force. Presented to Bundeskriminalamt Wiesbaden, Germany. March 1992.

Managing a Community-Oriented Police Department. Presentation to the Wiesbaden Police. March 1992.

Testimony on police pursuit to the Senate Transportation Committee, State of Pennsylvania. February 1992.

Principal Evaluator, State Evaluation Capacity Building Program. National Institute of Justice. 1992-present.

Presenter, Curriculum Development for the Bachelor's Degree in Law Enforcement. State of Minnesota. 1992.

Keynote Speaker, Risk Management and Pursuit Driving. Texas Municipal League. Arlington, Texas. August 1991.

Invited Participant, National Field Study on Gangs and Gang Violence. U.S. Department of Justice. Dallas, Texas. June 1991.

Presenter, The Importance of Data Quality for Practice and Research. National Conference on Improving the Quality of Criminal History Records. Washington, DC. June 1991.

Geoffrey P. Alpert

Presenter, Pursuit Driving Policy Development Seminar. Texas Commission on Peace Officer Standards and Training. Austin, Texas. May and November 1991.

Keynote Speaker, Training Versus Education in Law Enforcement. Virginia Criminal Justice Educators Annual Conference. Leesburg, Virginia. May 1991.

Presenter, Pursuit Driving and Risk Assessment Seminar. Indiana Police Chiefs Association. Jasper, Indiana. April 1991.

Invited Participant, Attorney General's Summit on Law Enforcement Responses to Violent Crime: Public Safety in the Nineties. Washington, DC. March 1991.

Presenter, Matching Structure to Objective. Law Enforcement Management Institute of The Texas Commission on Law Enforcement Officer Standards and Education. San Antonio, Texas. February 1991.

Presenter, Managing Risk: The Case of Pursuit Driving. National A.L.E.R.T. Conference. Columbia, South Carolina. February 1991.

Invited Speaker, Risk Assessment, Pursuit Driving and Police Use of Deadly Force. South Carolina Association of Counties. Columbia, South Carolina. December 1990.

Invited Speaker, Pursuit Driving: Analyzing Risk. National Municipal Lawyers Organization. Boston. September 1990.

Keynote Speaker, Police Pursuit Driving. Texas Municipal League. San Antonio, Texas. July 1990.

Consultant, Monroe County (Florida) Sheriff's Department. Key West, Florida. June-July 1990.

Commencement Speaker, Charleston County Police Academy. Charleston, South Carolina. September 1989.

Consultant, Duval County Grand Jury. Florida. April-July 1989.

Invited Speaker, Civil Disorders and Police Use of Deadly Force. Southwestern Law Enforcement Institute. Dallas, Texas. March 1989.

Keynote Speaker, Seminars on Pursuit Driving. Southwestern Law Enforcement Institute. 1989-1990.

Invited Participant, Cross-Gender Supervision, National Academy of Corrections. Boulder, Colorado. December 1988.

Invited Participant, Workshop on Communities and Crime Control, National Research Council. Miami, Florida. January 1988.

Geoffrey P. Alpert

Conférencier, La Maison des Sciences de L'Homme. Paris, France. December 1987.

Invited Speaker, Criminal Law Section, Annual Meeting of the Oregon State Bar. Seaside, Oregon. September 1987.

Keynote Speaker, Sports and Violence. The American College of Sports Medicine. Las Vegas, Nevada. May 1987.

Keynote Research Address, Police Pursuit Seminar. Empirical Determinants of Police Pursuits. The Police Foundation. Los Angeles, California. March 1987.

Member, Board of Directors, Adolescent Chemical Dependency Program. Dade County, Florida. 1987-1988.

Educational Consultant, G. Gordon Liddy Institute of Corporate Security and Private Investigation. Miami, Florida. 1986.

Member, Board of Directors, Citizens' Crime Commission. Miami, Florida. March 1985-August 1988.

Member, Dade County Community Task Force on Jury Selection, Florida. May 1984-December 1984.

Invited Speaker, John Jay College of Criminal Justice. New York. Police Use of Deadly Force in Miami. New York, New York. April 1984.

Member, Dade County Mayor's Committee to Develop an Action Plan for Social and Economic Development for the Black Community. Florida. May 1983-January 1984.

Member, City of Miami Blue-Ribbon Committee to Study Racial Unrest. Florida. January 1983-July 1984.

Consultant, Dade County Grand Jury. Florida. February 1982-August 1986.

Consultant, Florida Department of Corrections. Tallahassee, Florida. January 1982-June 1984.

Consultant and Trainer, National Street Law Institute, Georgetown University Law Center. Washington, DC. 1982-1984.

Member, Dallas Criminal Justice Task Force. Dallas, Texas. October 1975-December 1975

COURSES TAUGHT:

<u>Graduate</u>	<u>Undergraduate</u>	<u>Law Enforcement</u>
Criminal Justice	Corrections	Accountability Systems
Criminology	Criminal Justice	Ethics and Integrity
Formal Organizations	Criminology	Performance Measures
Juvenile Delinquency	Juvenile Delinquency	Police Use of Deadly Force
Law and Society	Law and Society	Police Use of Force
Policing in America	Police and the Community	Pursuit Driving Decisions
Politics of Crime	Social problems	Report Writing
Research Methods	Sociology of Organizations	
Social Control	Survey Research Methods	

PROFESSIONAL ASSOCIATIONS:

Academy of Criminal Justice Sciences	
Ad Hoc Policy Committee	2010-2012
Chair, Bruce Smith Award Committee	2010-2011
Editorial Selection Committee	2009-2010
Chair, Publications Committee	2010-2011
Publications Committee	2009-2010
American Bar Association	
Committee on Corrections	1980
American Society of Criminology	
Chair, Bloch Award Committee	2010-2011
Bloch Award Committee	2009-2010
Committee on Criminal Justice Education	1977-1978
Chair, Local Arrangements Committee	1978
Membership Committee	1975-1977
National Policy Committee	1995-1998
Program Committee	1995-1997
Publications Committee	1985-1986
Site Selection Committee	1984-1985
Chair, Site Selection Committee	1983-1984
Student Affairs Committee	1989-1990
American Sociological Association	
International Association of Chiefs of Police	
Ethics Training Sub-Committee	1997-1999
Justice Research and Statistics Association	
Board of Directors	2004-2005
Western Society of Criminology	
Vice-President	1979-1980
Executive Secretary	1977-1978
Chair, Program Committee	1976-1977

EXHIBIT 4

CURRICULUM VITAE

GARY MICHAEL VILKE, M.D., FACEP, FAAEM

HOME ADDRESS:

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

OFFICE ADDRESS:

Department of Emergency Medicine
UCSD Medical Center
200 W. Arbor Drive
San Diego, CA 92103-8676
Phone: [REDACTED]
Fax: [REDACTED]
E-mail: [REDACTED]

PERSONAL: Born September 12, 1966 in Cleveland, Ohio

EDUCATION:

Academic: 1983-88	B.S. in Zoology, University of California, Berkeley Berkeley, California
Medical School: 1988-92	M.D., University of California, San Diego School of Medicine La Jolla, California
Internship: 1992-93	Department of Surgery University of California, San Diego Medical Center San Diego, California
Residency: 1993-96	Department of Emergency Medicine University of California, San Diego Medical Center San Diego, California (Chief Resident: 1995-96)
Physician Leadership Academy: 2007-09	University of California, San Diego Medical Center San Diego, California

LICENSURE: California Medical License Number G-78057

BOARD CERTIFICATIONS:

National Board of Medical Examiners, 1993
American Board of Emergency Medicine, 1997, renewed 2007 and 2017

APPOINTMENTS:

- 9/11 - Present Professor of Clinical Emergency Medicine and Medicine, University of California, San Diego (UCSD) School of Medicine
- 7/19-Present Medical Director, North County Dispatch Joint Powers Authority
- 1/17-Present Vice-Chair of Clinical Operations, UC San Diego Department of Emergency Medicine
- 2/14- Present Assistant Director, Division of Emergency Medical Services (EMS)/Disaster Medicine, UCSD Medical Center, Department of Emergency Medicine
- 7/12 – Present Medical Director, Risk Management, UC San Diego Health System
- 7/94 - Present Base Hospital Physician, University of California Medical Center

PREVIOUS EXPERIENCE/APPOINTMENTS:

1/13 – 6/19 Medical Director, Carlsbad Fire Department

10/09 – 6/19 UCSD Department of Emergency Medicine Clinical Research Scholar Fellowship Director

10/15 – 5/19 Medical Director, AirLinkUSA Air Ambulance Service

1/18-7/18 Medical Director, Chula Vista Fire Department

2/06 – 6/18 Director, Division of Clinical Research, UCSD Medical Center, Department of Emergency Medicine

1/16 – 6/18 Co-Medical Director, Department of Emergency Medicine, UCSD Medical Center

9/15- 9/17 Staff Physician, El Centro Regional Medical Center Department of Emergency Medicine

6/12 – 6/17 Associate Director, Department of Emergency Medicine Behavioral Emergencies Research (DEMBER) Lab

1/16 – 1/17 Emergency Medicine Clinical Service Chief, UC San Diego Health System

4/07 – 12/16 Medical Director of the American Heart Association Training Center at the UCSD Center for Resuscitation Science

7/96 – 12/15 Assistant Director, Department of Emergency Medicine, UCSD Medical Center

7/13 – 9/15 Chief, Division of Custody Medicine, UCSD Medical Center, Department of Emergency Medicine

4/99 – 9/15 Director, Custody Services, UCSD Medical Center (Co-Director 1999-2013)

3/13 – 9/15 Medical Director, AviaMedix Air Ambulance Service

10/11- 2/14 Chief, Division of Emergency Medical Services (EMS)/Disaster Medicine, UCSD Medical Center, Department of Emergency Medicine

4/12 – 3/13 Medical Director, Aeromedevac Air Ambulance Service

7/09 – 6/12 Chief of Staff, UCSD Medical Center

7/07 - 6/09 Vice Chief of Staff UCSD Medical Center

7/04 – 6/09 EMS/Disaster Medicine Fellowship Director, Department of Emergency Medicine.

PREVIOUS EXPERIENCE/APPOINTMENTS (cont.):

3/02 - 2/06 Medical Director, San Diego County Emergency Medical Services
3/03 - 12/05 Medical Consultant, San Diego Chapter Red Cross Disaster Health Services
6/04 - 2/05 Interim Chief, San Diego County Emergency Medical Services
1/01 - 2/04 Medical Director, Southwestern College Paramedic Training Program
7/00 - 2/04 Medical Director, Palomar College Paramedic Training Program
7/97 - 1/03 Director, Prehospital Services, UCSD Medical Center
6/97 - 1/03 Medical Director, Paramedic Base Hospital, UCSD Medical Center
7/96 - 1/03 Medical Director, Mercy Air Medical Transport Service, San Diego, California

4/99 - 3/01 Medical Co-Director, San Diego Central Jail Medical Services
1/96 - 7/96 Flight Physician, Mercy Air Medical Transport Service, San Diego, California

7/95 - 7/96 Associated Emergency Physicians Medical Group, San Diego, California
12/94 - 7/96 Kaiser Permanente Emergency Department, San Diego, California
10/94 - 7/96 Med America Health Resource Company, San Diego, California

4/94 - 7/95 Sharp-Rees-Stealy Urgent Care, San Diego, California
7/93 - 12/95 Flight Physician, Life Flight Air Medical Transport Service

PREVIOUS ACADEMIC APPOINTMENTS

7/05 – 9/11 Professor of Clinical Medicine, UCSD School of Medicine
7/01 - 6/05 Associate Professor of Clinical Medicine, UCSD School of Medicine
7/96 - 6/01 Assistant Clinical Professor of Medicine, UCSD School of Medicine

HONORS AND AWARDS:

- 1990 Random House Medical Student Award
- 1996 American College of Emergency Physicians, California Chapter Challenge Bowl Winner
- 1996 Council of Residency Directors (CORD) Resident Academic Achievement Award
- 1996 Outstanding Emergency Medicine Resident
- 1996 UCSD Emergency Department Staff Support Award
- 1996 *Journal of Emergency Medicine* Outstanding Contribution Award
- 1999 “Golden Apple” Teaching Award, UCSD Emergency Medicine Residency Graduating Class of 1999
- 2000 Faculty of the Year, UCSD Emergency Medicine Residency Graduating Class of 2000
- 2000 Best Research Poster Presentation, California Chapter of the American College of Emergency Physicians (CAL/ACEP) Scientific Assembly, Dana Point, California
- 2000 Outstanding Scientific Abstract, State of California EMS Authority Annual Emergency Medical Services for Children Conference, San Diego, California, November 2000
- 2001 Best Oral Presentation, CAL/ACEP Scientific Assembly, Santa Clara, California
- 2004 Academy of Clinician Scholars, University of California San Diego
- 2004 Top Doctor in San Diego County, San Diego Magazine
- 2004 Top Peer Reviewer, *Annals of Emergency Medicine*
- 2005 Top Doctor in San Diego County, San Diego Magazine
- 2005 Clinical Investigation Institute, University of California San Diego
- 2006 Top Doctor in San Diego County, San Diego Magazine
- 2007 Finalist San Diego Business Journal Health Care Champion Award
- 2007 Top Doctor in San Diego County, San Diego Magazine
- 2007 Top Peer Reviewer, *Annals of Emergency Medicine*
- 2008 Top Doctor in San Diego County, San Diego Magazine
- 2008 UCSD Undergraduate Campus Outstanding Faculty Mentor of the Year
- 2009 Clinical and Translational Research Institute, Charter member
- 2009 Top Doctor in San Diego County, San Diego Magazine
- 2010 Top Doctor in San Diego County, San Diego Magazine
- 2011 Top Doctor in San Diego County, San Diego Magazine

HONORS AND AWARDS, continued:

2012 Top Doctor in San Diego County, San Diego Magazine

2013 Top Doctor in San Diego County, San Diego Magazine

2014 Top Doctor in San Diego County, San Diego Magazine

2015 "25 Emergency Medicine & EMS Professors You Should Know" From Medical Technology Schools at: <http://www.medicaltechnologyschools.com/emt/emergency-medicine-ems-professors-to-know>

2018 Top Doctor in San Diego County, San Diego Magazine

2019 Top Doctor in San Diego County, San Diego Magazine

PROFESSIONAL SOCIETY MEMBERSHIPS:

American Medical Association, 1988-97

California Alumni Association, 1988

American College of Emergency Physicians, 1991

Fellow, American College of Emergency Physicians, 2000

California Chapter of the American College of Emergency Physicians, 1991

Society for Academic Emergency Medicine, 1995

Society for Academic Emergency Medicine, EMS Interest Group, 2019

National Association of EMS Physicians, 1998

Fellow, American Academy of Emergency Medicine, 2000

California Chapter of the American Academy of Emergency Medicine, 2000

American Association of University Professors, 2002

California Conference of the American Association of University Professors, 2002

San Diego Faculty Association, 2002

San Diego County Medical Society, 2003

American Association of Emergency Psychiatry, 2014-2017

PATENTS:

WO 2010/011976 A2: Medication Delivery Devices Having Penetrable Sterility Barriers and Alignment Features (January 28, 2010)

WO 2010/011976 A2: Medication Delivery Devices Having Penetrable Sterility Barriers and Alignment Features (January 28, 2010)

US 2010/011966 A2: Medication Delivery System (January 28, 2010)

US 2010/0022987 A1: Medication Delivery System (January 28, 2010)

US 61476836 Medication Delivery Apparatus (April 19, 2011)

Content Expert

Reviewer, Practical Summaries in Acute Care, Thomson American Health Consultants, 2006

Expert Editorial Advisor, *Managing the Ankylosing Spondylitis Patient in an Emergency Setting for the Spondylitis Association of America (SAA)*. 2008

Content Expert for Cable News Network (CNN), 2009

Content Expert for ABC News, 2011

Journals

Editor-in-Chief, *Advances in Legal Medicine*, Longdom Publishing, 2014-2015.

Senior Associate Editor/Editorial Board, *Journal of Emergency Medicine*, Elsevier Science, Inc., 2013 (Associate Editor since 2007, Editorial board since 2000; reviewer since 1994)

Editorial Board, *Prehospital Emergency Care*, Taylor & Francis Group, 2006 (Reviewer since 2004)

Editorial Board, *Journal of Forensic and Legal Medicine*, Elsevier Science, Inc. 2012 (Reviewer since 2011)

Editorial Board, *Emergency Medicine and Healthcare*, Herbert Publications, 2013

Editorial Board, *Saudi Journal of Emergency Medicine*, 2019

Senior Reviewer, *Annals of Emergency Medicine*, Mosby, 2007 (Reviewer since 1998)

Journals (cont.)

Reviewer, *European Journal of Epidemiology*, Kluwer Academic Publishers, 1996-97
Reviewer, *Western Journal of Emergency Medicine*, 2001
Reviewer, *American Journal of Emergency Medicine*, Elsevier Science, Inc., 2005
Reviewer, *Emergency Medicine Journal*, BMA House, 2006
Reviewer, *Forensic Science International*, 2007
Reviewer, *California Journal of Emergency Medicine*, 2007
Reviewer, *Journal of the American Medical Association (JAMA)*, 2009
Reviewer, *BioMedical Engineering OnLine*, 2009
Reviewer, *Bioelectromagnetics*, 2010
Reviewer, *Forensic Science, Medicine and Pathology*, 2010
Reviewer, *Psychology Research and Behavior Management*, 2010
Reviewer, *Academic Emergency Medicine*, 2010
Reviewer, *Medicina*, 2012
Reviewer, *Injury Prevention*, 2013
Reviewer, *Therapeutics and Clinical Risk Management*, 2013
Reviewer, *Pediatrics*, 2013
Reviewer, *Journal of Forensic Toxicology and Pharmacology*, 2014
Reviewer, *Journal of Injury and Violence Research*, 2014
Reviewer, *International Journal of Molecular Sciences*, 2015
Reviewer, *Emergency Medicine International*, 2015
Reviewer, *Policing: A Journal of Policy and Practice*, 2016
Reviewer, *International Journal of Law and Psychiatry*, 2017
Reviewer, *Journal of Correctional Health Care*, 2019
Reviewer, *Clinical Toxicology*, 2019
Reviewer, *Medicine, Science and the Law*, 2019
Reviewer, *Medicine, Science and the Law*, 2019
Reviewer, *International Journal of Legal Medicine*, 2019

CURRENT UCSD COMMITTEE MEMBERSHIPS:

Research Committee, Department of Emergency Medicine, 1997
UCSD Faculty Association, 2002
Quality Improvement/Peer Review Committee, Department of Emergency Medicine, 1999
UCSD Academy of Clinician Scholars Executive Committee, 2005
UCSD Medical Staff Executive Committee, 2007
Chair, UCSD Medical Risk Management Committee, 2012
Chair, UCSD Allocation Committee, 2012
UCSD Significant Events Committee, 2012
Co-Chair, UCSD/Rady Children's Joint Risk Management Committee (JRMC), 2013
UCSD Patient Experience Executive Committee, 2013
UCSD Faculty Leadership Group, 2014
Patient Advocacy Reporting System (PARS) Oversight Team, 2014
UCSD Leadership Council, 2015
UCSD Department of Emergency Medicine Clinical Operations Committee, 2016
UCSD Department of Emergency Medicine Executive Committee, 2016
UCSD Department of Emergency Medicine Management Committee, 2016
UCSD Department of Emergency Medicine/Psychiatric Committee, 2016
UCSD Hillcrest Emergency Department Patient Flow Task Force, 2016
UCSD Health System Patient Grievance Review Committee, 2016
UCSD Threat Assessment Management Committee, 2016
UCSD Medical Staff Bylaws Committee, 2018
UCSD Department of Emergency Faculty Search Committee 2018
UCSD Medical Staff Professionalism Committee, 2019
UCSD Academic Assembly alternative representative, 2019
UCSD Ligature Prevention Task Force, 2019
UCSD Emergency Medicine Workplace Violence Initiative Committee, 2019
UCSD Urgent Care Leadership Committee, 2019
UCSD Department of Emergency Medicine Staff Research Associate Interview Committee, 2019
UCSD Department of Emergency Medicine Residency Interview Committee, 2019
UCSD Flu Capacity Task Force, 2019
UCSD Urgent Care Pharmacy Committee, 2020
UCSD Health Novel Coronavirus Planning and Response Workgroup, 2020

CURRENT COMMITTEE MEMBERSHIPS:

American Academy of Emergency Physicians, Clinical Practice Committee, 2011

San Diego County Base Station Physicians' Committee, 2013

San Diego County Prehospital Audit Committee, 2013

EMS Directors Association of California, 2019

San Diego County North Zone EMS Committee, 2019

San Diego County Health Services Capacity Task Force, 2019

San Diego County EMS Protocol Task Force, 2019

Oceanside Fire Department CQI Committee, 2019

San Diego North Zone Dispatch Protocol Task Force, 2019

San Diego County Fire Chief Association, EMS Section, 2019

San Diego Health Connect, EMS Workgroup, 2019

PREVIOUS UCSD COMMITTEE MEMBERSHIPS:

UCSD Department of Emergency Medicine Academic Affairs Committee, 2013-15
President, UCSD Academy of Clinician Scholars, 2013-15
UCSD Board of Governor's Committee, 2013-15
UCSD Academic Senate Representative Assembly, Alternate, 2011-13
UCSD Sheriff Managed Care Oversight Committee
Ladder Rank Recruitment Committee, UCSD Department of Emergency Medicine, 2013
UCSD Medical Staff Bylaws Work Group, 2014
Chair, Emergency Department Staffing Committee of Process Action Team, 1994-95
Hospital Infection Control Committee, 1994-95
Emergency Medicine Housestaff Association Representative, 1994-96
Emergency Department Clinical Practices Committee, 1994-96
Emergency Department Peer Review/Quality Assurance Committee, 1995-96
Emergency Department Critical Care Room Process Action Team, 1996
Paramedic/Emergency Department Interface Task Force, 1998-99
Emergency Department Staffing Committee, Department of Emergency Medicine, 1999
Credentials Committee, 1997-2000
Faculty Search Committee, Department of Emergency Medicine, 1999, 2000, 2002
Medical Director's Group, 1997-2002
Patient Care Review Committee, 2003
Medical Risk Management Committee, 2002-07
Patient Improvement and Outcome Committee, 2003-05
Medical Staff Executive Committee Reorganization Ad Hoc Committee, 2005-2006
UCSD Phasing Strategy Ad Hoc Committee, 2005-06
Clinical Representative, Trauma Quality Assurance Program, 1998-2006
Vice Chief of Staff, UCSD Medical Center, 2007-2009
UCSD/San Diego Sheriff Security Working Group, 2003-10
Chief of Staff, UCSD Medical Center, 2009-2012
Vice-Chair, Quality Council Committee, 2009-2012 (member since 2003)
Chair, Medical Staff Executive Committee, 2009-2012
UCSD Governance Advisory Committee, 2009-2012

PREVIOUS UCSD COMMITTEE MEMBERSHIPS, continued:

UCSD Department of Medicine Clinical Operations Redesign Enterprise (CORE) Initiative Team, 2009-2012

Director of Risk Management Selection Committee, 2007

Chair, Medical Risk Management Committee, 2003-07 (member since 2002)

Medical Risk Management Executive Committee, 2003-07

UCSD Medical Center Allocation Committee 2005-07

Patient Safety Committee, 2003-07

Vice Chair, Medical Staff Executive Committee, 2007-09

Chair, Patient Care and Peer Review Committee, 2007-09 (member since 2005)

Trauma Multidisciplinary Committee, 2000-09

Department of Medicine Committee on Advancement and Promotions (DOMCAP), 2007-09

Vice Chair, Quality Council Committee, 2009-2012

UCSD Medical Center Syncope Task Force, 2010-11

LIFESHARING, A Donate Life Organization Advisory Board, 2010-2014

UCSD Director of Risk Management Selection Committee, 2012

Secretary-Treasurer, UCSD Academy of Clinician Scholars, 2005-12

UCSD Root Cause Analysis Committee, 2013

UCSD Department of Emergency Medicine Chair Selection Committee, 2012-13

UCSD Department of Emergency Medicine Faculty Coverage Committee, 2012-13

UCSD Integrated Delivery Network Design Team, 2012-13

UCSD Department of Emergency Medicine Patient Satisfaction Committee, 2012-13

UCSD Department of Emergency Medicine Faculty Search Committee, 2013

Rady Children's Root Cause Analysis Committee, Ad hoc, 2012-2015

Rady Children's Emergency Department Faculty Search Committee, 2015

PREVIOUS MEMBERSHIPS/ACTIVITIES:

Vice-President, California Chapter of Emergency Medicine Residents Association, 1994-95

Editor-in-Chief, California Chapter of Emergency Medicine Residents Association Newsletter, 1994-95

Co-Director, School of Medicine 225: Introduction to Emergency Medicine, UCSD School of Medicine, 1994-95

Strike Team Leader, DMAT Olympics 1996 Biological & Chemical Antiterrorist Medical Support

Director, Mercy Air Medical Transport Services Continuing Clinical Education, 1996-2003

Member, San Diego County 911 Dispatch Quality Review Board, 1997-98

Co-Director, University of California, San Diego School of Medicine, Course SOM 224I, 1997-2002

Pediatric Advanced Life Support Course Director, 1997-2002

Editor-in-Chief, UCSD Medical Center EMS Run Review, 1997-2003

Sponsor, Palomar College Emergency Medical Education Department Paramedic Training, 1997-2003

Medical Support Physician, Super Bowl XXXII, San Diego, California, January 25, 1998

Medical Support Physician, Suzuki Rock-n-Roll Marathon, San Diego, California, June 21, 1998

Marketing Director, California Chapter of the American College of Emergency Physicians (CAL/ACEP) Scientific Assembly, 1998-99

Member, Program Committee, CAL/ACEP Scientific Assembly, 1998-99

Howard Hughes Foundation Undergraduate Preceptor, 1998, 1999

Co-editor, Pearls from PAC Newsletter, 1998-2000

Preceptor, Introduction to Clinical Medicine 201-B, UCSD School of Medicine, 1999

EMS Team Leader, San Diego County Metropolitan Medical Strike Team, 1999

Co-Chair, Program Committee, CAL/ACEP Scientific Assembly, 1999-2000 and 2000-01

Member, San Diego County Bio-Terrorism Planning Group, 1999-2003

Moderator, EMS Poster Section, Western Regional Society for Academic Emergency Medicine Conference, Portland, Oregon, April 2000

Preceptor, California State University Dominguez Hills Statewide Nursing Program, 2000

Affiliate Faculty, Southwestern College Paramedic Training Program, 2000-03

PREVIOUS MEMBERSHIPS/ACTIVITIES, continued:

Medical Director, EPIC “Eliminate Preventable Injuries of Children” Medics, San Diego County, 2000-03

San Diego Port District AED (Automated External Defibrillator) Program RPF Panel, 2001

Peer Reviewer, *Pediatric Emergency Medicine Reports*, 2001

Reviewer, Scientific Abstract Presentations, CAL/ACEP Scientific Assembly, 2001-02

Member, Board of Directors, CAL/ACEP, 2001-03

Moderator, Western Regional SAEM Research Presentations, San Diego, California, April 2002

Clinical Coordinator, Southwestern College Emergency Medical Technician Program, 2001-03

Santa Clara County/Regional Medical Center Trauma Designation Review Committee, 2004

San Diego County Health Services Capacity Issues Task Force, 2002-06

San Diego Regional Safety Consortium Inter-facility Transfer Protocol Task Force, 2004-06

San Diego Regional Fire Prevention Emergency Preparedness Task Force, 2004-2006

San Diego County Task Force on Fire Prevention, 2004-06

President-Elect, EMS Medical Director’s Association of California, 2005-06

Medical Director, San Diego County Metropolitan Medical Strike Team, 1998-2008

American College of Emergency Physicians (ACEP) Task Force on Excited Delirium Syndrome
2009-10

Objective Structured Clinical Examiner, UCSD School of Medicine, 1997-10

Evaluator, UCSD Physician Assessment and Clinical Evaluation (PACE) Program, 2000-06

Tactical EMS Care Provider for San Diego Sheriff’s Special Enforcement Detail (SED), 2007-10

San Diego State Pre-Med Preceptor, SDSU, 2008-13

Phi Delta Epsilon Faculty Mentor, UCSD, 2008-12

National Institute of Justice Task Force on Excited Delirium, 2011

Member, Disaster Medical Assistance Team (CA-4), 1994-2011

Operations Committee, San Diego County Metropolitan Medical Strike Team, 1998-2010

Physician Member, San Diego County Metropolitan Medical Strike Team, 1998-07

PREVIOUS COMMITTEE MEMBERSHIPS:

Practice Management Committee, CAL/ACEP, 1994-95
Committee on Prehospital Stroke Triage, San Diego County Medical Society, 1998
Research Subcommittee, San Diego County Prehospital Audit Committee, 1997-99
Prehospital RSI Task Force, San Diego County Prehospital Audit Committee, 1997-99
Chair, San Diego County Prehospital Audit Committee, 1998-2000
San Diego County Pediatric CPR Task Force, 1999-2000
San Diego Sheriff's Source Selection Committee, 2000
Steering Committee, San Diego County Metropolitan Medical Strike Team, 1998-2001
Program Committee, CAL/ACEP Scientific Assembly, 1998-2001 (Co-Chair for 1999-2001)
Awards Committee, CAL/ACEP Scientific Assembly, 1999-2001
EMS Committee, San Diego County Metropolitan Medical Strike Team, 1999-2001
San Diego Metropolitan Medical Response System Bio-Terrorism Planning Group, 1999-2001
San Diego County EMS QA Net Prehospital Design Steering Committee, 2000-01
Chair, CPR Subcommittee, San Diego County Prehospital Audit Committee, 1998-2002
San Diego County SIPs (Serial Inebriate Program) Task Force, 2000-02
Task Force Leader, CAL/ACEP Scientific Assembly, 2001-02
Chair, Training Committee, San Diego County Metropolitan Medical Strike Team, 2001-02
Co-Chair, EMS Committee, CAL/ACEP, 2001-02
Policy Committee, CAL/ACEP, 2001-02
Chair, Research Subcommittee, San Diego County Prehospital Audit Committee, 2000-02
Governmental Affairs Committee, CAL/ACEP, 2001-02
Didactic Subcommittee, SAEM Program Committee, 2001-02
Program Mgmt Committee, San Diego County Metropolitan Medical Strike Team, 2001-03
Air Medical Transport Section, American College of Emergency Physicians, 2001-03
San Diego County Sheriff's Mortality Review Committee, 2001-03
San Diego County Sheriff's Pharmacy and Therapeutics Committee, 2001-03
City of San Diego EMS Physicians' Advisory Committee, 1998-2006
City of San Diego Prehospital Cardiac Advisory Committee, 1998-2006
Education Committee, CAL/ACEP, 2000-03
SAEM EMS Interest Group, 2001-2006 (Co-chair 2003-04)

PREVIOUS COMMITTEE MEMBERSHIPS, continued:

San Diego County EMS for Children (EMSC) Advisory Committee, 2002-05
Scientific Subcommittee, SAEM Program Committee, 2002-05
Police Executive Research Forum Task Force on Conductive Energy Weapons Use, 2005
San Diego County EMS for Children (EMSC) Advisory Committee, 2002-05
Scientific Subcommittee, SAEM Program Committee, 2002-05
Member-at-large, EMDAC Officer Board, 2004-05
San Diego County Fire Chief's Association, 2004-06
San Diego County Sheriff's Helicopter Program Ad Hoc Advisory Committee, 2004-06
Chair, San Diego County HRSA Work Group, 2004-06
San Diego County Regional Helicopter Advisory Committee, 2004-06
San Diego County HRSA Executive Steering Committee, 2004-06
San Diego County Critical Care Transport Working Group, 2005-06
San Diego County Prehospital Patient Record IT Steering Committee, 2005-06
San Diego County Cardiac Advisory Committee, 2005-06
San Diego County Stroke Advisory Committee, 2005-06
San Diego County Emergency Medical Care Committee, 2006
Co-Chair, San Diego County Medical Society EMS Medical Oversight Committee, 2002-2006
Chair, EMS Committee, American Academy of Emergency Medicine California Chapter, 2000-06
EMS Medical Director's Association of California, 2002-06
San Diego County Trauma Administrators Committee, 2002-06
Chair, San Diego County EMS Research Committee, 2002-06
Chair, San Diego County Paramedic Protocol Revision Committee, 2002-06
San Diego County Public Health Services Physicians Group, 2003-06
SAEM EMS Interest Group, 2001-2006 (Co-chair 2003-04)
San Diego County Healthcare Advisory Committee on Terrorism, 2003-06
San Diego County Paramedic Training Joint Advisory Committee, 2000-06
San Diego County Public Health Preparedness Team, 2001-06
EMS Section, American College of Emergency Physicians, 2001-06
Chair, San Diego County Aeromedical Protocol Committee, 1998-2006
San Diego County Committee on Pediatric Emergency Medicine, 1998-2006

PREVIOUS COMMITTEE MEMBERSHIPS, continued:

San Diego County Base Hospital Physicians Committee, 1997-2006
San Diego County Trauma Audit Committee, 1997-2006
San Diego County Prehospital Audit Committee, 1997-2006
EMS Medical Director's Association of California, 2002-06
SAEM Program Committee, 2001-2007
Chair, Photography Subcommittee, SAEM Program Committee, 2002-2007
Training Committee, San Diego County Metropolitan Medical Strike Team, 2001-09
San Diego BEACON/EMS Hub Technical Committee, 2012-13
San Diego Central Jail Quality Assurance Committee, 1999-2013
San Diego Central Jail Medical Oversight Committee, 1999-2013
Resuscitative Outcomes Consortium (ROC) Executive Committee, 2014-15
Resuscitative Outcomes Consortium (ROC) EMS Operations Committee, 2014-15
Resuscitative Outcomes Consortium (ROC) Management Committee, 2014-15
Resuscitative Outcomes Consortium (ROC) Hospital Practices Cardiac Committee, 2014-15
Resuscitative Outcomes Consortium (ROC) Publications Committee, 2014-15
Resuscitative Outcomes Consortium (ROC) Cardiac Committee, 2014-15
Resuscitative Outcomes Consortium (ROC) Trauma Committee, 2014-15
Carlsbad Fire Department EMS Oversight Committee, 2013-17

CURRENT FUNDED RESEARCH:

1. Co-Investigator with Chris Coyne (Co-PI) for study entitled, “A blinded non-randomized comparison of inhaled loxapine (ADASUVE®) versus IM haloperidol/lorazepam”. Funded by Teva Pharmaceuticals, 2015-present. Amount: \$28,300.
2. Co-Principal Investigator with Susan Little for study entitled, “FOCUS program (On the Frontlines of Communities in the United States): Routine Screening for HIV Infection at the UCSD Hillcrest and Thornton Emergency Departments”. Funded by Gilead, 2016-present. Amount: \$490,937.41.
3. Co-Investigator with Chris Coyne for study entitled, “FOCUS program (On the Frontlines of Communities in the United States): Routine Screening for HCV Infection at the UCSD Hillcrest and Thornton Emergency Departments”. Funded by Gilead, 2018-present. Amount: \$306,770.

PREVIOUS FUNDED RESEARCH:

1. Co-Investigator with Tom Neuman (PI) for evaluation of positional asphyxia in the hobble restraint position, funded by the County of San Diego, 1995--\$33,900
2. Co-Investigator, with Theodore Chan (PI), for evaluation of the Melker percutaneous cricothyrotomy kit in human cadavers, funded by Cook Medical Products, 1997--\$10,000
3. Co-Investigator with John Eisele (PI) for the evaluation of positional asphyxia in the hobble restraint position with weight on subjects' backs, funded by the American Academy of Forensic Sciences, 1998--\$2,500
4. Co-Investigator, with Theodore Chan (PI), for study entitled, "The Impact of Oleoresin Capsicum Spray on Respiratory Function in Human Subjects in the Sitting and Prone Maximal Restraint Positions." Study funded by the National Institute of Justice, U.S. Department of Justice, 1998-99. UCSD No. 98-7107; USDOJ Federal Award #98-IJ-CX-0079. Amount: \$128,176
5. Principle Investigator (PI) for study entitled "Evaluation of Hurracaine anesthetic in patients with dyspnea" funded by Beutlich Pharmaceuticals for, 2001. Amount: \$1,500
6. Co-Investigator, with Theodore Chan (PI), for evaluation of the Melker percutaneous cricothyrotomy kit in human cadavers, funded by Cook Medical Products, 2003. Amount: \$12,000
7. Co-Investigator, with David Hoyt (PI) for the Resuscitation Outcomes Consortium: UCSD / San Diego Resuscitation Research Center, funded by the NIH, 9/1/04 to 6/30/09. UO1 HL077908. Amount: \$2,250,522
8. Co-Principal Investigator (Co-PI), with Theodore Chan, for study entitled, "The effect of Taser on Cardiac, Respiratory and Metabolic Physiology in Human Subjects." Study funded by the National Institute of Justice, U.S. Department of Justice, 10/1/2005 to 9/30/2007. UCSD No. 2006-0846; USDOJ Federal Award #98-IJ-CX-0079. Amount: \$213,941.4
9. Co-Investigator, with Daniel Davis (PI) for the study entitled, "ROC Interventional Trials: Hypertonic Resuscitation for Traumatic Injury, Trauma Epistry, PRIMED", funded by the NIH, 7/1/06 to 6/30/08. UO1 HL077863. Amount: \$331,320
10. Co-Investigator, with Daniel Davis (PI) for the, "ROC Cardiac Epistry", funded by the AHA, 7/1/06 to 6/30/08. Amount: \$133,427
11. Co-Investigator, with Theodore Chan (PI) for study entitled, "Multi-Center Study of the Impact of Nurse-Patient Ratios on Emergency Department Overcrowding." funded by the Emergency Medicine Foundation, 7/1/07 to 6/30/08. Amount: \$50,000
12. Principal Investigator (PI) for study entitled, "Evaluation of the Ventilatory and Respiratory Effects of a Restraint Chair on Human Subjects." Funded by the Institute for the Prevention of In-Custody Deaths, Inc, 1/1/07 to 12/31/07. Amount: \$11,658

PREVIOUS FUNDED RESEARCH (cont):

13. Co-Investigator, with Edward Castillo (PI) for study entitled, "California ED Diversion Project Evaluation." funded by the California Healthcare Foundation, 5/15/08 to 10/15/08. Amount: \$50,990
14. Principal Investigator (PI) for study entitled, "Ventilatory Effects of Prone Restraint on Obese Human Subjects." Funded by the Institute for the Prevention of In-Custody Deaths, Inc, 1/1/09 to 12/31/09. Amount: \$13,423
15. Principal Investigator (PI) for study entitled, "FAST TRAC: Finding ACS with Serial Troponin Testing for Rapid Assessment." Funded by the Nanosphere, Inc. 2/1/09 to 2/1/11. Amount: \$85,000
16. Principal Investigator (PI) for study entitled, "CHOPIN: Copentin Helps in the Early Detection of Patients with Acute Myocardial Infarction." Funded by Brahms AG, 8/1/09 to 8/1/12. Amount: \$103,950
17. Co-Investigator, with Christine Hall for the study titled, "RESTRAINT - Risk of dEath in Subjects That Resisted: Assessment of Incidence and Nature of faTal events", funded by the Vancouver Island Health Authority. 7/1/09 to 6/30/11. Amount \$50,000
18. Co-Investigator for study titled "STAT MERCURY: Studying the Treatment of Acute HyperTension: A Multicenter EmeRgency Department Clevidipine Utilization RestrY" funded by the Medicines Company, 7/27/10 to 11/1/11. Amount \$1400
19. Co-Investigator for study titled "A Phase II, Randomized, Double-blind, Placebo-controlled Study to Evaluate the Safety and Efficacy of MN-221 when Administered Intravenously as an Adjunct to Standard Therapy to Adults with an Acute Exacerbation of Asthma." Study funded by MediciNova, Inc. 1/1/11 to 1/31/12. Amount \$50,000
20. Principle Investigator for study titled "AKINESIS: Acute Kidney Injury N-gal Evaluation of Symptomatic heart failure." Study funded by Alere and Abbott, 4/1/11 to 6/30/12. Amount \$32,000
21. Principle Investigator for study titled "Evaluation of Ecallantide (DX-88) for the Acute Treatment of Angiotensin Converting Enzyme Inhibitor Induced Angioedema, a Phase II, double-blind study. Study funded by Dyax Corporation. 4/1/11 to 6/30/12. Amount \$20,000
22. Principle Investigator for study titled "REAL: Rapid Evaluation of Acute Kidney Injury with NGAL in Acutely Ill Patients in the ICU." Study funded by Alere, 5/1/11 to 6/30/12. Amount \$74,435
23. Principle Investigator for study titled "A Mult-Center, Open-Label, Surveillance Trial to Evaluate the Safety and Efficacy of a Shortened Infusion Time of Intravenous Ibuprofen Protocol CPI-CL-015." Study funded by Cumberland Pharmaceuticals, Inc., 6/1/11 to 6/30/12. Amount \$50,000

PREVIOUS FUNDED RESEARCH (cont):

24. Co-Investigator, with Edward Castillo (PI) for the study titled, “Restraint Chair Literature Review and Policy Gap Analysis”, funded by the Ontario Ministry of Community Safety and Correctional Services, 7/1/13 to 9/30/13. COS-0010. Amount: \$15,000
25. Co-Investigator, with Daniel Davis (PI) for the study titled, “Resuscitation Outcomes Consortium (ROC) Regional Clinical Center, San Diego”, funded by the NIH, 3/1/10 to 6/30/14. U01 HL077908-09. Amount: \$1,389,389
26. Co-Investigator with Edward Castillo (PI) for study entitled, “Diagnostic Evaluation using ClearView in Decision Making in the Emergency Room”. Funded by EPIC Research and Diagnostics, Inc, 2012-2014. Amount: \$650,840.10 (based on 570 total participants).
27. Co-Investigator with Edward Castillo (PI) for study entitled, “Point-of-Care Testing for Illicit Drugs and Alcohol Intoxication in an Emergency Room”. Funded by the National Institute on Drug Abuse through Seacoast Science, Inc., 2013-2015. Amount: \$50,163.
28. Co-Investigator with Edward Castillo (PI) for study entitled, “Evaluation of downward force placed onto prone subjects.” Funded by the Institute for the Prevention of In-Custody Deaths, Inc., 2014-2015. Awarded, contract in process. Amount: \$7,500.
29. Co-Investigator with Edward Castillo (PI) for study entitled, “Acute Bacterial Skin and Skin Structure Infection (abSSSI) Practice Pattern Assessment.” Funded by Durata Therapeutics International B.V., 2014-2015. Amount: \$15,000.
30. Co-Investigator with Edward Castillo (PI) for study entitled, “Exploring emergency room physician’s knowledge and attitudes concerning the use of appropriate and safe home care as an alternative to hospital admission.” Funded by the Gary and Mary West Health Institute, 2014-2015. Amount: \$118,021.
31. Co-Investigator with Allyson Kreshak (PI) for study entitled, “Telephone, Text or Type? Comparing Tools for Improving Physician-Patient Communication Beyond the Walls of the Emergency Department after Discharge.” Funded by the UCSD Academy of Clinician Scholars, 2014-2015. Amount: \$10,000.
32. Principal Investigator (PI) for the study titled, “Resuscitation Outcomes Consortium (ROC) Regional Clinical Center, San Diego”, funded by the NIH, 7/1/14 to 12/31/15. U01 HL077908-09. Amount: NCE
33. Principal Investigator (PI) for study entitled, “EXCITATION Study: Unexplained In-Custody Deaths: Evaluating Biomarkers of Stress and Agitation.” Study funded by the National Institute of Justice, U.S. Department of Justice, 11/1/2012 to 6/30/2016. USDOJ Federal Award # 2012-R2-CX-K006. Amount: \$431,943
34. Principal Investigator (PI) for the study titled, “Resuscitation Outcomes Consortium (ROC) Protocol -ALPS”, funded by the NIH, 7/1/13 to 12/31/15. 5U01HL077863-11 subaward 758500. Amount: \$289,003

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35. Co-Investigator with Edward Castillo (PI) for study entitled, “Acute Home Care as an Alternative to Inpatient Admission from the Emergency Department”. Funded by the Gary and Mary West Health Institute, 2015 – 2016. Amount: \$499,125.
36. Co-Investigator with Theodore Chan (PI) for study entitled, “The Gary and Mary West Geriatric Center of Excellence (West COE): Phase 1 Research Development”. Funded by the Gary and Mary West Health Institute, 2015-2016. Amount: \$243,610.

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36. Chan TC, Vilke GM. In: TASER® Conducted Electrical Weapons: Physiology, Pathology, and Law. Kroll MW, Ho JD (Eds.); New York: Springer, 2009, pp 109-118.
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200. Marston N, Shah K, Mueller C, Neath SX, Christenson R, McCord J, Nowak R, Vilke G, Daniels L, Hollander J, Apple F, Cannon C, Nagurney J, Schreiber D, DeFilippi C, Hogan C, Diercks D, Limkaken A, Anand I, Jaffe A, Peacock WF, Maisel A, Wu, A: Can a second measurement of copeptin improve acute myocardial infarction rule out?. J Am Coll Cardiol 2014;63(12_S).

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202. Castillo EM, Dang AQ, Chan TC, Vilke GM. Mortality and Timing of Death in Patients With Runaway Pacemakers. *Ann Emerg Med* 2014; 64(4s):S111.
203. Brennan JJ, Chan TC, Hsia RY, Vilke GM, Killeen JP, Castillo EM. Predicting Frequent Use of Emergency Department Resources. *Ann Emerg Med* 2014; 64(4s):S118 – S119.
204. Campillo A, Castillo EM, Vilke GM, Wilson MP. Use of Quetiapine in the Emergency Department for Acute Agitation and Associated Physiologic Effects. *Ann Emerg Med* 2014; 64(4s):S138.
205. Vilke GM, Lev R, Chan TC, Lucas J, Smith J, Painter NA, Castillo EM. Prescription Drug Prescribing Patterns in a Large Regional Area. *Ann Emerg Med* 2014; 64(4s):S139-S140.
206. Hopper AB, Deen J, Smith C, Campillo A, Vilke GM, Castillo EM, Wilson MP. Hypotensive Effects of Oral Second Generation Antipsychotics in the Emergency Department. *Ann Emerg Med* 2014; 64(4s):S140-S141.
207. Marston N, Shah K, Mueller C, Neath SX, Christenson R, McCord J, Nowak R, Vilke GM, Daniels L, Hollander J, Apple F, Cannon C, Nagurney J, Schreiber D, deFilippi C, Hogan C, Diercks D, Limkakend A, Anand I, Wu A, Clopton P, Jeffe A, Peacock F, Maisel A. Does Copeptin Provide Additional Risk Stratification in Chest Pain Patients With a Mild Troponin Elevation? *Circulation* 2014; 130:A12996.
208. Egnatios J, Lev R, Petro S, Castillo E, Vilke G. Long Active Death: Medadone. *Ann Emerg Med* 2015; 66(4s):S140-S141.
209. Vilke GM, Guss DA. Pilot Study of Telemedicine in a County Jail to Assess and Treat Acutely Ill Inmates. *Ann Emerg Med* 2015; 66(4s): S14.
210. Brennan JJ, Vilke GM, Hsia RY, Chan TC, Killeen JP, Huang J, Castillo EM. Transient Ischemic Attack “Bouncebacks”: Emergency Department Discharges Who Return as Admissions Within Seven Days. *Ann Emerg Med* 2015; 66(4s):S112.
211. Brennan JJ, Chan TC, Vilke GM, Killeen JP, Hsia RY, Tehaney K, Castillo EM. Admissions Within Seven Days of an Emergency Department Discharge. *Ann Emerg Med* 2015; 66(4s):S89.

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213. Castillo EM, Chan, TC, Vilke GM, Hsia RY, Ishamine P, Shah S, Kapoor K, Brennan JJ. A Description of Pediatric Frequent Users of Emergency Department Resources. *Ann Emerg Med* 2015; 66(4s):S8.
214. Rentmeester L, Clark RF, Joshua A, Vilke, GM. (2015). Undetectable Total Phenytoin in a Patient with Elevated Kappa Light Chains. *Clinical Toxicology*. 2015;53. 658.
215. Chan TC, Brennan JJ, Vilke GM, Hsia RY, Killeen JP, Castillo EM. The Changing Landscape of Emergency Department Visits in California. *Acad Emerg Med* 2016; 23:S15
216. Castillo EM, Vilke GM, Killeen JP, Hsia RY, Wilson MP, Brennan JJ. ED Utilization Prior to a Suicide and Self-Inflicted Injury Related ED Visit. *Acad Emerg Med* 2016; 23:S17.
217. Supat B, Brennan JJ, Vilke GM, Ishimine P, Shah S, Hsia RY, Castillo EM. Assessing Factors Associated with Pediatric Frequent Emergency Department Utilization. *Acad Emerg Med* 2016; 23:S32.
218. Coyne CJ, Chiu C, Brennan JJ, Castillo EM, Vilke GM. Medication Adherence in the Emergency Department: What are the Barriers? *Acad Emerg Med* 2016; 23:S41.
219. Spinosa DL, Brennan JJ, Castillo EM, Hsia RY, Vilke GM. Multivariate Analysis of 30-Day Readmission for Acute Myocardial Infarction. *Acad Emerg Med* 2016; 23:S118.
220. Castillo EM, Brennan JJ, Shah S, Vilke GM, Hsia RY, Nguyen M. Asthma and Asthma-Mimicking Pediatric ED Revisit Within Three Days of an ED Discharge. *Acad Emerg Med* 2016; 23:S120.
221. Castillo EM, Brennan JJ, Chan TC, Killeen JP, Hsia RY, Vilke GM. ED Utilization 3-Days Prior to a Fall-Related ED Visit Among Elderly Patients. *Acad Emerg Med* 2016; 23:S139.
222. Coyne CJ, Le V, Brennan JJ, Castillo EM, Shatsky RA, Vilke GM. Low-Risk febrile Neutropenia: Can These Patients be Safely Discharged from the Emergency Department? *Acad Emerg Med* 2016; 23:S161.
223. Brennan JJ, Vilke GM, Chan TC, Killeen JP, Hsia RY, Castillo EM. ED Revisits Within 3 Days of an ED Discharge Among Elderly Patients. *Acad Emerg Med* 2016; 23:S169.

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224. Nakajima Y, Vilke GM, Castillo EM, Brennan JJ, Hsia R. Asthma Bouncebacks Emergency Department Discharges Who Return as Admission Within Three Days. Acad Emerg Med 2016; 23:S202.
225. Benaron D, Castillo E, Vilke G, Guluma K. Emergency Department Patient Perception of Stroke: A Comparison of Elderly and Nonelderly Knowledge of Stroke. Acad Emerg Med 2016; 23:S256.
226. Vilke GM, Castillo EM, Brennan JJ, Killeen JP. What Happens to Emergency Patients Who Leave Without Being Seen by a Physician? Ann Emerg Med 2016;68(4):S33.
227. Castillo EM, Morgan AO, Vilke GM, Killeen JP, Hsia RY, Brennan JJ. Characteristics of Frequent Users of Emergency Departments With Pain-Related Diagnoses. Ann Emerg Med 2016;68(4):S56-57.
228. Brennan JJ, Vilke GM, Killeen JP, Hsia RY, Castillo EM. Trends Among Emergency Department Visits for Suicide-Related Diagnoses, 2008 – 2014. Ann Emerg Med 2016;68(4):S385.
229. Coyne CC, Brennan JJ, Castillo EM, Vilke GM. Cancer-Related Emergency Department Bounce Backs: Describing the Population and Assessing Outcomes. Ann Emerg Med 2016;68(4):S387.
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232. Castillo EM, Ko K, Howard J, Vilke GM, Hsia R, Killeen JP, Brennan J. The Rate and Patient Characteristics of 7-Day ED Revisits among Senior Patients. Acad Emerg Med 2017; 24 (S1):S37-S38.
233. Hornbeak K, Castillo EM, Sloane C, Vilke GM. Injuries Associated with Law Enforcement Use-of-force Incidents with and without Subject Intoxication. Acad Emerg Med 2017; 24 (S1):S131.

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234. Coyne C, Li D, Brennan J, Castillo E, Vilke GM. Evaluating cancer-related pain management in the emergency department setting. *Acad Emerg Med* 2017; 24 (S1):S148-S149.
235. Brennan J, Vilke GM, Hsia R, Killeen JP, Castillo EM. Emergency department visits following hospital admissions. *Acad Emerg Med* 2017; 24 (S1):S159.
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237. Coyne CJ, Brennan J, Castillo EM, Vilke GM. Conducting Meaningful Population-Based Research on Patients with Cancer Who Present To the Emergency Department - A Study on The Methodology of Categorization. *Acad Emerg Med* 2017; 24 (S1):S223.
238. Miller A, Brennan J, Vilke GM, Castillo EM. Knowledge and Concern over Ingredients in Packaged Food and Personal Hygiene Products among Emergency Department Patients. *Acad Emerg Med* 2017; 24 (S1):S248.
239. Killeen JP, Castillo EM, Vilke GM, Chan TC, Dunford JK, Kahn C, Powell R, Sparks J, Pringle J, Chavez DJ, Branning MD. Prehospital to Emergency Department Data Exchange-a SAFR Transition of Care. *Ann Emerg Med* 2017; 70(4): S2.
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241. Brennan JJ, Chan TC, Vilke GM, Killeen JK, Hsia RY, Castillo EM. ED Revisits within 3 Days of an ED Discharge for Urinary Tract Infection among Geriatric Patients. *Ann Emerg Med* 2017; 70(4): S85.
242. Kreshak, Tolia VT, Chan TC, Killeen JP, Vilke GM, Castillo EM. A Four-Year Descriptive Analysis of Geriatric Patients' Visits to the Emergency Department. *Ann Emerg Med* 2017; 70(4): S97.
243. Nakajima Y, Brennan JJ, Castillo EM, Vilke GM. Factors Associated with Ambulance Use in Emergency Department Patients. *Ann Emerg Med* 2017; 70(4): S102.
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246. Brennan JJ, Chan TC, Vilke GM, Hsia RY, Killeen JK, Castillo EM. Geriatric visits to California Emergency Department from 2008 through 2014. *Ann Emerg Med* 2017; 70(4): S158-S159.
247. Coyne CJ, Ence T, Smyres C, Brennan J, Castillo E, Vilke GM. The relationship between medication knowledge, perceived importance, and medication adherence. *Ann Emerg Med* 2017; 70(4): S169.
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249. Coyne CJ, Ha E, Brennan JJ, Castillo EM, Birring P, Shah S, Vilke GM. Cancer-Related Venous Thromboembolism in the Emergency Department: A Retrospective Cohort Study. *Acad Emerg Med* 2018;70(4):S72.
250. Castillo EM, Vuong CL, Vilke GM, Brennan JJ, Hsia RY, Killeen JP. 30-Day Readmissions among Elderly Patients Discharged with an Acute Myocardial Infraction. *Acad Emerg Med* 2018;70(4):S120.
251. Coyne CJ, Brennan JJ, Castillo EM, Vilke GM. Cancer-Related Emergency Department Visits in the Elderly: Comparing Characteristics and Outcomes. *Acad Emerg Med* 2018;70(4):S121.
252. Vilke GM, Lutz M, Sloane C, Castillo E, Brennan J, Swift S, Coyne C. Physiological Effects of a Spit Sock. *Ann Emerg Med* 2018; 72(4): S56.
253. Tolia VM, Kreshak AA, Chan TC, Brennan JJ, Vilke GM, Castillo EM. Initial Risk Screening and Impact of Evaluation for Geriatric Emergency Department Patients. *Ann Emerg Med* 2018; 72(4): S83.
254. Castillo EM, Cronin AO, Chan TC, Brennan JJ, Vilke GM, Killeen JP, Hsia RY. Trends in Drug and Alcohol Use from 2008 Through 2016. *Acad Emerg Med* 2019; 26(S1):S41.
255. Castillo EM, Brennan JJ, Hsia RY, Vilke GM, Killeen JP, Chan TC. Trends in Emergency Department Discharges from 2008 Through 2016. *Acad Emerg Med* 2019; 26(S1):S61.
256. Castillo EM, Tolia VM, Kreshak AA, Brennan JJ, Chan TC, Vilke GM, Hsia RY. A Description of Geriatric Patients Presenting to California Emergency Departments for a Fall-Related Complaint. *Acad Emerg Med* 2019; 26(S1):S90-1.

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257. Killeen JP, Docter TA, Brennan JJ, Castillo EM, Vilke GM, Chan TC, Tolia VM. Comparison of Length of Stay for Patients with High Sensitivity Troponin vs Standard Troponin. Acad Emerg Med 2019; 26(S1):S352.
258. Tolia VM, Chan TC, Brennan JJ, Castillo EM, Vilke GM, Wardi G, Kreshak AA. The Impact of a Short Hospital Worker Strike on Emergency Department Utilization. Acad Emerg Med 2019; 26(S1):S236.
259. Vilke GM, Mash D, Pardo M, Bozeman W, Hall C, Sloane C, Wilson M, Coyne CJ, Xie C, Castillo EM. Excitation Study — Unexplained In-Custody Deaths: Evaluating Biomarkers of Stress and Agitation. Acad Emerg Med 2019; 26(S1):S260.

ORAL PRESENTATIONS AT NATIONAL MEETINGS:

1. Chan TC, Buchanan J, Anderson M, Vilke GM: Patient ethnicity and age in prehospital emergency ambulance use and acuity rates. NAEMSP Mid-Year Meeting, Lake Tahoe, Nevada; July 1998.
2. Vilke GM, Dunford JV, Buchanan J, Chan TC: Are opiate overdose deaths related to patient release after naloxone? ACEP Research Forum, San Diego, California; October 1998.
3. Gerling MC, Hamilton RS, Davis DP, Morris GF, Vilke GM, Hayden SR: The effects of cervical spine immobilization on technique and laryngoscope blade selection on an unstable cervical spine injury in a cadaver model of intubation. ACEP Research Forum, San Diego, California; October 1998.
4. Vilke GM, Chan TC, Ray LU, Anderson ME: Use of prehospital crash injury data to assess regional automobile safety restraint use. NAEMSP Annual Meeting, Marcos Island, Florida; January 1999.
5. Chew GS, Chan TC, Bramwell K, Davis DP, Vilke GM: Does gastric distention from air insufflation affect the accuracy of the syringe esophageal detector device in detecting esophageal intubation? SAEM Western Regional Research Forum, Redondo Beach, California; March 1999.
6. Davis DP, Kimbro T, Vilke GM: The use of midazolam for prehospital rapid-sequence intubation may be associated with a dose-related increase in hypotension. NAEMSP Annual Meeting, Dana Point, California; January 2000.
7. Marino AT, Sharieff G, Gerhart AE, Chan TC, Vilke GM: The efficacy and complication rate of prehospital midazolam for the treatment of pediatric seizures. NAEMSP Annual Meeting, Dana Point, California; January 2000.
8. Eisele JW, Chan T, Vilke G, Neuman T, Clausen J: Effect of weight placed on the back of subjects in the hobble restraint position. American Academy of Forensic Sciences Annual Meeting, Reno, Nevada; February 2000.
9. Chan TC, Vilke GM, Neuman TS, Clark RF, Clausen JL: The effect of oleoresin capsicum spray inhalation on pulmonary and respiratory function. SAEM Western Regional Research Forum, Portland, Oregon; April 2000.
10. Vilke GM, Chan TC, Seltzer A, Fisher R, Dunford JV: Outcome of out-of-hospital refusal of paramedic transport by parents of pediatric patients. State of California EMS Authority EMS for Children Annual Conference, San Diego, California; November 2000.
11. Deitch S, Vilke GM, Marino A, Vroman D, Chan TC: Effect of prehospital use of nitroglycerine on EKG findings in patients with chest pain. American Academy of Emergency Medicine Annual Conference, Orlando, Florida; March 2001.

ORAL PRESENTATIONS AT NATIONAL MEETINGS, continued:

12. Vilke GM, Steen PJ, Smith AM, Chan TC: Pediatric intubation by paramedics: The San Diego County experience. SAEM Western Regional Research Forum, Irvine, California; March 2001.
13. Davis DP, Ochs M, Hoyt DB, Dunford JV, Vilke GM: The use of the Combitube as a salvage airway device for paramedic RSI. SAEM Western Regional Research Forum, Irvine, California; March 2001.
14. Chan TC, Dunford JV, Vilke GM: Impact of a community multidisciplinary homeless outreach team. SAEM Annual Meeting, Atlanta, Georgia; May 2001.
15. Chan TC, Dunford JV, Vilke GM: Impact of a community multidisciplinary homeless outreach team. CAL/ACEP Scientific Assembly, Santa Clara, California; June 2001. (Won Award for Best Oral Presentation)
16. Valentine C, Davis D, Ochs M, Hoyt D, Bailey D, Vilke G: The use of the Combitube as a salvage airway device for paramedic rapid sequence induction. NAEMSP Annual Meeting, Tucson, Arizona; January 2002.
17. Vilke GM, Lev R, Castillo EM, Metz MA, Murrin PA, Chan TC: Prospective countywide trial to decrease ambulance diversion hours. SAEM Western Regional Meeting, Scottsdale, Arizona; April 2003.
18. Vilke GM, Lev R, Castillo EM, Murrin PA, Chan TC: Prospective countywide trial to decrease ambulance diversion hours. SAEM Annual Meeting, Boston, Massachusetts, May 2003.
19. Vilke GM, Lev R, Castillo EM, Metz MA, Murrin PA, Chan TC: San Diego County improved patient destination trial to decrease emergency department diversion hours and diverted patients. American College of Emergency Physicians Research Forum, Boston, Massachusetts; October 2003.
20. Vilke G, Castillo E, Metz M, Murrin P, Ray LU, Lev R, Chan T: Community trial to decrease ambulance diversion of patients and hours. NAEMSP National Conference, Tucson, Arizona; January 2004.
21. Marcelyn Metz, Patricia Murrin, Gary M. Vilke: The three-phase EMS cardiac arrest model for ventricular fibrillation. ENA Annual Meeting; San Diego, California; October 2004.
22. Michalewicz, BA, TC Chan, GM Vilke, SS Levy, TS Neuman, and FW Kolkhorst: Ventilatory and metabolic demands during aggressive physical restraint in healthy adults. American College of Sports Medicine Annual Meeting, Denver, CO; June 2006. [*Medicine and Science in Sports and Exercise* 38(5 Supplement), 2006].
23. Vilke GM, Ali S, Simmons T, Witucki P, Wilson MP. Does an alcohol-based sanitizer impact breathalyzer levels? SAEM Annual Meeting, Chicago, Illinois; May 2012.

SELECTED SPEAKING ENGAGEMENTS:

1. “Death of a Child: How to Treat the Survivors” -- Grand Rounds, Department of Emergency Medicine, UCSD Medical Center; April 1996.
2. “Assessing GCS and the Field Neurologic Exam” -- Palomar College Paramedic Training; June 1998.
3. “Prehospital Shock”; “Management of the Field Trauma Patient” -- Mercy Air, Ventura County Lecture Series; August 1998.
4. “ER: Not Just a Television Show, But a Field of Research” -- Howard Hughes Foundation Lecture Series, University of California, San Diego; November 1998.
5. “Multi-Casualty Incident” -- UCSD Medical Center Trauma Conference; March 1999.
6. “Managing the Prehospital Multi-Casualty Incident” -- Southwestern College Paramedic Training Institute; May 1999.
7. “Aeromedical Transport: The Past and Current Environment” -- Trauma Morbidity and Mortality Conference, Children’s Hospital, San Diego, California; July 1999.
8. “Altitude Medicine”; “Carbon Monoxide Poisoning and Treatment Options”; “Aeromedical Transport Options”; “Emergent Airway Management Options” -- Rural Emergency Medicine Conference, Jackson Hole, Wyoming; August 1999.
9. “Abdominal and Chest Trauma in Sports” -- First Annual San Diego County Athletic Coaches Workshop, San Diego, California; June 2000.
10. “Tabletop Discussion on Chemical Weapon of Mass Destruction” -- Facilitator of Tabletop Training for San Diego County Metropolitan Medical Strike Team; July 2000.
11. “Pediatric IV Access”; “Spinal Immobilization”; “Children with Special Health Care Needs”; “Cardiovascular Emergencies” -- American Academy of Pediatrics Pediatric Education for Prehospital Professionals Conference, San Diego, California; November 2000.
12. “New Frontiers in Field Management of Pediatric Status Epilepticus” -- State of California EMS Authority Annual EMS for Children Conference, San Diego, California; November 2000.
13. “EMS Medical Control: Avoiding your Day in Court” -- ACEP’s Emergency Medicine Connection Conference, San Diego, California; March 2001.
14. “Pediatric Intubations by Paramedics” -- San Diego Chapter of the Committee on Pediatric Emergency Medicine; April 2001.
15. “Warfare and Terrorism: A Review of Chemical Agents -- San Diego County Metropolitan Medical Strike Team Training; August 2001.

SELECTED SPEAKING ENGAGEMENTS, continued:

16. "Bioterrorism and San Diego County" -- Council of Community Clinics Meeting; October 2001.
17. "Bioterrorism and San Diego County Readiness" -- CTN interview with Bill Horn; October 2001.
18. "Future of Prehospital Care" -- Keynote Speaker, Southwestern Paramedic College Graduation; November 2001.
19. "Biological Agents for Terrorism" -- San Diego County Metropolitan Medical Strike Team Training; November 2001.
20. "Clinical Aspects of Bioterrorist Agents" -- Palomar Paramedic College; November 2001.
21. "Clinical Aspects of Bioterrorism" -- Grand Rounds, Fallbrook Hospital; January 2002.
22. "Bioterrorism and San Diego County Readiness" -- Poway Town Hall Meeting; January 2002.
23. "Bioterrorist Preparedness" -- National Medical Association, San Diego County; January 2002.
24. "Chemical Agents of Terrorism: Diagnosis and Treatment" -- Topics and Advances in Internal Medicine, San Diego, California; March 2002.
25. "Bioterrorism: Implications for the Legal and Domestic Community" -- Thomas Jefferson School of Law, San Diego, California; April 2002.
26. "Prehospital Management of Pediatric Seizures" -- EMS-Children Annual Conference; San Diego, California; November 2002.
27. "Paramedicine – Past, Present and Future" -- Keynote Speaker, Southwestern Paramedic College Graduation; San Diego, California; December 2002.
28. "Medical Group Preparedness: How would you Respond to a Possible Victim of Bioterrorism?" -- Bioterrorism Preparedness Training Conference; San Diego California; January 2003.
29. "Update on Bioterrorism" -- The Western States Winter Conference on Emergency Medicine; Park City, Utah; January 2003.
30. "Academic Emergency Medicine and Research Opportunities" -- San Diego Health Information Association, San Diego, California; February 11, 2003.
32. "Blast and Radiological Injuries: Myths and Realities" -- San Diego County Metropolitan Medical Strike Team Training; San Diego, California; August 2003.

SELECTED SPEAKING ENGAGEMENTS, continued:

33. "Clinical Aspects of Bioterrorism" -- American Correctional Health Services Association, California and Nevada Chapter Annual Conference, San Diego, California; September 2003.
34. "Bioterrorism" -- UCSD/SDSU General Preventive Medicine Residency Lecture Series, La Jolla, California; October 2003.
35. "Prehospital Pediatric Airway Obstruction" -- Children's Hospital Grand Rounds, San Diego, California; July 2004.
36. "Future of Healthcare in San Diego: Trends Impacting our Delivery System" -- San Diego Organization of Healthcare Leaders, San Diego, California; August 2004.
36. "Firestorm 2003" -- Children's Hospital Grand Rounds, San Diego, California; January 2004.
37. "EMS research: Unique ethical and regulatory issues" -- Applied Research Ethics National Association Annual meeting, San Diego, California; October 2004.
38. "What happens when you call 911?" -- San Diego Sports Medicine Foundation, San Diego, California; October 2004.
39. "Making the Metropolitan Medical Response System Work for You" -- Emergency Response 2004 Conference, San Diego, California; November 2004.
40. "San Diego County Emergency Department Ambulance Bypass - Past, Present, Future" -- Urgent Matters Briefing, San Diego, California; November 2004.
41. "San Diego County Emergency Department Ambulance Bypass - Past, Present, and Future" -- San Diego Community Emergency Departments, San Diego, California; December 2, 2004.
42. "Emergency Response Management for Efficiency of Care and Fiscal Consideration" -- American Correctional Health Services Association, Oakland, California; April 2, 2005.
43. "Conducted Energy Devices -- Medical Updates and Issues" -- Police Executive Research Forum, Houston, Texas; October 18, 2005.
44. "Conducted Energy Devices Proximity Deaths and Medical Response" -- 2005 Critical Issues in Policing Series, Police Executive Research Forum, San Diego, California; December 8, 2005.
45. "Conductive Electrical Devices (Tasers®) and Patients with Excited Delirium for Law Enforcement and Emergency Medical Personnel" -- The U.S. Metropolitan Municipalities EMS Medical Directors Annual Meeting, Dallas, Texas; February 16, 2006.
46. "Tasers and Sudden Death" -- Keynote speaker at One Day Symposium on In-Custody Deaths by the Florida Sheriffs Association, Orlando, Florida; June 1, 2006.

SELECTED SPEAKING ENGAGEMENTS, continued:

47. “Medical Aspects of the Use of Force Continuum” -- Department of Justice Community Oriented Policing Services (COPS) Conference, Washington, DC; July 29, 2006.
48. “Resuscitation Outcomes Consortium” -- 7th Annual University of California Neurotrauma Meeting, Carmel, California; August 3, 2006.
49. “Use of Force: Sudden Death Myths and Excited Delirium” -- The Commission of Accreditation for Law Enforcement Agencies (CALEA) Less Lethal Technology Working Group Meeting, Washington, DC; September 10, 2006.
50. “Police In-Custody Deaths and the Taser Controversy” -- UCSD/SDSU General Preventive Medicine Residency Lecture Series, La Jolla, California; September 2006.
51. “Conductive Energy Devices: The medical aspects of Taser Electronic Control Devices (ECDs) and other Energy Devices” – Sudden Death, Excited Delirium and In-Custody Death Conference by the Institute for the Prevention of In-Custody Deaths, Inc. Las Vegas, Nevada; November 16-17, 2006.
52. “Cardiac, Respiratory and Metabolic Effects of EMD” – Study of Deaths Following Electro Muscular Disruption, Meeting of the Chief Medical Panel for the National Institute of Justice. Washington D.C.; January 9, 2007.
53. “The Medical Implications of Tasers and the Impact on EMS ” – National Association of EMS Physicians National Conference. Naples, FL; January 12, 2007.
54. “Excited Delirium” - Solutions For Corrections Seminar for the California State Sheriff’s Association. Ontario, CA; February 7, 2007.
55. “Excited delirium, positional asphyxia and restraint” -- EMS Today Conference, Baltimore, Maryland; March 10, 2007.
56. “Medical implications of Tasers and other Conductive Energy Devices” -- EMS Today Conference, Baltimore, Maryland; March 10, 2007.
57. “Excited Delirium” -- American Correctional Health Services Association, Oakland, California; September 19, 2007.
58. “Human Physiologic Effects of Tasers” – Study of Deaths Following Electro Muscular Disruption, Meeting of the Chief Medical Panel for the National Institute of Justice. Washington D.C.; September 27, 2007.
59. “The clinical impacts of TASER and other Conductive Energy Devices on Humans: A Review of the latest Medical Research” – Sudden Death, Excited Delirium and In-Custody Death Conference by the Institute for the Prevention of In-Custody Deaths, Inc. Las Vegas, Nevada; November 28-30, 2007.

SELECTED SPEAKING ENGAGEMENTS, continued:

60. “Physiological Effects of Tasers” – The City Council of Miami-Dade. Miami, Florida; January 17, 2008.
61. “Excited Delirium: What is it? Why does it kill? What do we need to know about it?” Western States Winter Conference on Emergency Medicine. Park City, Utah, February 8, 2008.
62. “Medical Effects of Tasers” – The City Council of Houston. Houston, Texas; March 10, 2008.
63. “Less Lethal Weapons” - Emergency Nurses Association, San Diego Chapter. San Diego, California; April 18, 2008.
64. “The Clinical Impacts of TASER and other Conductive Energy Devices on Humans and Why People Die Afterwards” -- American Correctional Health Services Association, San Diego, California; September 17, 2008.
65. “Police In-Custody Deaths and Excited Delirium” -- UCSD/SDSU General Preventive Medicine Residency Lecture Series, La Jolla, California; October 2008.
66. “The Clinical Impacts of TASER and other Conductive Energy Devices on Humans” – Sudden Death, Excited Delirium and In-Custody Death Conference by the Institute for the Prevention of In-Custody Deaths, Inc. Las Vegas, Nevada; October 29, 2008.
67. “Agitated Delirium – Role of Illicit Drug Use in Sudden Restraint Death” Western Medical Toxicology Fellowship Conference. San Diego, California; April 29, 2009.
68. “Conducted Energy Devices: Are They Safe Options?” Excited Delirium Conference by the Canadian Institute for the Prevention of In-Custody Deaths, Inc. Niagara Falls, Canada; May 26, 2009.
69. “The Physiologic Effects of the Taser on Humans” UCSD Biomedical and Clinical Research Seminars. San Diego, California; June 2, 2009.
70. “The Taser-Plastic Surgery Interface” UCSD Department of Plastic Surgery Grand Rounds. San Diego, California; June 17, 2009.
71. “ECD Research Update and Safety Issues” – Sudden Death, Excited Delirium and In-Custody Death Conference by the Institute for the Prevention of In-Custody Deaths, Inc. Las Vegas, Nevada; November 12, 2009.
72. “Use of the Restraint Chair and Positional Asphyxia” – Southern California Jail Manager’s Association. Temecula, California; January 21, 2010.

SELECTED SPEAKING ENGAGEMENTS, continued:

73. “Excited Delirium Challenges and Best ER Practices” Excited Delirium Conference by the Canadian Institute for the Prevention of In-Custody Deaths, Inc. Niagara Falls, Canada; April 19, 2010.
74. “Excited Delirium and TASERS: What Physicians Need to Know” – Grand Rounds Scripps Encinitas Hospital. Encinitas, California; July 15, 2010.
75. “Excited Delirium and TASERS: What Physicians Need to Know” – Grand Rounds University Medical Center. Las Vegas Nevada; August 10, 2010.
76. “Review of ECD Research and Reported Cardiac Capture” – Sudden Death, Excited Delirium and In-Custody Death Conference by the Institute for the Prevention of In-Custody Deaths, Inc. Las Vegas, Nevada; November 17, 2010.
76. “The Science Behind the American Heart Association ACLS Guidelines” – Puerto Vallarta ACLS Resuscitation Conference. Puerto Vallarta, Mexico; February 18, 2011.
77. “The Science Behind the American Heart Association ACLS Guidelines” – Cabo San Lucas ACLS Resuscitation Conference. Cabo San Lucas, Mexico; March 25, 2011.
78. “ROC Cardiac Arrest Outcomes” – San Diego Resuscitation Conference. San Diego, California; April 9, 2011.
79. “Do Electronic Control Devices Kill Humans: Review of the Data” – Sudden Death, Excited Delirium and In-Custody Death Conference by the Institute for the Prevention of In-Custody Deaths, Inc. Las Vegas, Nevada; November 16, 2011.
80. “Evaluation After Choking or Strangulation” – UCSD Forensic Nursing Conference. San Diego, California; April 28, 2012.
81. “Prehospital Hypothermia for Cardiac Arrest” – Santa Clara County EMS Conference. San Jose, California; May 23, 2012.
82. “The Science Behind the American Heart Association ACLS Guidelines” – Cabo San Lucas ACLS Resuscitation Conference. Cabo San Lucas, Mexico; August 21, 2012.
83. “Acute Cerebral Accidents” – Hermosillo ACLS Resuscitation Conference. Hermosillo, Sonora, Mexico; September 11, 2012.
84. “Excited Delirium Syndrome: TASERS, Restraints, and Sudden Death” – Emergency Nurses Association Annual Conference. San Diego, California; September 15, 2012.
85. “Electronic Control Devices and the not so Shocking Truth about their Lethality” – Sudden Death, Excited Delirium and In-Custody Death Conference by the Institute for the Prevention of In-Custody Deaths, Inc. Las Vegas, Nevada; November 14, 2012.

SELECTED SPEAKING ENGAGEMENTS, continued:

86. “Medical Evaluation and Detection of Dementia and Delirium” – Annual Update on Behavioral Emergencies Conference. Las Vegas, Nevada, December 5, 2012.
87. “Acute Cerebral Accidents” – Puerto Vallarta Resuscitation Conference. Puerto Vallarta Mexico; January 17, 2013.
88. “Excited Delirium Syndrome: TASERS, Restraints, and Sudden Death” – San Diego County Emergency Nurses Association 911 Conference. San Diego, California; April 19, 2013.
89. “Acute Cerebral Accidents” – Cabo San Lucas Resuscitation Conference. Cabo San Lucas Mexico; April 27, 2013.
90. “Acute Myocardial Infarction” – Mazatlan Resuscitation Conference. Mazatlan Mexico; May 7, 2013.
91. “Hypothermia Post Cardiac Arrest” –Acapulco Resuscitation Conference. Acapulco, Mexico; May 28, 2013.
92. “Bath Salts and In-Custody Death”- National Sheriff’s Association. Charlotte, NC; June 25, 2013.
93. “Updates in Cardiac Arrest: The ROC Trials” – Mexico Association of Emergency Medicine Emergency Update Conference. Mexico City, Mexico; June 28, 2013.
94. “Management of Head Trauma” – Mexico Association of Emergency Medicine Emergency Update Conference. Mexico City, Mexico; June 28, 2013.
95. “Hypothermia Post Cardiac Arrest” –La Paz Resuscitation Conference. La Paz, Mexico; July 22, 2013.
96. “Management of Head Trauma” – Mexico Association of Emergency Medicine Emergency Update Conference. Monterrey, Mexico; September 26, 2013.
97. “Updates in Cardiac Arrest: The ROC Trials” – Mexico Association of Emergency Medicine Emergency Update Conference. Monterrey, Mexico; September 26, 2013.
98. “Risk Management and Minimizing Malpractice Exposure” – UCSD Department of Orthopedics Grand Rounds, San Diego, CA October 2, 2013.
99. “Decreasing Your Risk in Labor and Delivery” – UCSD 9th Annual Perinatal Symposium, San Diego, CA October 11, 2013.
100. “Excited Delirium Syndrome: TASERS, Restraints, and Sudden Death” – UCSD Department of Emergency Medicine Grand Rounds, San Diego, CA November 11, 2013.

SELECTED SPEAKING ENGAGEMENTS, continued:

101. “Excited Delirium Syndrome” – Annual Update on Behavioral Emergencies Conference. Orlando, Florida; December 12, 2013.
102. “The importance of CT on the initial evaluation of a trauma patient: ABC or AB-CT ?” – Primero Simposium Internacional BNH con UCSD Celebrado en Los Cabos. Los Cabos, Mexico; December 7, 2013.
103. “Management of Head Trauma” –Emergency Medicine Update Conference. Puerto Vallarta, Mexico; December 18, 2013.
104. “Updates in Cardiac Arrest: The ROC Trials” – Emergency Medicine Update Conference. Puerto Vallarta, Mexico; December 18, 2013.
105. “Pulmonary Embolism: Evaluation and Treatment”- 25th Annual Mexico Emergency Medicine Congress. Acapulco, Mexico; February 20, 2014.
106. “Management of Head Trauma” –Emergency Medicine Update Conference. Puerto Vallarta, Mexico; March 5, 2014.
107. “Updates in Cardiac Arrest: The ROC Trials” – Emergency Medicine Update Conference. Puerto Vallarta, Mexico; March 5, 2015.
108. “Management of Burns” –Trauma Update Conference. Puerto Vallarta, Mexico; April 3, 2014.
109. “Management of Head Trauma” –Trauma Update Conference. Puerto Vallarta, Mexico; April 3, 2014.
110. “Cuffs, Chains and Chairs” – Restraint and In-Custody Death Conference by the Institute for the Prevention of In-Custody Deaths, Inc. Las Vegas, Nevada; April 24, 2014.
111. “Management of Burns” –Trauma Update Conference. Los Cabos, Mexico; June 5, 2014.
112. “Management of Head Trauma” - Primera Feria Annual de la Salud. Guadalajara, Mexico; July 18, 2014
113. “Management of Burns” - Primera Feria Annual de la Salud. Guadalajara, Mexico; July 18, 2014.
114. “Updates in Cardiac Arrest: The ROC Trials” – Primera Feria Annual de la Salud. Guadalajara, Mexico; July 18, 2014.
115. “Pulmonary Embolism: Evaluation and Treatment”- Primera Feria Annual de la Salud. Guadalajara, Mexico; July 18, 2014.

SELECTED SPEAKING ENGAGEMENTS, continued:

116. “Risk Management and Minimizing Malpractice Exposure” – UCSD Department of Anesthesia Pain Service Grand Rounds, San Diego, CA September 24, 2014.
117. “The ABCs of CPR” –Huatulco Resuscitation Conference. Huatulco, Mexico; October 2, 2014.
118. “Risk Management and Minimizing Malpractice Exposure” – UCSD Division of Gastroenterology Grand Rounds, San Diego, CA October 16, 2014.
119. “Identification and Treatment of Excited Delirium Syndrome” - Annual Update on Behavioral Emergencies Conference. Scottsdale, Arizona; December 11, 2014.
120. “Autopsy of an In-Custody Death” – Defense Research Institute Annual Conference, San Diego, CA January 30, 2015.
121. “TASERS: The shocking truth”- 26th Annual Mexico Emergency Medicine Congress. Mazatlan, Mexico; February 5, 2015.
122. “Resuscitation Update: CPR, Hypothermia and new devices” - 26th Annual Mexico Emergency Medicine Congress. Mazatlan, Mexico; February 5, 2015.
123. “Management of Head Trauma” - Segundo Feria Annual de la Salud. Guadalajara, Mexico; May 22, 2015.
124. “Updates in Cardiac Arrest: The ROC Trials” – Segundo Feria Annual de la Salud. Guadalajara, Mexico; May 22, 2015.
125. “Pulmonary Embolism: Evaluation and Treatment”- Segundo Feria Annual de la Salud. Guadalajara, Mexico; May 22, 2015.
126. “Resuscitation Update: CPR, Hypothermia and new devices” – Altitude and Travel Medicine Symposium. Cusco, Peru; August 21, 2015.
127. “Approaches to Stabilization, Transfer and Disposition of Tourist with Multiple Trauma – Altitude and Travel Medicine Symposium. Cusco, Peru; August 21, 2015.
128. “Risk Management and Minimizing Malpractice Exposure” – UCSD Department of Orthopedics Grand Rounds, San Diego, CA December 2, 2015.
129. “Ketamine and EMS” – Annual Update on Behavioral Emergencies Conference. Las Vegas, Nevada; December 3, 2015.
130. “Pulmonary Embolism: Evaluation and Treatment”- 27th Annual Mexico Emergency Medicine Congress. Puerto Vallarta, Mexico; February 4, 2016.

SELECTED SPEAKING ENGAGEMENTS, continued:

131. “The importance of CT on the initial evaluation of a trauma patient: ABC or AB-CT ?” – 27th Annual Mexico Emergency Medicine Congress. Puerto Vallarta, Mexico; February 4, 2016.
132. “Risk Management and Minimizing Malpractice Exposure” – UCSD Department of Dermatology Grand Rounds, San Diego, CA February 11, 2016.
133. “Remembering the Provider” – Southern California Association of Health Risk Managers, Palm Desert, CA May 4, 2016.
134. “The ABCs of CPR” –San Miguel Health Fair. San Miguel, Mexico; July 15, 2016.
135. “Beware of the Medically Fragile Patient”- Special Needs Conference by the Institute for the Prevention of In-Custody Deaths, Inc. Las Vegas, Nevada; March 7, 2017.
136. “Avances en Tromboembolia Pulmonar”- 3rd Annual Congreso Binacional de Medicine de urgencias y Trauma, Tijuana, Mexico; May 5, 2017.
137. “Caso Clinico de Trauma”- 3rd Annual Congreso Binacional de Medicine de urgencias y Trauma, Tijuana, Mexico; May 5, 2017.
138. “Avances en Aeromedicina”- 3rd Annual Congreso Binacional de Medicine de urgencias y Trauma, Tijuana, Mexico; May 6, 2017.
139. “Science of Restraint, Position/Compression and Asphyxia, and Science Behind Asphyxial Death” – Police Use of Force in Today’s World. Miami, FL; June 26, 2017.
140. “Excited Delirium Syndrome and the Risk of Litigation” – California Crisis Intervention Team Association Annual Meeting. Costa Mesa, CA; August 24, 2017.
141. “Medico-legal Issues in the Acutely Agitated Patient” – Coalition on Psychiatric Emergencies Pre-Conference. Scottsdale, Arizona, December 15, 2017.
142. “Updates on Excited Delirium” – Annual Update on Behavioral Emergencies Conference. Scottsdale, Arizona, December 15, 2017.
143. “When Should Ketamine be Used in the Treatment of Agitation?” – International Conference on Emergency Medicine. Mexico City, Mexico, June 8, 2018.
144. “Avances en Tromboembolia Pulmonar”- 3rd Annual Congreso Binacional de Medicine de urgencias y Trauma, Tijuana, Mexico; June 7, 2019.
145. “Excited Delirium in the ED: Clinical Pearls” – Southern California EM Symposium, Los Angeles, California. February 1, 2020.
146. “Updates in Treating Excited Delirium Syndrome”- 31st Emergency and Reanimation Congress, Acapulco, Mexico. February 12, 2020.

SELECTED SPEAKING ENGAGEMENTS, continued:

147. “Management of Acute Agitation in the Emergency Department”- 31st Emergency and Reanimation Congress, Acapulco, Mexico. February 12, 2020.