STATE OF NEW YORK

MONROE COUNTY GRAND JURY

DAY 5:

Investigation into the death of Daniel T. Prude

Transcript of the Proceedings held before the Monroe County Grand Jury, at the Monroe County, Hall of Justice, 99 Exchange Blvd., Rochester, New York, 14614, on December 16th, 2020.

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GJ 45	BWC [redacted] 767 W MAIN		14
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(Proceeding commenced.)

MR. SMITH: Good morning, everybody. We're back on the record in the investigation into the death of Daniel Prude. Michael Smith and Jennifer Sommers present on behalf of the Attorney General's Office.

For the record, we do have 21 grand jurors present this morning and as such, we do have a quorum.

I want to start, ladies and gentlemen, the last time we were here, we heard from the Medical Examiner -- the Erie County Office of the Medical Examiner -- I'm sorry. Strike that. The Monroe County Office of the Medical Examiner, Doctor [redacted] Doctor [redacted] identified Grand Jury Exhibit 36-A, which was for ID as the case summary report, the autopsy report, and the lab report that pertain to the autopsy of Daniel Prude that she conducted under case number 20-00902.

I would note, for the record, that Grand Jury Exhibit 36-A for ID bears a certification from Doctor [redacted] and notarized by [redacted]. As such, at this time, we're going to offer Grand Jury 36-A pursuant to CPL 180.60 and 190.30 in evidence.

(Whereupon, Grand Jury Exhibit 36-A was then received into evidence.)

MR. SMITH: Ladies and gentlemen, you are

free to review Grand Jury 36-A now that it is in evidence.

I would note, ladies and gentlemen, during Doctor [redacted] testimony, or following her testimony, a question came up regarding the collection time of the sample from Mr. Prude that was tested at the lab that was the basis for the toxicology report that Doctor [redacted] talked about. I would note that the lab report is contained within Grand Jury 36-A and I would direct the grand jurors' attention to the specimens received at the bottom of the first page of that lab report to the collection time of 4:01 a.m. on March 23rd, 2020.

Ladies and gentlemen, I would also note, just for scheduling purposes, that we anticipate calling six witnesses today. Ideally, in a perfect world, ladies and gentlemen, we would have gotten all the witnesses that we intended to call this week today, gotten everybody out of the way. I know there's snow coming that may be of concerns. But, due to some issues with the availability of a witness, one of whom is testifying electronically tomorrow, we are going to bring you back tomorrow for three witnesses. Hopefully, it will be a shorter day, a half day.

So, I want to make everyone aware of that.

But, unfortunately, we are going to have to come back tomorrow for those reasons. So, unless anybody has any questions about that, with that, we're going to call Lieutenant [redacted]

MS. SOMMERS: Can I just add one thing? That in light of the fact that tomorrow's a little bit of a shorter day, I want to address the fact, I think, previously, you've been presented with a lot of stuff and previously we had, kind of, talked about maybe reviewing some of the evidence if you wanted, if that would be helpful. So, perhaps, tomorrow, if there's some evidence that you would like to, sort of, look at, listen to again, that might be an opportunity. There might be an opportunity for that. It could also happen another time. I just wanted to put that out there. I'm sorry. Go ahead.

(Whereupon, the witness entered the Grand Jury room at a time of 9:32 a.m.)

L T. [redacted] [redacted]
after being duly called and sworn, testified as follows:

EXAMINATION BY MR. SMITH:

Q. Good morning, sir?
A. Good morning.
Q. Could you state and spell your first and last names for the record?
A. My name is [redacted]. And, my last name is spelled [redacted].
Q. How are you employed, sir?
A. I'm employed by the City of Rochester Police Department.
Q. What's your current rank?
A. Lieutenant.
Q. How long have you been with the Rochester Police Department in total?
A. Working on my 25th year.
Q. How long as a Lieutenant, sir?
A. I think I'm about eight years in grade.
Q. And, can you describe the -- what is your current

assignment?
A. Currently, I'm assigned as the Major Crimes Lieutenant in the Central Investigation Section.
Q. Lieutenant, when it comes to the Buffalo Police Department, did you have special duties -- I'm sorry, the Rochester Police Department. When it comes to the Rochester Police Department, do you have any special duties, sir, over the Rochester Body Worn Camera Program?
A. Yes. I'm the highest ranking member that administers that program.
Q. Can you just generally describe for the Grand Jury how the Rochester Body Worn Camera Program works?
A. Sure. Each officer is assigned a body worn camera, their own camera. They have to affix it to the outside of their uniform before they start a shift. During their shift, anything in which they're going to take some type of police action, they're required to hit the record button and record that event. Once it's over, they can stop the recording. At the end of the night, when they're done with all those events and all those files, they take the camera off of their body, they put it into a docking station which, essentially, is a wholly contained computer. The computer then takes the files off of that camera,

then uploads them to a secured server, where they can be accessed using body worn camera software.

Q. Lieutenant [redacted] do individual officers operate the cameras themselves, turn them on and off manually?

A. Yeah, all cameras are manual, yes.

Q. How are those body worn camera videos stored to the secured server?

A. Well --

Q. Is there a way that they're identified, was my question, Lieutenant [redacted] Is there a way they're identified?

A. Yeah. Each file -- so, each camera is associated with some type of identifying factor with the officer, either an employee ID number or what we call an IBM number from many years ago that's unique to that officer. And then, all the files that that officer takes are filed under his name in order of date.

Q. Lieutenant [redacted] can the individual officers -- are they able in any way to change or alter what's stored on their body worn camera?

A. No. The camera is fully contained. They can't get to the battery. They can't get to the SD card. Short of the camera falling and getting destroyed in some way, there's no way to alter any files that are

on there.
Q. Lieutenant [redacted] is anybody in the Rochester Police Department able to alter those videos ones that are on the secured server?
A. Yeah. We do have people that can alter them. However, alterations to any videos, in terms of enhancements that we're looking for, sometimes we'll take multiple sources of a video and, kind of, put it together in a story board, so to speak. That's done by our digital media specialist. However, all those changes are a copy of the original file. So, the original file is never changed, only copies of that original file.
Q. And, when those enhancements are done and labels are placed on, is the actual content of the video changed in any way, Lieutenant [redacted]
A. No, the content's not changed, no.
Q. I'm going to ask you some questions about the Daniel Prude investigation, sir. As part of that investigation, did you retrieve some body worn camera videos from the secured server?
A. Yes, I did.
Q. And, Lieutenant [redacted] are MCU investigations in the Rochester Police Department assigned CR number?
A. Yes. Essentially, every police call for service

that we go to is assigned a crime report number.
Q. And, are these body worn camera videos, once they're uploaded to the secured server, are they stored according to that CR number?
A. Yes. According -- well, they're labeled -- there's, basically, three pieces of information that's on each file. It's a crime report number, an address and usually a classification tag in terms of what type of call that file pertains to.
Q. And, in this case, was there a crime report number 2020-00061280 assigned to this investigation, the death of Daniel Prude?
A. Yes, sir.
Q. And, did you access and retrieve the body worn camera videos pursuant to that CR number?
A. Yes, sir.
Q. And, did that -- did those body worn camera videos, sir, relate to the scene at 435 Jefferson Avenue, some of them?
A. There were a few addresses all associated with the 435 Jefferson event and the body worn camera video, to the best of my memory, was all -- any address associated with that event was all filed under that crime report number.
Q. And, was some of that body worn video from

Officer [redacted]
A. Yes, sir.
Q. Was some of it from Officer [redacted]
A. Yes, sir.
Q. And, was there also a body worn camera video from Officer [redacted]?
A. Yes, sir.
Q. Lieutenant [redacted] I'm showing you what's been marked as Grand Jury Exhibits 45 through 48 in order and starting first with Grand Jury Exhibit 45. I'm going to ask if you recognize what that is, sir?
A. Yes. This is the [redacted] body worn camera video from the burglary portion of this at 767 West Main Street.
Q. How do you know that, sir?
A. Well, my initials are on it, I see it's got the address on it and I also identify [redacted] ID number.
Q. Did you place those initials and date on it after you reviewed it, sir?
A. Yes.
Q. Is this an accurate copy of the video stored on the secured server under that CR number?
A. Yes, sir.
Q. Sir, I'm going to ask you the same questions

about Grand Jury Exhibit Number 46, do you recognize that Exhibit?
A. Yes, sir.
Q. What do you recognize that Exhibit to be?
A. This is the body worn camera video from 435 Jefferson Avenue from [redacted].
Q. How do you recognize it to be that, sir?
A. It's marked with Jefferson Avenue, it has his identification number on it and I also initialed and dated it when I reviewed it.
Q. So, you reviewed that Exhibit, sir?
A. Yes, sir.
Q. Again, this is an accurate copy of the body worn camera video from [redacted] from the scene at Jefferson Avenue that you retrieved from the secured server pursuant to that CR number?
A. Yes, sir.
Q. Same question about Grand Jury Exhibit 47, sir. Do you recognize that Exhibit?
A. Yes, sir.
Q. What do you recognize that Exhibit to be?
A. This is the body worn camera video from [redacted] at Jefferson Avenue.
Q. And, how do you recognize as such, sir?
A. Well, it has [redacted] number on it, I also

recognize parts of his identification number marked on it, and I also have my initials and date when I reviewed it.

Q. So, you reviewed this Exhibit, sir?

A. Yes, sir.

Q. And, this is an exact copy of the body worn camera that was stored on that secured server for Officer [redacted]?

A. Yes, sir.

Q. And, finally, sir, I'm going to ask you the same question about Grand Jury Exhibit 48. Do you recognize that Exhibit, sir?

A. Yes, sir.

Q. What do you recognize that to be?

A. Well, this is the body worn camera video from Officer [redacted] from Jefferson Avenue.

Q. How do you recognize that to be that?

A. Well, I see his name on the envelope. I also see his ID number. Although, it's not marked with Jefferson Avenue, I believe, if I'm correct, he only had a body camera video from Jefferson Avenue. I also have my initials on it and the date that I reviewed it.

Q. And, you reviewed this, sir?

A. Yes, sir.

Q. And, this is an accurate copy of -- exact copy, rather, of the body worn camera video from Officer [redacted] from the scene at Jefferson Avenue that you retrieved from that secured system by that CR number?

A. Yes, sir.

MR. SMITH: Thank you. At this time, I'm going to offer Grand Jury Exhibits 45 through 48.

(Whereupon, Grand Jury Exhibits 45 through 48 were then received into evidence.)

BY MR. SMITH:

Q. Finally, Lieutenant [redacted] were you present, sir, at the scene of the incident where Mr. Prude was restrained that is the subject of this Grand Jury investigation in the early morning hours of March 23rd of 2020, around 3:00 o'clock to 3:30 a.m.?

A. Yes, sir.

Q. You were present?

A. I was present at the scene after the incident was completed.

Q. My question, sir, was if you were at the scene during the restraint?

A. No, sir. I was not.

MR. SMITH: Thank you. Do any of the grand jurors have any questions for Lieutenant [redacted]

GRAND JURY POOL: (All jurors indicating a negative response.)

MR. SMITH: Seeing as there are none, you are excused.

THE WITNESS: Thank you.

(Whereupon, the witness left the Grand Jury room at a time of 9:43 a.m.)

MR. SMITH: Ladies and gentlemen, at this time, we are going to play Grand Jury Exhibits 45 through 48 one at a time, starting with Grand Jury Exhibit 45, which was identified by Lieutenant [redacted] as the body worn camera video from Officer [redacted] from the scene of the burglary at 767 West Main Street.

MS. SOMMERS: It doesn't appear to be showing on my computer yet.

Okay. Everybody good, or do you want the lights up?

MR. SMITH: Do you guys like the lights like this or on?

GRAND JURY POOL: (All jurors indicating a positive response.)

MS. SOMMERS: Okay. For the record then, we're going to start playing.

MR. SMITH: Playing Grand Jury Exhibit 45, start to finish.

(Whereupon, Grand Jury Exhibit 45, body worn camera video was then played for the Grand Jury.)

MR. SMITH: Which officer is this?

MS. SOMMERS: I want to -- for the record, it is -- for the record, I'm going to stop that. I accidentally put in Grand Jury Exhibit 46. I'm going

to take that out and put in Grand Jury Exhibit 45. Just so we can go in order.

MR. SMITH: Yes.

(Whereupon, Grand Jury Exhibit 46 was removed and Grand Jury Exhibit 45 was then played for the Grand Jury.)

A JUROR: There's two for [redacted]

MR. SMITH: Yeah. Just so we're clear here, before we start, ladies and gentlemen, Exhibit 45, we inadvertently started playing 46. 45 is what we intend to play first. We're going to go in order. Exhibit 45 is identified by Lieutenant [redacted] as Officer [redacted] body worn camera video from the scene of the burglary at 767 West Main Street.

MS. SOMMERS: Okay. Sorry about that.

MR. SMITH: That's okay. Playing 45 now.

(Whereupon, Grand Jury Exhibit 45, body worn camera video, was then play for the Grand Jury.)

(Whereupon, the video terminated.)

MR. SMITH: Ladies and gentlemen, that concludes Grand Jury Exhibit 45. We are now going to play Grand Jury Exhibit 46 identified by Lieutenant [redacted] as Officer [redacted] body worn camera video from the scene of the restraint of Mr. Prude at Jefferson Avenue.

(Whereupon, Grand Jury Exhibit 46, body worn camera video, was then played for the Grand Jury.)

(Whereupon, the video terminated.)

MR. SMITH: That concludes Grand Jury Exhibit 46. Ladies and gentlemen, at this time, we're going to play Grand Jury Exhibit 47 identified by Lieutenant [redacted] as the body worn camera video of Officer [redacted] from the scene at Jefferson Avenue.

MS. SOMMERS: Is the volume okay? Once it kicks in can everyone in the back hear?

GRAND JURY POOL: (All jurors indicating a positive response.)

MS. SOMMERS: Okay.

(Whereupon, Grand Jury Exhibit 47, body worn camera video was played for the Grand Jury.)

MS. SOMMERS: I apologize.

MS. SMITH: For the record, ladies and gentlemen, that was 48 inadvertently played instead of 47. So, now, we are going to play 47.

Again, 47 being the body worn camera video of Officer [redacted]

(Whereupon, Grand Jury Exhibit 47, body worn camera was then played for the Grand Jury.)

MS. SOMMERS: Pause. For the record, we're

restarting the Exhibit.

(Whereupon, the video continued to play for the Grand Jury.)

(Whereupon, the video terminated.)

MR. SMITH: That concludes Grand Jury Exhibit 47. And, finally, ladies and gentlemen, we're going to play Grand Jury Exhibit 48, identified by Lieutenant [redacted] as Officer [redacted] body worn camera video from the scene on Jefferson Avenue.

(Whereupon, Grand Jury Exhibit 48, body worn camera video was play for the Grand Jury.)

(Whereupon, the video terminated.)

MR. SMITH: Ladies and gentlemen, that concludes Grand Jury Exhibit 48.

And again, I remind the grand jurors that Exhibits 45 through 45 -- sorry, 45 through 48 are in evidence and are available for your review.

(Whereupon, there was a short break off the record.)

(Proceeding reconvened.)

MR. SMITH: At this time, we call [redacted].

(Whereupon, the witness entered the Grand Jury room at a time of 10:34 a.m.)

[redacted] after being duly called and sworn, testified as follows:

EXAMINATION BY MR. SMITH:

Q. Good morning, sir?

A. Good morning.

Q. Could you state and spell your first and last names for the record, please?

A. [redacted]

Q. Investigator [redacted] remind the grand jurors of your employment, sir?

A. Right now, I work for the Attorney General's Office, Special Operations Unit.

Q. Investigator [redacted] you testified previously in this matter for this Grand Jury regarding some synchronization of some videos, is that correct?

A. Correct.

Q. And, since that time, Investigator [redacted] have you discussed this case with any other witnesses?

A. No.

Q. And, sir, as part of your duties as a Supervisor in the Special Operations Unit, does that include

video and audio processing in evidence?
A. It does.
Q. And, as part of that work, were you asked to do, again, additional video synchronizations as part of this case in the investigation into the death of Daniel Prude?
A. Yes.
Q. And, Investigator [redacted] were you asked to synchronize the body worn camera videos from the officers at a scene as it pertains to the investigation?
A. Can you repeat that question?
Q. The videos that you were asked to create, that you're testifying to at this time, was that video from body worn cameras from the police officers that were at the scene of the restraint of Mr. Prude?
A. Yes, sir.
Q. On March 23rd?
A. Yes, sir.
Q. Okay. And, do those body worn cameras, sir, include the body worn camera videos from Officer [redacted]
[redacted]
A. Yes.
Q. [redacted]?
A. Yes.

Q. Sergeant [redacted]
A. Yes.
Q. Officer [redacted]
A. Yes.
Q. And, Officer [redacted]?
A. Yes.
Q. Showing you what's been marked as Grand Jury Exhibit 49, do you recognize that Exhibit?
A. I do.
Q. What do you recognize that Exhibit to be?
A. This is a copy of the five camera views from the body cameras that you just mentioned that I actually compiled. My initials are on it and the date that I made it.
Q. And, Grand Jury Exhibit 49, Investigator [redacted] this is the synchronized video that you made from the five body worn camera videos that we just discussed?
A. Yes.
Q. And, you reviewed it and initialed it after you reviewed that Exhibit?
A. True.
Q. Is this a copy of the video you created?
A. Yes.
MR. SMITH: At this time, I'm going to offer Grand Jury Exhibit 49 into evidence.

(Whereupon, Grand Jury Exhibit 49 was then received into evidence.)

BY MR. SMITH:

Q. Now, specifically, Investigator [redacted] what did you do with the five videos that you were given?

A. Well, I took each one separately. I think I took off the -- a little bit of the leader, once the camera started when the officer was in the car, so they started once the officers arrived on scene or just before. I then added the name of the officer on each video. I then synced each video by time using the audio files. And then, displayed them on the screen in a manner where, when the first camera came on view, it occupied the whole screen. As a second camera came up, I made it small and moved it to the left, added a second camera, and then moved those around on the screen, up to five cameras. And, as the officers turned the body cameras off, I again, opened it up.

Q. So, Investigator [redacted] is it possible then, on this video, to view all five body worn cameras at the same time while they are all on?

A. Yes, that was the purpose.

Q. Sir, is the audio also synced?

A. Yes.

Q. And, other than adding the name plates of the

officers and cutting off a little of the beginning of the transport, or of the trip in the vehicle, sir, did you alter that footage in any other way?

A. No, sir.

MR. SMITH: At this time ladies and gentlemen, we're going to play Grand Jury Exhibit 49. And, I would state for the record, that the five videos that Investigator [redacted] created this video from are in evidence before this Grand Jury as Exhibits 41, 44, 46, 47 and 48. And, at this time, we're going to play 49.

(Whereupon, Grand Jury Exhibit 49 then played for the Grand Jury.)

MR. SMITH: Actually, ladies and gentlemen, we're going to pause for just two minutes while we address some technical issues here.

MS. SOMMERS: How about five minutes?

MR. SMITH: Let's take a five minute break.

MS. SOMMERS: Sorry everyone.

(Whereupon, there was a short break off the record.)

(Proceeding reconvened.)

MR. SMITH: Okay. Ladies and gentlemen, I believe we do have all 21 grand jurors back in the room. It appears we have fixed the technical issue

regarding Grand Jury Exhibit 49. So, at this time, we're going to play that Exhibit again.

(Whereupon, the video played for the Grand Jury.)

(Whereupon, the video was experiencing technical issues.)

THE WITNESS: It's having a problem moving data from the external drive.

(Whereupon, the video continued to play for the grand jury.)

(Whereupon, the video terminated.)

Mr. SMITH: Ladies and gentlemen, that concludes Grand Jury Exhibit 49.

I have no further questions for Investigator [redacted] Do any of the grand jurors have any questions?

GRAND JURY POOL: (All jurors indicating a negative response.)

MR. SMITH: Seeing as there are none, you are excused, sir. Thank you.

THE WITNESS: Thank you.

(Whereupon, the witness left the Grand Jury room at a time of 11:01 a.m.)

MR. SMITH: Ladies and gentlemen, at this time, we can take a brief five minute break. Thank you.

(Whereupon, there was a short break off the record.)

(Proceeding reconvened.)

MS. SOMMERS: Everyone is back. So, just a little bit of housekeeping. We'll have a hard stop at 11:45 to get ready for a witness who is testifying virtually. So, if we get through this witness, great. I don't want anyone to feel like they didn't get to ask questions or anything, so if we don't get through this witness -- this witness, she will stay. But, we're going to -- we have another witness that we have to take at 11:45. Well, actually, we're going to test some equipment at 11:45.

A JUROR: Cross our fingers.

MS. SOMMERS: Right. You can see how talented we are.

Okay. At this time, we would like to call [redacted]

(Whereupon, the witness entered the Grand Jury room at a time of 11:13 a.m.)

[redacted] after being duly called and sworn, testified as follows:

EXAMINATION BY MS. SOMMERS:

Q. Good morning. So, just try to keep your voice up or just make sure you're in the direction of the microphone. Could you please state your name and spell it as well?

A. [redacted]

Q. Where do you work?

A. AMR, Rochester.

Q. Can you tell the Grand Jury what AMR stands for?

A. American Medical Response.

Q. And, what -- what is AMR?

A. AMR is the company that currently has the city contract to provide the emergency medical services for the City of Rochester.

Q. So I'm going to ask you to slow down a tiny bit, because the woman in front of you has to take all of your words down. What is your current -- I'd like to withdraw that. In what capacity do you work for AMR currently?

A. I am currently a Paramedic.
Q. Can you explain for the Grand Jury what a Paramedic is?
A. A Paramedic is the advanced level of care above an EMT basic. It requires two years of schooling. We are trained to provide advanced life support, including, you know, intubation care and cardiac arrest, interpretation of EKGs and things along those lines.
Q. Are you current on your certifications?
A. I am.
Q. Before becoming a Paramedic, what level of care were you? Did you start with something less than that?
A. I started as an EMT basic.
Q. What is an EMT basic?
A. So, it's the entry level of care for EMS. It is basic life support, so splinting, a couple of medications, CPR and AED use.
Q. What does AED stand for?
A. Automated external defibrillator.
Q. Is that when people see patches put on individuals' bodies, is that an AED?
A. Correct. When you're, like, out in public, they're the ones you walk past in the boxes are AED.

Q. All right. Can you please tell the Grand Jury, where did you work before AMR?
A. My very first EMS position was at a first response agency, SUNY First Responders on Geneseo's Campus. I then volunteered with the Geneseo Fire Department, Avon Ambulance, and then CHS Mobile Integrated Health Care.
Q. Where is that located?
A. It serves Chili, Henrietta, Scottsville and a couple of other towns.
Q. Were you a Paramedic at those --
A. I was not.
Q. -- entities?
A. No, I was not.
Q. Is AMR the first company where you have actually been working as a Paramedic?
A. Full time, yes. At Avon Ambulance I was a Paramedic for about six months before I left.
Q. Thank you. In your capacity -- I'd like to withdraw that. EMTs and Paramedics and individuals involved in ambulance type responses, is that commonly referred to as pre-hospital care?
A. Yes.
Q. Thank you. In your capacity as an individual involved in providing pre-hospital care, have you ever

heard of the term excited delirium?
A. Yes.
Q. When was it that you first heard or learned of that?
A. In class. Initially, as an EMT basic, and then more extensively so in paramedic school.
Q. Have you ever also, or have you ever, in addition to your Paramedic school or EMT class, had the occasion to watch training videos or anything of that sort?
A. Yes.
Q. Any of them deal with the term excited delirium?
A. Yes, there's a regional training video that goes through excited delirium.
Q. And, have you also seen that?
A. Yes.
Q. Is this, what I've just phrased, excited delirium, something well known in the pre-hospital care universe?
A. Fairly.
Q. Okay. What about the Paramedics?
A. It's well known enough that we were taught how to identify it.
Q. Okay. And, just -- have you ever been taught how to recognize it?

A. Yes.

MS. SOMMERS: So, I'm just going to caution the Grand Jury. Technically, what the witness was told or taught is hearsay, but it goes to this witness' state of mind as to what she was perceiving and aware of or becoming aware of on the date and time of question -- in question.

BY MS. SOMMERS:

Q. So, what have you learned or been trained are, sort of, the hallmarks or symptoms associated with excited delirium?

A. So, in these patients, we typically see, if we're able, a very high heart rate. They have very rapid, quick breaths, typically, very deep breaths. They very commonly appear stronger than they should be. They don't react to pain like you would expect them to. They may not appear to be feeling pain at all. Very often, we find that they are either partially clothed or entirely naked. It's believed that they have a high body temperature, which causes them to strip down. They very often are very sweaty. They ramble, and you can try to talk to them and, if you can understand what they're saying, it doesn't often make sense, or it's just groans, moans, screams, things along those lines.

Q. If you are dealing with an individual who appears to fit that description that you just discussed, does AMR have any type of a protocol that should be used?
A. The region has a protocol. AMR does not, specifically.
Q. What is the practice at AMR relative to what should be done in the field with individuals expressing these types of symptoms?
A. So, to follow the regional protocol, which our goal is with care, to try to keep the patient from injuring themselves or anybody else and getting them safely restrained, whether through medication or physical restraint.
Q. Okay. What types of chemical restraints are available to a Paramedic, such as you at AMR?
A. At AMR me, personally, I only carry Midazolam, also known as Versed.
Q. I'm just going to ask you to slow down a tiny bit. You only carry what?
A. Midazolam.
Q. Also known as?
A. Versed.
Q. Okay. Is that a sedative type drug?
A. It is. It's a benzodiazepine.
Q. Okay. And, are you authorized to administer

that?
A. Yes.
Q. What other sedative is provided in the field through AMR?
A. Our Supervisors carry ketamine.
Q. And, what is ketamine?
A. Ketamine is another sedative. It's in a different drug class.
Q. Are you authorized to carry ketamine?
A. In the region, yes. AMR has a separate policy that prevents me from carrying it.
Q. Are you authorized to administer it once it's provided on the scene?
A. Yes.
Q. What's the difference between versed and ketamine; when would you use one versus another?
A. The biggest difference is versed, is known to have some effects on your blood pressure and on your respiratory drive, so how fast and how deeply you're breathing and ketamine does not.
Q. When it comes to excited delirium, is there a mandatory preference for one over the other?
A. It's not mandatory. If it's available, ketamine is the first choice.
Q. Okay. Based upon your knowledge of excited

delirium, just based on what's framed in your knowledge base, how is a -- an individual experiencing excited delirium most likely to die, based on what you've learned?

A. So, we're taught that these patients become very acidotic. So, the level of acids in their body is very high due to metabolic reasons. They, as a result, have the very high respiratory rate to try to compensate for that. They're vulnerable to cardiac arrest if that gets hindered in any way. Whether it being they have an underlying lung disease, or they're in a position where they can't take the deep rapid breaths, or medications that slows their respiratory rate.

Q. Okay. So, I just want to be clear. Is it your understanding, based on what you've learned, that cardiac arrest would be the end result?

A. Yes.

Q. Based on what you just said, the acidotic nature?

A. Yes.

Q. Okay. I'd like to show you what's been marked for identification, Grand Jury Exhibit Number 50. Do you recognize that?

A. Yes.

Q. And, what is that?

A. That is my patient care report.
Q. Is that the patient care report that deals with the call you took on March 23rd, 2020?
A. Yes.
Q. What is a patient care report?
A. That is the documentation that we use to, you know, keep track of everything that was done, medications, treatments, and any information that we have regarding the patient's history, what happened, and what the result was.
Q. Okay. Are documents, such as Grand Jury Exhibit Number 50, made in the normal course of business of AMR.
A. Yes.
Q. Are the entries on this document made at or about the time the incident is occurring or shortly thereafter?
A. Yes.
Q. And, are these pre-hospital care reports kept in the normal course of business of AMR?
A. Yes.
Q. Thank you.
MS. SOMMERS: I will offer 50, please.
(Whereupon, Grand Jury Exhibit Number 50 was then received into evidence.)

BY MS. SOMMERS:
Q. So, if -- if you need to refer to it, it's in evidence now, so you can look at it. What was your shift on -- on March 23rd?
A. I don't remember my exact hours at that point but it was overnight in some capacity.
Q. So, at about 3:00 o'clock in the morning, were you starting, or ending or in the middle of your shift?
A. That would have been close to the end of my shift.
Q. Who was your partner?
A. [redacted]
Q. What level of care provision -- what level of care provider is [redacted]
A. [redacted] an EMT basic.
Q. So, if I understood what you said previously, that is below the level of care of a Paramedic?
A. Correct.
Q. All right. What was -- I'd like to withdraw that. Were you assigned to a particular ambulance?
A. We were.
Q. Where were you originally, when you began to get the calls on this matter that we're going to talk about?

A. We were posted at Main and Broad. I believe we were up the road, towards State Street a little bit.
Q. All right. So, does there come a point in time when you're advised of an initial call?
A. Yes.
Q. How were you advised of this?
A. Our dispatcher will contact us on the radio at the caller truck number, ask our location and then dispatch the job.
Q. Do you have any other means of being updated about calls other than the dispatcher?
A. Every ambulance is assigned a company phone.
Q. Okay.
A. When you are dispatched to a job, that information gets sent to the phone and it gives us the location and the initial note that was taken by the 911 dispatcher.
Q. Okay. Where was the initial call dispatched to; where was your understanding of where the call was?
A. Main Street and Jefferson.
Q. What type of call was it?
A. We were dispatched with a psychiatric.
Q. Now, is that the type of call that you would go straight to the scene?
A. Not usually.

Q. And, why is that?
A. We try to keep ourselves safe and anything that has the potential to be violent or have weapons involved or things along those lines, we will stage until the police get there first.
Q. Okay. And, who clears you to come in?
A. The police contact their dispatcher, who then calls our dispatcher, who then clears us in.
Q. Okay. Approximately, what time was it that the original call came in for the psych?
A. Um.
Q. I'm not asking exact just --
A. Ten after three.
Q. Ten after three?
A. Yes.
Q. Okay. Did you go straight to the scene or did you stage?
A. We staged.
Q. And, do you recall approximately where you're staged?
A. I believe it was in the Nick Tahou's parking lot at Main and Broad.
Q. And, I'm not asking for exact distances, but approximately how many minutes would it take at, you know, 3:15, 3:30, to get from the Nick Tahou's parking

lot to Jefferson and Main?
A. About a minute, maybe two, if we hit every light.
Q. And then, to get from Main to -- Main and Jefferson to Main and Cady?
A. Again, maybe about a minute, a little less.
Q. Okay. All right. When you were in the parking lot of Nick Tahou's, did you get updated information about the call?
A. We got the information to our phone.
Q. And --
A. Which stated that, you know, the patient was running in the street naked, and covered in blood.
Q. So, upon hearing that information, did you start to form an opinion as to what type of call you may be responding to?
A. It made us concerned that we may be responding to an excited delirium patient.
Q. Okay. So, does AMR have any type of protocol where, if it appears just by virtue of description going on over the air, that somebody's naked and bleeding, that the person who is capable of providing ketamine should be directed to go to the scene or staged just to be available?
A. There's not.
Q. Okay. Did there come a point in time when you

are cleared to go to the scene?
A. Yes.
Q. And, where were you cleared to respond to?
A. Jefferson and Cady.
Q. And, did you proceed there immediately?
A. Yes.
Q. What did you see -- well, I'd like to withdraw that. Did you and your partner have any type of discussion as to who would do what when you arrived on scene?
A. Yes.
Q. What was the ultimate outcome of that?
A. So, our discussion consisted of our plan, should the patient be in excited delirium. The initial plan was that [redacted] was going make initial patient contact, attempt to work with the police to get him restrained safely to the stretcher, if possible, and I was to get medications drawn up to sedate the patient, if he needed to be, and to get in contact with our Supervisor to get ketamine to the scene.
Q. Okay. Who was driving the ambulance at that point?
A. I was.
Q. So, are you also authorized to drive, as well as be a Paramedic?

A. Yes.
Q. Can you explain to the Grand Jury when you arrived, what did you see?
A. As we pulled up on scene, we noticed the patient was being held to the ground, face down by a number of officers, I believe it was four. He was naked. He was covered in, whether it was sweat or water, we're not sure. There was a spit sock over his head. He was screaming, I could not make out what was being said, if anything, and he appeared to be actively struggling against the officers, arching his back, rolling side to side.
Q. Okay. So, were you able to see whether he was able to move against the restraint that was being used?
A. He did appear to be able to move against it.
Q. Okay. Did you note that in your PCR?
A. Yes.
Q. Did what you were seeing confirm what you had originally suspected?
A. Yes.
Q. All right. And, that was?
A. That he was most likely experiencing excited delirium.
Q. What did you do at that point?

A. So. I exited the ambulance, along with my partner, I walked around the back of the ambulance. I believe I got a brief report from the officer just stating, we found him like this, we've been fighting with him. I then proceeded to the side door of the ambulance to get to where my ALS equipment is kept to get a syringe and a needle to start drawing up versed to sedate him. At the same time I was on the phone and radio requesting my Supervisor to the scene to get the ketamine that was more appropriate for his condition.

Q. So, were you going to administer both?

A. My goal was to get ketamine there and administer just that, but at the time I did not know where in the City my Supervisor was, and in order to try to protect the patient from any injuries, if she did not make it to the scene, I was going to administer versed.

Q. Okay. Are you aware of what was going on relative to your partner and Mr. Prude?

A. Not entirely. We had -- we had a level of trust where he had a job, I had a job, we went and did those jobs. So, I had -- you know, my back was turned to him at that point so I could draw up the medication. I was using the bench in the ambulance as a table at that point. So, aside from him communicating with me,

I had really no interaction.
Q. Okay. So, did you actually have the versed drawn at the time that you learned something had changed?
A. The dose of versed for excited delirium requires two vials of medication. I had had the first vial drawn up and was in the process of drawing up the second.
Q. What happens when you're in the process of drawing up the second?
A. [redacted] calls my name and says he needs me.
Q. What happens at that point?
A. I turned and proceeded to the patient. At this point, he was quiet and no longer struggling. The officers had backed off of him. I believe it was me who instructed them to roll him onto his back and I asked if he had a pulse.
Q. And, what did you learn?
A. I was told that they weren't sure if he had a pulse but they didn't believe so, and I instructed them to begin CPR while we got the handcuff key to get the handcuffs off.
Q. Are you aware -- or, is it your memory that it was you that said to roll Mr. Prude over?
A. I believe so.
Q. And, is it your memory that it was you that

requested that he be un-handcuffed?
A. Yes.
Q. Did there come a point in time when you made any type of comment to an officer relative to what you believed had happened?
A. While we were waiting for the handcuffs to be removed, I had stepped back. Somebody, I don't recall who, made a comment saying, what the F happened, and I had a brief interaction of, you know, I believed he was in excited delirium and that was probably what caused his cardiac arrest. Beyond that, I didn't have any conversation with them.
Q. Okay. Did you begin CPR?
A. [redacted] did.
Q. Okay. Was Mr. Prude's heart or pulse in any way monitored?
A. So, I applied defibrillator pads to him, just like you see with the AED, and they were connected to my cardiac monitor, which allows me to see the heart rhythm.
Q. Okay. And what, if anything, did you observe?
A. So, he was in what's called PEA, which is pulseless electrical activity.
Q. Okay.
A. So, there was electrical activity going on. It

was a slow rate, but there was no pulse associated with it.
Q. Okay. And, what, if anything, did that indicate to you?
A. It indicated that, you know, it was very possible that his cause of arrest was acidosis or excited delirium and that we needed to treat it as such.
Q. Okay. Did there ever come a time when Mr. Prude regained a pulse?
A. Yes.
Q. Was this on his own or with medical assistance?
A. It was after medication had been administered.
Q. Which medications?
A. Epinephrine and sodium bicarbonate.
Q. What do epinephrine and sodium bicarbonate do relative to individuals who have suffered cardiac arrest?
A. So, epinephrine is theoretically believed to cause basal constriction, it slows down --
Q. So, can you just say what is basal constriction?
A. It's squeezing down the blood vessels and the extremities and any none core of the body.
Q. Okay. And, is the idea that when that happens, more blood is available to the core organs?
A. Theoretically.

Q. And, you're not testifying as an expert?
A. Correct.
Q. Okay. You've been trained to provide epinephrine?
A. Correct. In all cases of cardiac arrest.
Q. And, that was done in this case?
A. Yes.
Q. And, I think you mentioned sodium bicarbonate?
A. Yes.
Q. And, what is that?
A. That is a medication that we give to try to correct acidosis.
Q. Okay. Approximately how long was it before Mr. Prude regained a pulse?
A. Approximately 18 to 20 minutes.
Q. Okay. At that point -- I'd like to withdraw that. If he had not regained a pulse, what would have happened?
A. We would have continued treatment on scene in an attempt to get his pulse back. If, after 30 to 40 minutes he did not have a pulse, we would have transported him to the hospital without a pulse and left it up to the hospital, kind of, what the next steps would be.
Q. Okay. So, you would have transported him even if

he did not have a pulse?
A. Only because we were in the back of the ambulance and on the street, yes.
Q. Okay. All right. What was his condition upon arrival at Strong Hospital?
A. He had a pulse. He did have a blood pressure. We were giving him medication to maintain that blood pressure. He had no respiratory effort on his own, we were breathing for him, and he had no signs of neurological function. No opening his eyes or anything like that.
Q. Can you explain what agonal or guppy breaths are?
A. They're gasping breaths, usually less than six breaths a minute. It's commonly associated with cardiac arrest and they're ineffective. They're not -- it's not true breathing.
Q. All right. What you just described as agonal or guppy breaths, do they occur before or after a cardiac arrest?
A. It's not truly known. It's believed they may start immediately before, but it's hard to say.
Q. All right. So, it's just something that's associated?
A. Correct.
Q. And, this is based on your training and

experience?
A. Correct.
Q. Okay. So, you -- in reviewing this matter, do you -- it appears from looking at the video, that there was -- I'd like to withdraw that. Would you agree that in an excited delirium type of situation, time is very important?
A. In every call, there is an element of time, yes.
Q. Right. Except that, there's probably a difference between, like, maybe a broken leg and something like this. I'm not trying --
A. Yes.
Q. -- to be -- would you agree with that?
A. Yes.
Q. Do you -- it may appear that there was really no sense of urgency with this situation, would you agree with that?
A. No.
Q. All right. Can you explain what you mean by that?
A. From an outside perspective maybe, it may appear that we are moving slowly or don't care, but that's entirely out of training. We're taught to move slowly and methodically to avoid making mistakes and avoid injuring ourselves or other people. I was taught slow

is smooth, smooth is fast. So, taking a moment to stop and think and assessing the scene before making any rash judgments tends to lead to better outcomes.
Q. Do you think, kind of, proceeding this way, like, slowly and deliberately, is that -- are you able to sort of, pick up information that's given to you better when you're moving slow?
A. In my experience, yes.
Q. Okay. And, I just -- was it your understanding, as you were going through this, that there was a bit of a search for a handcuff key?
A. Yes.
Q. Were you aware of whether or not a key was actually -- was available quickly?
A. No. I distinctly recall saying, we need to get the cuffs off, and there was some amount of time where nobody seemed to provide a key. Whether they had one or not, I'm not sure.
MS. SOMMERS: Okay. Does anyone have any questions for Ms. [redacted]? Yes?
A JUROR: Does the ambulance have a dash cam?
BY MS. SOMMERS:
Q. Does AMR ambulance have either body worn cameras or dash cam?

A. We have dash cams that are activated, either manually or by sudden movements and G forces.
Q. Okay. Do you know if they were activated in this instance?
A. I don't believe they were.
Q. Okay. Thank you.
A JUROR: On video, we heard you say to the police that it's not your fault, you need to do what you need to do to keep yourself safe. What were you referring to?
THE WITNESS: As I said earlier, I don't know who made the statement, what the F happened. At that point, I was trying to keep everybody calm. The police appeared very anxious and upset. At that point, my partner was anxious and upset and my primary goal was to keep everybody calm, focused and trying to provide the best care because I needed help.
A JUROR: All right. Thank you. I'm just wondering the keep yourself safe part. What were you referring to?
THE WITNESS: They had told me that he was combative and had been fighting with them. So, the use of a restraint to prevent him from injuring them would be my guess there.
A JUROR: I have another question. Your

partner has a lower level of training than you do and less experience, lower level of training?

THE WITNESS: Yes.

A JUROR: This might be a hypothetical, but if you had been at Daniel Prude's side and saw his breathing become very shallow and seemed to be gasping for air and that he also threw up, would there have been a different reaction, as far as what you might have said to the restraint on his back or his position.

THE WITNESS: It's possible. As written in my PCR, when I first saw the patient, there was not somebody on his head that I could see, but the only real reason that [redacted] was initially at the patient's side is because I'm the only one who can draw up the medication. He's not able to carry or draw up the medications. It's hard to speculate if it would have been different, because unfortunately it wasn't.

MS. SOMMERS: Thank you. Yes?

A JUROR: [redacted] in the witness' testimony, she mentioned that the patient got a pulse back 18 to 20 minutes later. Could you clarify where the patient was located at that time?

BY MS. SOMMERS:

Q. At the time that Mr. Prude obtained a pulse, was

able to get a pulse, where was he located?
A. On the stretcher in the back of the ambulance.
A JUROR: Enroute to the hospital?
THE WITNESS: No. We were still stationary. Our goal is to not move until we have a pulse, if possible.
MS. SOMMERS: So, unfortunately, we're going to have to take a break and come back. As I mentioned before, we have somebody that can't wait. How many questions are left? Can I ask how many?
A JUROR: One.
MS. SOMMERS: Let me see if -- well, actually, no. I don't want to rush anything.
I'm just going to instruct you, you're not to talk to any other witnesses when you leave here and you're going to be recalled at 1:30. So, I apologize but we just -- we have to -- to take somebody else.
Okay. So, with that, I'm going to excuse the witness. She's not going to discuss her testimony, nor is she going to discuss what occurred in here with anybody until after she is recalled and according to her choice. Okay?
THE WITNESS: Sounds good.
MS. SOMMERS: Thank you. All right. So the reason that -- well, I'll wait.

(Whereupon, the witness left the Grand Jury room at a time of 11:49.)

MS. SOMMERS: So, the reason that we, kind of, had a hard stop there is we do have a witness who is testifying virtually. We do have a -- I will note for the record that we do have a court order allowing this.

(Whereupon, the witness appeared virtually at a time of 11:52 a.m.)

MS. SOMMERS: Are you able to see me?

DR. [redacted]: I see you.

MS. SOMMERS: Thank you. So, just give me one second. The foreperson of the Grand Jury is going to come down and swear you in, and we're going to put you up on the screen.

D O C T O R [redacted] [redacted] after being duly called and sworn, testified as follows:

EXAMINATION BY MS. SOMMERS:

Q. In addition -- before we introduce you, in addition to swearing to tell the truth, do you swear that you are in a secure location with no other individuals present?

A. I do swear, yes.

Q. So, this is a Grand Jury. Grand Jury is a secret proceeding and you are also maintaining secrecy?

A. Yes.
Q. All right. Thank you. All right. Could you please introduce yourself to the Grand Jury, who can see you. And, when it comes time to ask questions, I'll actually turn my screen, but please introduce yourself?
A. Sure. My name is [redacted]. I'm an Emergency Physician here in San Diego.
Q. Thank you. I neglected to do one thing. We're recording this in case the Judge wants to review it. So, just one moment, please.
A JUROR: How do you spell the last name?
BY MS. SOMMERS:
Q. Could you spell your last name?
A. It's [redacted], as in [redacted]
Q. Okay. Thank you. Doctor [redacted], where do you work?
A. I work at the University of California San Diego Medical Center here in San Diego, California.
Q. Thank you. So, you are actually testifying from San Diego?
A. I am, yes.
Q. I imagine it's nicer out there than it is here, but we won't get into that. Do you know, or have you ever worked with anyone who is a member of the

Rochester Police Department?
A. I have not.
Q. Okay. Actually, do you know anyone in the City of Rochester?
A. Unless you live there, no, I know nobody.
Q. Okay. All right. Thank you. Can you explain for the Grand Jury what you do for a living?
A. Sure. I'm an Emergency Physician. So, my -- my training and practice is to work in the Emergency Departments taking care of patients of all types.
Q. All right. And, how long have you been a physician?
A. I finished medical school in 1992, so I've been practicing as an Emergency Physician for almost 30 years.
Q. Thank you. Are you still a practicing Physician?
A. I have a shift this afternoon, that's why I'm all dressed up for you.
Q. Okay. Thank you. Do you hold any other positions other than an Emergency Room Physician?
A. I have academic positions, so I'm a full professor of clinical emergency medicine in the School of Medicine at UCSD, and then I hold other, sort of, administrative roles and we work in the hospital and outside of the hospital.

Q. Thank you. Do you have any particular specialty relating to restraints and restraint related deaths?
A. I do, yes.
Q. Okay. Could you just please describe for the Grand Jury what that is based on, the kind of body of your knowledge base?
A. Sure. Really, since back in the 1990's when I was the chief resident for our program, I started doing research in the area of, it's a term you sometimes hear, as arrest related deaths. Restraints, some of the original restraint work back in the '90's looking at patients or subjects who would be on their stomach, in the prone position, handcuffed, legs pulled up. I've done research putting weights on their back, up to 225 pounds of weight to see what the physiologic effects are on individuals. How it effects, particularly, their breathing, their ability to ventilate, get oxygen in, get carbon dioxide out. Done research utilizing pepper spray, tasers, spit masks, or spit socks. So, I've looked at, really the research. And, it mainly focused on physiologic effects. How does one's physiology impact? Does it change heart rate, blood pressure, chemistry of parameters, but in particular, a lot of it's around the ventilation or breathing.

Q. Have you actually published anything relative to your area of expertise?
A. I have, yes. Probably about 40 to 50 peer review publications in the area of, sort of, arrests related deaths and agitation treatments. Um, written a textbook on the topic and I've written probably about, you know, 15 to 20 book chapters on the topic as well.
Q. In addition to working in an Emergency Room setting, do you -- do you also work at all in a custodial setting?
A. I've worked for 16 years at our county jail. So, San Diego Sheriff's Department is one of the busier areas. And, so, I worked, basically, every Monday down there in the clinics taking care of individuals at the jail sites, yes.
Q. Are you current on the scientific literature other than your own, relative to restraints and restraint related deaths?
A. I am, yes. In fact, with -- just a couple of months ago, I published a review of the entire literature, or the body of literature, on the topic of restraints and restraint related deaths, looking at all the research that's been published on that topic and consolidating to one paper.
Q. Okay. Thank you. During the course of your

career, as an Emergency Room Physician, up to and including today, have you had the opportunity to interact, work with, treat, individuals who are either in cardiac arrest or presenting with a history of cardiac arrest?

A. Yeah. I mean, on a regular basis, we see patients in our Emergency Department who have cardiac arrests. We take care of them over the phone as part of the base hospital. We see them in the ER. And, in fact, I was one of the National Institute of Health Principle Investigators in the largest cardiac arrest study done in the US and Canada in the last ten years. So, we look at tens of thousands of cardiac arrests or the perspective of evaluating the outcomes, treatments, you know, sort of, the cadence and treatment and things like that.

Q. Okay. Have you, during the course of your career also had the occasion to interact with, treat, observe, deal with individuals who have been subject to restraint?

A. On a daily basis.

Q. Okay.

A. Our Emergency Department -- well, I shouldn't say -- everyday that I'm in the ER, not that day is long. But, in the Emergency Department where the local

Department, sort of, does a lot of the screening for the Sheriff's Department and for the jail intake. So, a lot of field arrests come there directly. A lot of patients come there that are agitated with, sort of, an inner city population. So, we'll see a lot that come in full restraints or in forensic restraints as part of the restraining process, yes.

Q. And -- and, have you also had the opportunity to treat, observe clinically individuals who are under the influence of illicit substances?

A. Even more so than the restraints, yes. We have a very high population of illicit drug users. San Diego is very notorious for methamphetamine, but we still have cocaine, and PCP and LSD patients present. But, there -- you know, there's multiple patients per shift that have the influence of drugs but whether they're fully agitated and -- and wild and, sort of, that -- that aspect versus just under the influence in a recreational way. But, yeah, we see them on a daily basis.

Q. So, you just mentioned PCP. Is that something that you see and observe in San Diego rarely, regularly? Just curious.

A. Sure. It's probably, I would say, rare to intermittent. It comes in phases, as far as -- you

know, we'll see periods where we see a number of them come in and then it sort of fades out of favor. But, over my career, I've taken care of probably hundreds of people on PCP, but it's not a -- not a daily or weekly event, necessarily.

Q. Okay. Thank you. Does -- does San Diego see enough of it to include it on its -- well, let me withdraw that. Does San Diego have a -- a drug screen used in the Emergency Room?

A. So, our hospital, I can only speak to that. We do use the urine drug toxicology screen when -- when necessary to evaluate patients, yes.

Q. Okay. And, is PCP one of the substances that is tested for on the drug screen?

A. On our drug screen, yes.

Q. Okay. Thank you. Dr. [redacted] are you aware of a term called excited or agitated delirium?

A. I am, yes.

Q. Could you explain to the Grand Jury what that is?

A. I guess there's a long version and a short version. In short, it's basically, a very extreme level of agitation, thought to be from a central neuro -- neuro transmitter issue that's happening within individuals. Clinically, it presents with, sort of, the extremes of -- of physiology. High heart rates,

high breathing rates, often high temperatures, agitated hots, you know, not fatiguing to what normal people would fatigue to, so sort of having an endless energy, if you want to look at it that way. They just keep going and going. And, they can be -- they can be violent. They can be agitated and they're typically delirious, as is part of the name there.

Q. Okay. Let me take you back a second. When -- is this something new that -- that's just been, sort of, coined or discovered?

A. It is not. It's got a fairly long history actually.

Q. Okay. Thank you. Could you just kind of, briefly, give a little bit of the history?

A. Yeah. A quick -- quick review, yes. If you go back to the medical literature, back to the 1800's, it was first described in the medical literature by Dr. Luther Bell, not in the terms of excited delirium, but the concept of it. He saw psychiatric patients back in the day. There was schizophrenia, there was mania. And, unfortunately, in those days there was not treatments that were -- that well -- well done for it. There was no anti-psychotics. And, he reported patients who had come in and they would be agitated, they'd be hot, they'd be sweaty, they'd be delusional,

they'd think they were on fire, they would take off their clothes, temperatures of a 102, 103 from the psychiatric disorders. And, they would rev up, and rev up, and get more aggressive and he reported the mortality rate of 75 percent in that population. And, if you'd look through the medical literature over the 1800's to the 1900's even up to the 1950's, there are many, many reports that this type of agitated, delusional behavior that revs up in this population of psychiatric patients.

In the 60's, we came up with, we the medical community, had the, I guess, discoveries of Thorazine and other anti-psychotic calming medications. And, we started using it on these psychiatric patients. They did well. They didn't have the mortality rates that you once would see. But then, come the 80's, you know what, 40 years ago, you start to see the drug trade coming across, and, particularly, in Miami and South Florida with cocaine. You start seeing this type of behavior showing up again, more on a compressed time scale. Issues of subjects would be using the recreational doses, in this case, often it was cocaine. And, uses a dose and the next thing you know they're out in the streets, they're running around, they're taking off their clothes, they're sweaty,

they're hot, they're agitated, they're, you know, violent, their lack of tiring. And, in certain -- in some issues of these patients, you know, many of them, the police got called because, sort of, the naked man running in town. So, they would be trying to get them into a controlled situation so that the Paramedics can take them to the hospital and a number of these people would die.

So, that was where excited delirium was actually coined as a term. And then, you see over the next 40 years, probably, about a hundred and plus publications of the medical literature, it's out there, treatments and things like that. So, not a new term, but it's -- often it's out there, I guess you could say.

Q. Okay. So, I just want to make sure to trace it properly. So, first, the -- the sort of symptoms we're seeing is with a subset of schizophrenic patients?

A. Yes. Mental health disorder patients. Typically, schizophrenics or man -- or patients with mania.

Q. Okay. And then, there was kind of an uptick in the 80's relative to cocaine use?

A. Cocaine use. And then, you start seeing other

parts of the country with other stimulant drugs.
Q. Okay.
A. Cocaine. A lot of the west coast in LA, in the early 90's, particularly, with PCP at the time. There was a piece survey written up by Sam Stratten at that time of 200 plus patients transported by Paramedics in the back of the ambulance in the gurney, going to the hospital, 11 percent of them died. They had cardiac arrests and died. So, it's across the country. But, yeah, the first time you saw it was in the 80's in Miami.
Q. Okay. So, what are the precipitating -- if I understood you correctly, what types of events might more commonly precipitate one of these excited delirium type events?
A. Sure. So, currently in our current environment, the most common ideology or cause of an excited delirium event is typically stimulant drugs. So, rough estimates are, probably 90 percent, are caused by drugs and maybe 10 percent are caused by untreated or under treated mental health disorders still. Though, drugs that tend to cause it, tend to be the ones that are the stimulants and then, the frequencies tend to be regional frequencies. So, on the west coast, we see a lot more of the PCP. In the northern

areas, Southern California, we see a lot of crystal meth. East coast, a lot of cocaine. But, those stimulant drugs are the ones that tend to be more associated with excited delirium. But, you see with bath salts and flocka and LSD and other drugs as well can do it.

Q. And, I just want to understand -- or, is it -- at a physiological level or an anatomical level, could you explain what has been learned up to this point about this?

A. Sure. I mean, originally, as I described back in the 80's, it was found when these people were dying, and, in a skull text, it'd be a lethal disease. And, so the original papers came out from medical examiners, who are seeing these individuals in the morgues, and thought it was a universal lethal disease. The reality is, the emergency medicine community has been seeing and taking care of them just as long and many, if not most of them, actually, most will survive given the appropriate treatment and sedation and -- and they have the ability to be converted, but still, some die.

The physiology is such that there's been work looking at trying to find a cause for this. Work out of Miami and Debra Mash's Group down there has

looked at the brains of individuals; and, actually, who have died of symptoms and diag -- diagnosed clinically with excited delirium compared to other individual brains; people who use other drugs but didn't die of excited delirium, for example, were shot, or died in a car crash, or had some other event. And, when they looked at the brains, they actually see anatomic changes. There's differences in these brains. And, not to get into too much detail, but I think most people understand they're nerves that communicate with each other in our brains and throughout our bodies, and that's how, you know, things happen. I want to move my hand, nerve impulses, go down these chains and make things happen and happens at, you know, micro millisecond levels. But, at the nerve level, there are neuro transmitters that go from one nerve to the other nerve. And, it gets released and it goes across, called a synaptic gap, and makes the other one turn on. And, in the brains of individuals with excited delirium, they've noticed changes in the neuro transmitters. The re-uptick of the neuro transmitters, there's a down regulation of it. A lot of -- lot of, sort of, medical microbe type stuff. But, the reality is the neuro transmitter ends up sitting in that synapse

longer than it should be. So, instead of a firing off and, you know, pass the message on down, it fires off and fires off and fires off and it's still keeping that activity level going in the nerve itself. So, you sort of see that physiologically it is -- it's just revving up an engine. It's -- the nerve impulses are just going and firing, which is why, clinically, we'll see high heart rates, high blood pressures, high and fast respiratory rates. A lot of these we'll see very elevated temperatures, 102, 103, 104. It probably gives that physiologic feeling of being hot, which is why a lot of these people likely take off their clothes. They don't know what's going on but they're feeling hot. It also gives the -- that physiological component of you're breaking system is not there. Everything is revving up, your energy, it gets, so to speak, it's revving up. You don't fatigue when others fatigue. You don't feel as much pain when others might feel pain. And so, that is sort of the physiology. But, it's thought that a central component in a portion of our brain is studied more by that group in Miami.

Q. Is everybody who consumes -- does everybody who consumes, for instance, a stimulant type drug express excited delirium?

A. No. Actually, the -- the minority of people do. So, meaning, lots of people use stimulant drugs, many on a recreational, regular basis. But, the incidence of excited delirium is fairly low. It's -- it's out there. You'll see cases here and cases there, and we'll see them in the Emergency Department, but relative to the amount of drugs consumed or the amount of people using drugs, it's -- it's a rather infrequent event. The concept that it doesn't happen to somebody who uses drugs for the first time, in general, is the thought. The thought there's some pre -- or we think there's some predisposition or preconditioning that happens. So, the people who use recreational drug levels, meaning their, I guess, normal dose, if you want to look at it that way, the recreational level of intake. This isn't an overdose. This isn't too much. This isn't a difference -- recreation. It's something that triggers that brain, that we talked about there, that one it's time to synapses keep firing and firing. So -- but, it doesn't happen that frequently, but enough that we know about it.

Q. So, if two people even have the exact same history and consume the exact same amount, is there anything to say that they will -- one of them or both

of them will end up expressing this?
A. No. And, in fact, there may be some genetic predisposition at the synapse level we were talking about with those receptors. There may be some people who are more prone to getting that than others. But, there is no -- there is no way of looking at somebody physiologically or anatomic and saying, you're at risk and you're not, or your history puts you more at risk than not, beyond the idea that you're using drugs. So, if you're both using the same amount of drugs for the same period of time, there's no picking out if one or either of them will ever have excited delirium in their lifetime.
Q. Relative to the kind of universe of physicians and doctors who deal with this particular syndrome on a somewhat regular basis, I guess, who would those doctors be?
A. This -- this is primarily a disease of the Emergency setting -- this a sort of coming close to the time if something happens. In the field of a house, EMS gets called, law enforcement may get called. But, ultimately, the patient gets brought to the Emergency Department. These are our acute status patients that will get treatment. This is not somebody who ends up in the psychiatrist's chair.

This isn't something you feel coming on, that I'm not feeling well, I should go see my therapist or my -- my counselor. It is a trigger synapse, the switch flips and you're -- you don't even know what you're doing. I've taken care of many of these patients, where you sedate them, you calm them, you treat them overnight, you wake them up in the morning and they have no recall of what was going on that night because of the drugs and the central system that was going on.

But, this is an emergency medicine specific area. I've had -- gotten calls from my psychiatry colleagues down to see patients in the ED in the throes of this, and they want to have nothing to do with it. They're -- they're -- when patients calm, they think they need a psychiatrist, give me a call. So this is -- this is our world.

Q. And just to kind of follow up, what is the sort of most -- actually, I'd like to withdraw that. So, is syndrome recognized in the field of emergency medicine?

A. It is. It's actually formally been recognized by the American College of Emergency Physicians, which is our largest national body of -- of our specialty. So, they put out a white paper recognizing it, acknowledging it, going through the diagnostic

evaluation and recommended treatments at the time.
Q. Okay. And, as of today, I mean, I assume knowledge is increasing. What is the best treatment when someone is presenting with this collection or constellation of symptoms?
A. Sure. The -- the best things one can do for somebody who is in the throes of excited delirium is to rapidly or quickly restrain and control. And, you know, trying to avoid a lot of muscle contraction, a lot of arms and legs and stuff like that, that gets you a lot of that build up of lactic acidosis. The -- and then, once you get them in a controlled manner, then it's a matter of sedating them. You want to use calming medications to bring down the heart rate, the blood pressure, the agitation, the delusions, the temperature, all those things. There's other things, like, IV fluids and things like that. But, really, it's rapid control and rapid calming are the two things that are -- are the sort of at the foremost to try to address these individuals.
Q. Now, when you say sedation, can I -- I assume -- are you saying that everyone who's just, kind of, unruly should be sedated?
A. No. This is a very special population that is -- it's -- it's sort of, when you see it, it's an

aggressive, you know, rapid -- you know, sort of, not always violent, but certainly acting in a behavior that is just revving, revving, you know, going, going, going type of thing. Repetitive talking, just breathing fast, working fast. Their -- their metabolic processes are revved up and putting physiologic stress on their system, it's like putting a car to the red line there with the gas on. It's revving, it's running, it's moving. But, if you don't back it off a little bit, it can blow an engine. And, so, these people are revving, revving, revving. So, that's the population that needs calming, not just somebody who is under the influence or a little bit intoxicated or just, you know, odd behavior. That's -- that's not what we're referring to here.

Q. Okay. What is it that generally will -- or, what is commonly understood to cause death in individuals experiencing this?

A. You know, there -- there's no pure way of predicting this. That's the challenge of it. We know that the more aggressive, the more revved up they seem to be, the more often we'll see associated cardiac arrest with it. The longer a struggle goes on, meaning fighting and revving and doing things to get those muscle groups doing a lot of lactic acid

production, or a lot of activity preceding that, can potentially create the acidosis that puts them at risk. In patients or subjects in which you get a temperature that is significantly elevated, it's thought that that is associated with the higher risk of cardiac arrest, implying that there's a -- central system is already revving up and you can manifest that by an elevated temperature.

Q. Is that -- is the elevated temperature why these individuals being naked is -- well, let me -- I'd like to withdraw that. Is being naked a bit of a hallmark in these types of cases?

A. It certainly is. If you see a naked, sweaty person or naked, hot person running around, particularly, in an environment that you wouldn't expect to see it in, that -- and, I teach police officers and paramedics. That is a trigger that something is going on, and it's more likely than not it would be something like excited delirium. That's just -- it's not a common -- it's a very common feature for it. Does everyone for excited delirium come up naked, no. But, when you see that somebody doing that sort of behavioral pattern that we're discussing, that is excited delirium in my mind until otherwise.

Q. Based on -- so, if I understand correctly, is it the underlying acidosis that's believed to be the -- how does the acidosis affect a person's prognosis for a cardiac arrest?

A. Sure. So, there's a couple parts to the cardiac arrest aspect in this particular population. Oftentimes there are, you know, sort of, chronic genes in the heart that occurs with, sort of, chronic or intermittent drug use. The heart itself is an organ that likes to work. When you put drugs in the system, specifically, stimulant drugs, PCP, methamphetamine, cocaine, when you put that in the system, it revs up the heart. It makes the heart work harder, it makes it beat tougher, it makes it run faster. All that's a physiological stress on the heart. Now, you add acidosis to that. Acidosis is really a dropping of your pH. Our normal body pH is 7.4. What we'll see is people who are particularly more active, more aggressive, more physiologically moving things can drive that needle down, push the pH to a lower level because you're creating acid in their blood. Lactic acid is that -- that acid you feel when you feel the burn. If you've ever done a bunch of stairs or the Stairmaster or screwing a screw driver in, you get the forearm burning. That burning is the buildup of

lactic acid in that particular muscle group. These individuals are getting that in all the groups. You know, running around, struggling, fighting, jumping, doing things like that, those are using big muscle groups. Those muscle groups are creating more lactic acid, which goes into the bloodstream and lowers his pH.

So, now, you have a heart that's already irritated by the stimulant drugs, it's already working hard, it's already -- lactic acidosis in and of itself, even without drugs, can cause the heart to stop. So, now, you have two things in the system that are affecting the heart in a negative way. The drugs itself directly and the acidosis both can cause a sudden cardiac arrest.

Q. Thank you. Based on the scientific literature, as well as your own experiences, do all individuals who ultimately die after experiencing an excited delirium related event do so while being restrained by police officers?

A. No. They -- they die during restraint, they die without any restraints. They die in the back of ambulances as I referred to. There were two hundred plus cases reported by the group in LA many years ago, they were in the back of an ambulance. They die in

the Emergency Departments. We have had deaths in our own Emergency Department that weren't being restrained by police officers, they weren't prone, they weren't with, you know, different types of aspects. So, it is a -- it's a physiologic medical emergency. And -- but, they can die in any position or in any location.

Q. So, I was just going to ask, I think -- well, I'll withdraw that. Does a person need to be in the prone position, in other words, face down or -- or mid rift down in order to experience a cardiac arrest event related to excited delirium?

A. The answer is no. People in excited delirium die in a sitting position, they die in the back of an ambulance gurney on their back, they die in the prone position, they die on their sides, they die on hospital beds. So, the position itself is independent of the -- the deaths associated with excited delirium. It's the inside stuff that's going on. The revving of the engine, and all that stuff that causing it. It's not position based. The position doesn't impact it, it doesn't effect the metabolic processes or the ventilatory processes.

Q. Would you agree that the -- just the fighting against being restrained would, in and of itself, would generate some acid that wouldn't otherwise be

generated?
A. Well, that's -- that's a good question. So, the idea of having somebody being restrained. We've restrained people in the ED all the time, unfortunately, because of that type of very aggressive behavior, they will struggle against the restraint. Whether it's a forensic restraint, as the handcuffs or, you know, we have these restraints that keep people from moving around. They can move back and forth, but their not doing the flexion and contractions type of stuff. They're not using the big biceps and triceps. They're using large muscle groups that actually generate a lot more of that lactic acid. You can create a little bit of activity here, but the -- the risk of not having them in that, sort of, I think, swell -- you're holding them so they can't do that much. They can still resist a bit, but the reality is in the large muscle group. The thighs, the calves, those muscle groups, the arms create a lot of lactic acid in a very short period of time. That's why you see, if you ever watched MMA or boxing, they get very fatigued after a couple of minutes of rounds of fighting. It's a very fatigued type of thing because of that lactic acid. And, so, the controlling of them, whether it's restraints, forensic restraints

or hospital restraints, that reduces that ability to create the lactic -- doesn't stop it, but it reduces it.

Q. And, can I assume that in the Emergency Department, sedative, ketamine are readily available. You don't have to wait for someone to bring them to the Emergency Department?

A. We have them in the Emergency. Other than a couple of minutes of getting them out of the machine, yes, they're available to us.

Q. All right. Are you, in your capacity, ever asked to review matters in order to determine, whether in your opinion, a particular restraint caused or contributed to the death of an individual?

A. I have been asked to do that, yes.

Q. Okay. And, have you ever reviewed matters and determined that, yes, the restraint did cause or contributed, potentially, to an individual's death?

A. I have reviewed cases in which I thought the restraint process, procedure, was problematic and may have contributed, yes.

Q. Okay. And, have you, likewise, reviewed matters where you determined or based -- your opinion was that the restraint did not cause or contribute to the death?

A. That would be correct, yes.
Q. All right. Could you, just kind of, walk through -- walk the Grand Jury through the process that you used in order to form your opinion in that regard?
A. Sure. When asked to evaluate a case to see if there was issues with regard to a restraining process, you want to review the materials available. You want to obtain records, videos, testimony or interviews. You want to look at the EMS records, the hospital records. You want to look at the totality of the -- of the circumstances going on there, with specifically, to the restraining process though, you want to know certain things. You want to know how long somebody was in the restraint process, meaning, most of the time it's a concern about weight being placed on them. Did the weight have an impact and was ventilation being impacted? That's usually the question being asked. So, you want to know, was there weight being used? Where was the weight placed? How long was the weight being placed there? Was there any obstruction to the airway itself? Was there evidence that there wasn't obstruction of the airway? Were they able to talk or were they able to yell? Were they able to do so on a regular basis or was it intermittent? And then, you want the to know, sort

of, the timing of everything. How long this whole event occurred or took because if you're looking to see if the potential for asphyxia is there, it takes quite a while for somebody to truly asphyxiate, and so, the timing of it is important to look at as well.
Q. When you use the term asphyxia, could you -- could you describe what you are referring to?
A. Sure. I'm referring to the inability or the restriction of an individual to be able to get oxygen into their system. So, everything from -- well, from the mouth to covering the neck and, you know, crushing the airway to restricting breathing. All those would be ways of creating that environment of asphyxia, where you don't have the oxygen -- adequate oxygen coming into your lungs' system.
Q. Okay. If -- if the term asphyxia is used to mean, you know, inadequate blood pumping -- or, inadequate oxygen in the blood, could that also be caused by a cardiac arrest?
A. A cardiac arrest will stop all blood flow. A cardiac arrest will also stop all ventilation because people don't breathe during cardiac arrest. So, that would create a no flow state. So, that would be, I guess, in a technical sense, a form of asphyxiation because the cells are not receiving oxygen rich blood.

Q. Okay. In the case of Daniel Prude, were you asked to review this matter?
A. I was, yes.
Q. And, were you provided with the medical records, the Medical Examiner's report, photographs, the -- the video of the incident?
A. Yes, I was give a -- a large file to review that included all that material.
Q. Okay. And, were you able to form an opinion as to whether or not the restraint involved caused or contributed to Mr. Prude's death?
A. I did come to a conclusion, yes.
Q. All right. Could you explain to the Grand Jury the conclusions that you made relative to -- well, actually, I'd like to withdraw that. Did you analyze whether or not the -- the spit hood that was placed over Mr. Prude's head caused or contributed to his death?
A. I did, yes.
Q. And, could you explain for the Grand Jury what you determined and what you based that on?
A. Sure. So, my opinion is that the spit hood that was utilized did not have any cause or contribution to the cardiac arrest and ultimate death of Mr. Prude. The spit hood itself is a very loose, mesh material.

It's very easy to breathe through because of the meshiness of it. It goes around the head. It doesn't impact ventilations. It doesn't impact breathing. It doesn't impact the ability to get air in or oxygen in or CO2 carbon dioxide out. This has been studied. It's been published and it's reviewed to show that these devices are -- are safe from that perspective.

In the case of Mr. Prude, it was placed on him, it was on for a very modest period of time before he was actually moved to the ground for additional control. He was clearly breathing and talking and -- and articulating through there and expressing no events of respiratory distress. In general, people who have respiratory issues aren't yelling or talking or constantly talking. In the ER, if you have a bad asthmatic or a bad con -- congestive heart failure patient, they often say nothing. They answer with nods, and yeses and noes, that way. They tend to have one word sentences in speaking. So, his clinical presentations with the mask had no effect on him, which is what would be expected from all the scientific data out there. And then, when he was placed into the -- the on the ground position, the more prone position, you can still hear him talking. There was a period where he did have an episode of

vomiting during the end. But, that appeared to be more related to the cardiac arrest and didn't impact the ability to ventilate. And, first of all, it wouldn't be because there's plenty of air to go around. But, secondly, it was probably more related to the -- the actual heart stopping event that had occurred at that time.

Q. Okay. Did you form an opinion relative to whether or not Mr. Prude was experiencing an excited delirium syndrome event?

A. I did have an opinion, yes.

Q. And, what was your opinion in that regard?

A. My opinion that, after reviewing the materials, the video, and all the aspects we've talked about as far as things available to me, that he was showing signs and symptoms consistent with an excited delirium event.

Q. And, could you just very briefly say what those were?

A. Sure. The first thing that gets your attention is running around naked in 34 degree weather. That's a hallmark finding. It's not diagnostic, but it's certainly very common to have that diagnosis associated with it. But, the other signs and symptoms that were there was when he had a stimulant drug in

his system, PCP, so you have a cause for it.

He was definitely delirious and delusional, so you have the delirium aspect of it with a lot of the comments he was saying out there. He was a -- a lack of fatigue. He ran, I guess, almost a mile prior to this, and just was active, active, active, active. You watch him on the ground, he's still talking and moving, trying to get up and that type of activity. He was felt to be breathing -- known to be breathing fast. As far as the idea of him being hot, there is some evidence he may have been sweaty or not but it's hard to tell in the video there. He certainly was having lack of what appeared to be tolerance to pain. Running around in the streets in bare feet at nighttime, didn't seem to be bothered by that. There was evidence of some bleeding and stuff like that, potentially, that again, not being bothered by what seemed to be painful stimuli.

So, all those things are consistent with the diagnostic criteria for excited delirium syndrome.

Q. What, if any -- did you form an opinion as to what was the cause of death, or -- yeah. What was the cause of Mr. Prude's death?

A. Yes, I did have an opinion on that.

Q. What was it -- I want to rephrase it a little

bit. I understand that he was in the hospital, and that his -- his pulse was -- he was -- the EMTs were able to regenerate a pulse, but did you form an opinion as to what caused him to lose his pulse to begin with?

A. I did, yes.

Q. And, what was that?

A. So, the -- my opinion is that, he was having an excited delirium event. He was clearly, again, sort of, metabolically revved up. You can tell by his physiologic presence there, the agitation, the trying to -- the getting up. The fact that he was running around. We know that he had built up a -- a level of lactic acidosis in his system. So, his heart was working hard. He had PCP, which is a strong oxygen level drug in his system and it was clearly effecting him physiologically. And then, the acidosis itself. The continued activity lowered the pH. And, again, as I was saying earlier, not everybody goes into cardiac arrest, but oftentimes you get to a certain level. The heart just is not able to continue taking that, in a sense, intensity or the abuse of the drugs and the acidosis at the same time, it eventually -- it has a sudden event and goes into cardiac arrest. In this case, a PEA arrest, we call it, a pulseless electrical

activity, which is common in excited delirium, that PEA arrest caused a cascade of other events, which ultimately lead to the death, you know, days later. But, it's the cardiac arrest from the excited delirium that contributed to his death. The multiple organ failure and death.

Q. Did you form any opinions as to when Mr. Prude likely suffered the cardiac arrest?

A. I do have opinions to that, yes.

Q. What is that -- what do you base it on, and what was it?

A. Sure. So, if -- if you'd look at the video and the materials available, you know, looking at the point where he was placed on the ground and being held in several positions, he was talking, he was still mumbling, he was still saying things, he was moving air in and out. So, we know at those points he, I guess, in a sense, want to say showing signs of life. He was alive, he was conscious, he was breathing and would have had a heart beat at that time.

Around the time when the officer asked if he's okay, they noticed a slight change in his activity level, I guess. It -- sort of, in his movements. And then he, sort of, vomits or regurgitates, I look at it because I think vomiting is

more of a forceful activity. Often, in cardiac arrests you see sort of a regurgitation. Things sort of ooze their way back out. Right around that time is probably when his heart stopped and his effective breathing stopped.

Q. Is it uncommon to see regurgitation at or right after a cardiac event?

A. It is -- it's not uncommon. It doesn't happen all the time, but sometimes as the body, sort of, gets relaxed, as in a cardiac arrest phase, things tend to happen like that where you lose continence of your stool, or you vomit up. It's not everybody, but it does happen. We do see it in that time and period.

The other thing of note was when you look at the video, right after this event occurred, the officers were, sort of -- you can see the back of Mr. Prude and he has these, sort of, breaths that, sort of, pop up very quickly and, sort of, just, not -- not regularly breathing. Those are what we call agonal respirations or agonal breaths. Those are consistent, again, with a cardiac arrest because the body has -- the heart's not beating, it's not getting any blood flow from the brain or to the heart and there's these, sort of -- these -- these, I guess, rudimentary extra breaths of the heart. They're like, sort of, little

guppy breaths in a sense. That's also all around the same time period.

So, that's why my opinion is that right around the time when the officer's asking about, you know, hey, are you okay? We saw the regurgitation, then you see shortly right after that, the agonal respirations. That's probably when the cardiac arrest occurred as a sudden event.

Q. Did -- were you able to determine whether or not the individuals who had their hands on Mr. Prude, based on your review, your knowledge base, the scientific literature, in this regard, whether the manner in which they held him, caused or contributed to that cardiac arrest?

A. I do have opinions on that, yes.

Q. Okay. Could you just go perhaps, like, officers' body part by body part?

A. Sure.

MS. SOMMERS: So, I didn't realize, I guess there's five minutes left in our meeting.

THE WITNESS: Okay.

MS. SOMMERS: We're going to have to -- we're going to have to immediately do this. Do you want me to -- should I reschedule it right now and take -- I'm sorry. I didn't know that this was a time

limited thing. How about, I'm going to send you an invite and we'll get right back on. Okay?

THE WITNESS: Sounds perfect. Yep.

MS. SOMMERS: All right. Thank you.

THE WITNESS: I will be ready to go.

MS. SOMMERS: All right. I apologize. Thank you.

MR. SMITH: For the record, ladies and gentlemen, we're just going to take a two minute adjournment here while we figure out this technical issue.

(Whereupon, there was a short break off the record.)

(Proceeding reconvened.)

MS. SOMMERS: What we're going to do -- hold, please. We have to wait for one person to come back in the room. So, just -- we're almost -- thank you for your patience.

THE WITNESS: No problem.

MS. SOMMERS: All set?

MR. SMITH: We have one more.

MS. SOMMERS: Okay. Here we go.

MR. SMITH: Don't forget to record, Jen.

MS. SOMMERS: Just give me one moment. All right. Thank you. Okay. For the record, we are back

on the -- back with the recording. I apologize. We had to -- I didn't realize that we had to re-send a new invitation.

So, what I'm going to do at this point is ask the court reporter to read the last question -- maybe the last answer and question that was asked, please.

(Whereupon, a read back was read into the record at page 89 lines 9 through 18.)

MS. SOMMERS: Okay. Were you able to hear that?

THE WITNESS: I was, yes.

BY MS. SOMMERS:

Q. All right. Could you -- could you explain your opinion relative to that question?

A. Sure. So, my opinion was -- let's start with the officer at the legs. Officer [redacted] was holding the ankles crossed and holding him in the calves. And, maybe just a quick background because it's going to -- what drives my opinion is the -- what occurs with physiological weights. You -- in order, again, we talked about how to assess a case, how to review for possible ventilatory compromise. Where the weight is located is important. Weight on the torso, on the upper back, over the ribs. Those are things that we

want to look at that potentially may have some bearing on things. Weight on the lower back or buttocks doesn't impact ventilation. These have been studied, using studies looking at how much air you can breathe in and breathe out, how it affects your carbon dioxide levels and your oxygen levels. This has all been studied. And, so, weight on the lower back, buttocks and legs don't impact breathing. Our -- our breathing system is up here. So, from the perspective of that, sort of, you can immediately, sort of, say Officer [redacted] holding the legs down wasn't going to impact ventilations at all.

The other end of the body was the -- the head. The head was being held down. The head itself doesn't impact ventilations, right. The ventilations are done by the ribs opening and closing, by your diaphragm going up and down. That's what creates the movement of air. Holding one's head doesn't impact that unless, of course, you're blocking an airway but there wasn't evidence of that. You can hear speech, you could hear him talking. He was talking for almost a minute and a half, based on my review. At certain points, you can hear him groaning or moaning or we call it keeling at times, when he was in that position. So, we knew he was moving air through his

airway, through his mouth, through his trachea, down to his lungs because of the ability to communicate that way. So, we know air is going in and out. We also know that holding pressure on the head isn't going to impact the airway's ability to move air. It's a -- the skull is an affixed object, you're just holding pressure. In fact, I used to hold a lot of -- a lot of patients before we had a good security force by the head because it really helps to control people, but it doesn't impact their ability to breathe.

Then, the third individual was Officer [redacted] was, I guess, on the lower back and there's some good images when you have some still frames on there, showing the back.

Q. Let me stop you for a minute. I'm going to hold up, for the camera, what has been marked for identification Grand Jury Exhibit Number 51. Are you able to see that?

A. I am, yes.

Q. Okay. Were those images something that you actually clipped from the video that you reviewed?

A. It looks like the images that I clipped, yes.

Q. Okay. And, does it look like a fair and accurate copy of the clip that you took from the video?

A. Yes, it does.

Q. Okay.

MS. SOMMERS: Can you possibly just put it up on the visualizer real quick? So, we're going to -- we're not going to be able to see you for a moment, but we're still going to talk here. So, up on the visualizer, the Grand Jury is able to see -- I'm sorry. I will move People's -- Grand Jury 51 into evidence and we'll mark it. And then, I will place it up onto the visualizer. And I --

(Whereupon, Grand Jury Exhibit 51 was then received into evidence.)

MS. SOMMERS: All right. So, you can't see, but very briefly we're putting it up there.

BY MS. SOMMERS:

Q. Do the photos that you chose exemplify what you were talking about in terms of the placement of Officer [redacted] leg relative to the back?

A. Correct, yes. This is a -- again, it's always a dynamic situation. People are moving and wiggling and things like that, but when you look at the totality of the video, this is where he -- we can look at different angles and things -- this is where he demonstrates his position. His knee is near the lower back portion. I think more importantly to look at on that picture is that the whole upper back is open.

You don't see any weight on the shoulders, you don't see any weight on the thoracic spine, the back spine or the ribs. And, I have reviewed a number -- a lot of these cases, and often, that's the challenge because often, there is pressure being put at the upper chest to put handcuffs placed or things like that. That wasn't the case here. In fact, there was no weight being placed over the ventilatory muscles, where you'd worry about that.

And, when I say worry about it, I worry about it when there are high amounts of weights for long periods of time, meaning we've put 225 pounds of lead on people's backs and kept it there for over four minutes. Nobody dies, they breathe well, they move oxygen levels well. It doesn't kill people. There's even evidence that, you know, even more weight than that is, I guess, safe. It doesn't cause ventilatory compromise, it doesn't cause you to asphyxiate, it doesn't cause you to not be able to breathe out. And, that's using real sensitive machines that can measure your ventilatory function. It's also measuring your carbon dioxide levels, your oxygen levels. So, it's got to be a lot of weight to even start thinking about whether it might impact or cause a cardiac event. The other case is it has to be there for a long period of

time. It takes four to five minutes to cause somebody to die from asphyxiation even with complete blockage. And, this comes from data from drowning and events where you get crushed by vending machines or cars, or even strangulation type of hanging videos and things like that. It takes four to five minutes with complete airway blockage to go into cardiac arrest.

This whole event, if you'd really just take the extreme ends of it, was less than two and a half minutes from where he was potentially put in this prone restraint position and when it looked like he had his cardiac arrest event. It's actually a little shorter than that, but that's sort of the -- the longitudinal aspect of it. So, with the timing of it, wasn't long enough to cause an asphyxial cardiac arrest. The weight on the back was with me. There wasn't anything that would impact his ventilation impact. A little bit of that arm lifting on the right side there by Officer [redacted] if there was any question about it, it would even make it easier for him to breathe. But the physiology is such that it doesn't impact.

And then, the event itself, the cardiac event was, he's talking, he's talking, we know he's moving air, so it's not even a complete airway

blockage at all, and then things change suddenly, he regurgitates and he's got agonal respirations. That is consistent with a sudden cardiac arrest. A heart stopping event, not asphyxiation or a ventilatory events.

So, all those things allow me to be able to be comfortable saying my opinion is that none of the officers, their impact, individually or collectively, would have caused or contributed to that cardiac arrest.

And, to go even one step further, if he had been allowed to get up and run around and sort of, be held in a position of being, you know, moving around in a group of police officers, that would actually be more detrimental than being held down. I think we've talked about that. The muscle groups that move around a lot are a problem for acidosis. Being held in this position, even though it restricts his movement and actually, is in some ways, in my mind, protective of him from himself and trying to reduce his acidosis. But, in no way did that position cause ventilatory issues.

Q. Did -- so, I just want to be clear. If -- if Mr. Prude had not -- if -- if -- if there had been no hands on and he had, kind of, remained sitting and had

not stood up, that would be a different story, if I understand you correctly?
A. Right. If he just sat there indian style and waited for the ambulance to come and treat him, that's different. He's not increasing any levels of that lactic acidosis. He's just sort of sitting there. So, yes, that would be a different scenario. If he got up and started to try to get away and they circled him and said just stay here, stay here, but didn't go hands on him, that activity level is actually worse for him than being held in a restraint position, limiting his activity.
Q. Okay. Once Mr. Prude became unresponsive, so once, sort of, using the vomiting as a -- as a temporal guide post, was the failure to turn him over, did that failure in any way cause or contribute to his ultimate death?
A. It did not.
Q. And, how -- what do you base that on?
A. At that point, he's already in cardiac arrest. So, his heart had already stopped. You're seeing the agonal respirations on his back a couple little blips there as they're trying to assess what -- what's going on with him, prior to the medic coming back.
The body itself, actually, being in the

prone position is, in a sense, it's fortuitus because you're on your back and you regurgitate up, you're likely to aspirate in your airways. Being on your stomach actually helps getting it out of your system and in a safer environment. But, the idea of whether they rolled him, immediately rolled him, you know, when they did, that was not going to change his ultimate outcome. He was already in cardiac arrest. He needed to be assessed, he needed to be checked to see if there was a pulse. All of those things. And then, in turn, start CPR, which is ultimately what they did.

Q. My last question. And, I -- this is really a little bit off topic but I -- because you brought up the -- you know, if somebody can speak, they can breathe. Oftentimes -- I know it's not applicable to this case but I just -- I wanted to breeze it only because it is possible for people to feel that they're having difficulty breathing and actually be having issues, and be able to speak, is that correct? I just want to make sure. I just wanted to kind of, cover that a little bit.

A. Sure. As an Emergency Physician, we see people come in with difficulty breathing and shortness of breath all the time. And, there are many different

ways it happens. Typically, those who have the biggest ventilatory problems, ones who truly can't breathe, they're not able to move air in and out of their lungs for lung diease, asthma, CHF, pneumonias, they're not speaking, they're not talking, that's when we get nervous. That's when we say, if you can't speak, we're -- we're anxious because you're so far down that ventilatory pathway that we're concerned.

There are certainly others that come in and say, I can't breathe, and they're breathing just fine. Their oxygen levels are normal, everything looks fine, but what they're having is a cardiac event. If you ever heard a friend or heard stories of the elephant on my chest, I can't breathe. It feels like there's something, you know, a ton of bricks on my chest. That's not a ventilatory problem. The lungs are working fine. Plenty of oxygen in your bloodstream. Everything's working great. It's the heart and the vessels of your heart that are the problem. So, the heart's not getting blood flow because of this blockage and it feels like you can't breathe because that cardiac ischemia, that cardiac event. The lungs are functioning. So, people can feel like they can't breathe and have absolutely normal lung function. Those who really can't breathe, typically don't talk.

And, if they do talk, they're certainly not talking over and over and over, they're talking in one or two words sentences, how we look at them.

Q. And, I know it's not directly a flip fold, I just wanted to make sure that everyone understood, like, when people say they can't breathe, they are experiencing -- it's obviously -- you might be experiencing something that feels to you, as a lay person, as if you can't breathe. That's all.

A. Right. It may not be a lung issue, it may be a heart issue. But, if you're -- the other end, if you're speaking and speaking and speaking from an ER doctor's evaluation, that is a -- that is a reassuring thing that we have a patenint and a functional fairway of ventilations.

MS. SOMMERS: Okay. I do not have any further questions for Dr. [redacted], but I want to give the Grand Jury the opportunity. So, do any grand jurors have any questions? Yes, first over here?

A JUROR: I think I know the answer, but did you see anything in the video that you would recommend be done differently?

MS. SOMMERS: So, were you asked to evaluate the video to determine whether -- well, actually, I'll just go ahead and -- the grand juror has asked, upon

watching the video, is there anything that you would have done differently? And, are asking relative to the restraint?

A JUROR: That or the timing on the CPR. Anything that he saw that he would have liked to see differently?

THE WITNESS: Okay.

BY MS. SOMMERS:

Q. Sure. Is there anything upon watching that video that you feel could have been done better?

A. Sure. That's a great question. The Monday morning quarter backing. You can always, sort of, try and refine things, but in a global sense, you know, the officers were fortunate to be able to get him handcuffed relatively easy without a lot of struggle, which is great. They let him be in space. That was great. They just let him do -- when they thought he was going to get up, it would be in Mr. Prude's best interest not to do so from an activity level, from a obviously, law enforcement level, law enforcement safety perspective. But, to decide to hold him to a position that they did, very reasonable. Again, that's -- we're trained -- that's our swaddle way of keeping him from doing a lot of activity.

The way they held him, avoiding the

respiratory or ventilatory structures was -- was -- it would be textbook in my mind. They had the knees in the lower back, they had the legs restrained, as those can be a way to hurt people. And then, maintaining the head is a great way to keep people from getting up without it impacting them in any negative way, physiologically. The recognition. They actually did a good job because from his last vocalization to when they thought something may have changed and asked, hey, how you doing, was only a matter of seconds, like, 10 or 15 seconds. So, they recognized something changed very quickly. They saw the vomiting, they got the Paramedic back, they were looking for breathing. They saw those agonal breaths, which are hard to sometimes identify, but they recognized that.

And, ultimately, they turned him on his side and started CPR within less than two minutes. That may seem like a long time to people, that is a reality of what happens. That is EMS medicine, that is field medicine. That's the Emergency Department medicine.

We do have to do an assessment. Is there a pulse? Is there breathing? Get them in position. So, you know, I wouldn't do anything differently. It's all -- it's one of those, the medics got there, they're getting the meds drawn up by their protocols.

It takes time to do that, you know, could people run back and forth? I guess that's a possibility, but that's also not a true reality. It's -- we think time dependent but not seconds dependent.

So, again, that's my assessment. Overall, the management was good as you're going to be able to get under the circumstances that were there. The timing, the availability of the individuals coming in.

Q. What about having a protocol, where if -- if a call comes out that someone's naked and bleeding and having kind of those sedatives right on hand immediately?

A. Well, you know, it's interesting, right? So, even if they -- the Paramedic had to run to the ambulance to get the sedatives and have them in hand -- you know, these are controlled substances, so nobody keeps them in hand. They can't load them in your pockets. You have to have them locked up and safe for many reasons, from a DEA perspective. But, even if they ran to get the medications and came back, the medic still has to do a quick assessment and make sure that they have a good, strong pulse before you start putting medications in them.

So, even though there are things, you have to do a quick assessments and make sure things are

okay. There was no way that Paramedic wasn't going to be able to get the meds on board him before he had his cardiac arrest. That's -- you know, they came over and saw, went to the ambulance, you know, the cadence was the cadence. But, even if you optimize things, you have to go unlock it, get it, do -- come back and do an assessment. You don't give medicine without checking somebody's heart rate and try to get a blood pressure, if you can, in general, and then you give the medications for various reasons. Obviously, we don't want to give calming medicines to somebody who's got a low blood pressure or who has got a real thready pulse even though they are agitated. We have to assess that. So, the protocols -- there's different protocols across the country and different ways of using it, we're trying to be safe. We want to protect individuals like this and try to get them treatment as fast as possible. On the other end of the coin, we don't want to both reuse it and cause harm to people that didn't meet the criteria and didn't have the appropriate evaluations.

MS. SOMMERS: Yes, [redacted]?

A JUROR: In reviewing the Medical Examiner's report, does he have an opinion in agreement with the Medical Examiner saying that

homicide was part of the cause of death?
BY MS. SOMMERS:
Q. In New York State, Medicals Examiners are required to put a manner of death, not just the cause of death. And, the Medical Examiner who previously testified, indicated that she determined a homicide since the death occurred at the hands of another. She also -- and, I don't want to mis-state anything, I believe, indicated that she was not determining whether it was legally justified -- not justified, or whatever. In California, where you are, first of all, are you a Medical Examiner?
A. I am not a Medical Examiner.
Q. Okay. Actually, are you a -- are you -- do you have any pathology training or certification?
A. I don't have any certifications. I get general training, but nothing specific.
Q. Okay. And, are you aware of whether or not in the State of California, Medical Examiner reports require the same designation as to manner -- cause and manner of death?
A. So, I'm not a Medical Examiner. I don't -- I do write cause of death. I do fill out death certificates. I don't do a manner of death. That is a Medical Examiner's specific area. I've reviewed

hundreds of autopsies in cases and there is a challenge on that manner of death. And, this is country wide, not just New York or California, at the hands of another, meaning if somebody was holding on or doing something, there is disagreement amongst their own speciality about whether it should be natural, whether it should be accidental or whether it should be homicide. And, if you ask three Medical Examiners on the same case, you may get three different answers. So, it's difficult. But, I think the important piece you brought up there, this isn't the determination of causation, this isn't a determination of legal something. This is, basically, the hands are on when it happened, they -- they consider it a homicide and it's what it is. If I'm holding somebody during a cardiac arrest in a heart attack and I'm doing something with them, they will consider that a homicide because my hands are on them during that time in some cases, and others will not. So, it's very varied from Medical Examiner to Medical Examiner.

MS. SOMMERS: All right. I'm going to leave that one there. Any other questions? Yes, [redacted]?

A JUROR: He said the cause of death was excited delirium and he had -- his heart had stopped

at that point, you mean, the AED would not have done anything?

MS. SOMMERS: So, this is -- one of the -- thank you.

BY MS. SOMMERS:

Q. One of the grand jurors -- so, first of all, is the -- was the actual cause of death excited delirium or cardiac arrest generated by excited delirium? Could you just first of all clarify that?

A. Sure. It would be PCP induced excited delirium, leading to cardiac arrest.

Q. Okay. And, one of the grand jurors asked if -- what about an AED being administered quickly, more quickly? I understand, you know, Monday morning quarter backing, but one of the grand jurors has asked about that?

A. Great question. AEDs are automatic -- automatic external defibrillators are designed to defibrillate. So, if you're in a shockable rhythm, like, ventricular fibrillation, a little wiggly thing that goes across that you sometimes see on TV shows, that's the kind that you can shock. Mr. Prude was not in ventricular fibrillation. So, an AED would not have shocked him. It would not have had any impact on his outcome. They would have done an assessment, set his hands off,

wait, non-shockable or no shock indicated, hands back on for CPR. So, in his case, it wouldn't have made a difference at all.

Q. Is that what you were referring to previously as pulseless electrical activity?

A. That was the rhythm he was found to be in and that is not a shockable rhythm and that's very common in these excited delirium cases.

Q. Thank you.

MS. SOMMERS: Yes, [redacted]

A JUROR: So, what -- question about, aside from the term homicide, were there any -- is his findings conclusive with the Medical Examiner or were there some differences in opinion?

BY MS. SOMMERS:

Q. Okay. So, one of the grand jurors has asked, other than, you know, whether -- and, about -- with the understanding that you're not determining manners of death, and with the understanding, that the Medical Examiner who testified, indicated that the death -- that her definition of asphyxia was, I -- I submit or I believe; and, again, I want to make sure that the Grand Jury agrees, was a lack of oxygen, available oxygen? Other -- so, with that as an understanding, do you agree with the actual physical -- with the

findings of the Medical Examiner?
A. I'd have to look at the exact wording that they had. I don't remember the exact wording.
Q. Complications of asphyxia -- complications of asphyxia and, for the record, I'm reading from admitted Exhibit 36-A. Complications of asphyxia in the setting of physical restraint was finding number one. Finding two was excited delirium. Finding three was acute phencyclidine intoxication. And then, finding four was a post donor -- post organ donor indication.
A. So, obviously, the phencyclidine intoxication, yes. The excited delirium, yes. And, if the Medical Examiner, again, explained that the issues with the patient or the subject was restraint, we know that. But, the asphyxia or the complications of asphyxia was not because of the restraint, but rather because of the cardiac arrest and lack of flow, then physiologically, I'd be agreeing. I probably would word it differently. But, if they are saying that the position caused asphyxia, that's what their testimony was, that position caused asphyxiation, then I'd, obviously, would be disagreeing.
MS SOMMERS: Does that answer your question?
A JUROR: Yes.

MS. SOMMERS: Any other questions? Yes?
A JUROR: Can you ask if there's a way to measure lactic acidosis built up, either at the hospital or possibly afterwards?
BY MS. SOMMERS:
Q. Sure. A grand juror asked if -- if there was a way to determine if there was actually a high acid level when an individual presents at the Emergency Room; are you able to do that?
A. Lactaid levels can be measured. Or pHs can be checked. But, after cardiac arrest, it often throws off those numbers. So, which means, you know, somebody comes in with a low pH after having had chest compressions or cardiac arrest, it could be in part due to the acid levels from what occurred previously, or it could be due to the fact that they were in cardiac arrest. So, it does -- there's things to measure, but it's not always able to point exactly what the cause was.
MS. SOMMERS: Anyone else? Oh, yes, I'm sorry. I apologize.
A JUROR: After reviewing the body cam footage, at approximately 3:20 a.m., Daniel is being restrained and he's -- there's a distinctive point where he's speaking and then all of a sudden his voice

becomes muffled. In your medical perspective, what do you think is the best explanation for that?

BY MS. SOMMERS:

Q. So, were you able to hear the question asked?

A. I believe I've got most it.

Q. Do you have an opinion as to why his voice becomes muffled?

A. Yeah. That can be for a number of things. That's a good question as well. Clearly, he's more clear initially. Sometimes they adjust their face and it goes down a little bit more and, sort of, can muffle it, you know, from that perspective. Sometimes they get fatigued. Sometimes they do what we call keening, which is just making sounds that aren't really words and you're not trying to articulate something but you're more groaning type of thing. So, something along those lines.

I can't say specifically what it was. But, what I do recognize that -- that there is air movement going in and out, to continue to do that. But, you're right, there was a change in there. I suspect it's probably more of a slight position change or a little bit of lack of effort.

Q. But, you're not able to -- to say, kind of, with

that sort of certainty, or you're not really offering an opinion on that? You're not really able to say?
A. I can -- I feel comfortable saying that I don't -- there's no evidence that there was an obstructed airway as far as that goes. He's still moving air in and out. He's still moving making sounds. But, why the phonation change? It could be a number of things. But, none of them would have blocked the way to ventilate.

MS. SOMMERS: Does that answer the question?

A JUROR: Yes.

MS. SOMMERS: Any other questions? Dr. [redacted], thank you very much. Very much appreciate it. And, you are officially done with Grand Jury. Thank you.

THE WITNESS: Thank you all for your service. Be safe.

(Whereupon, the witnessed was excused at a time of 1:16 p.m.)

MS. SOMMERS: So, before you go for your lunch here, real quick, I want to say a few things. So, a couple things. I didn't want to interrupt because of the times here, but Dr. [redacted] said some things that I really think are more your province and not his. Particularly to when he akined about whether things could have been done differently.

So, he was called as an expert in terms of causation. And, that's why we submitted that to you. But, when -- when -- and, I completely understand the question. And, you know, when it comes to, you know, if things could have been done differently, that's not why he was brought in. He was not asked to evaluate in that regard. He was brought in as an expert in restraint related deaths and causations.

So, I want to make clear that you -- it's your opinion if -- if ultimately asked to, kind of, weigh anything in that regard.

I also wanted to mention that in Dr. [redacted] testimony, we can also have read back to you if necessary, only because one of the questions elicited from Dr. [redacted] sort of, a response that, I think, where he could almost be read to characterize her testimony. Again, she testified. Her testimony speaks for itself.

And then, at one point in describing Mr. -- or the principle of excited delirium, Dr. [redacted] indicated that the literature said that it was more an issue that is seen in chronic users as opposed to a first time user. Just advising that you are not to, kind of, draw negative conclusions based upon that fact alone. Okay. So, I just wanted to kind of put all of that out there.

With that said, I know it's been a very long morning. It's 1:18. How about we reconvene --

A JUROR: But the EMT is coming back at 1:30.

MS. SOMMERS: Yeah, I know. Did I say 1:30 or 1:45. Is she out there? Why don't we bring her --

A JUROR: I'm curious as to why the Medical Examiner put the main cause of death as asphyxiation.

MS. SOMMERS: So, again, her -- her testimony speaks for itself. We can reread it if -- we can have it reread to you if you'd like.

A JUROR: I think she needs to be called in again.

MS. SOMMERS: So, I submit that she explained what her -- what she meant by asphyxiation and I don't want to mis-state what she said. And, I also -- that's why I'm cautious about kind of asking

another witness to characterize it and I want to mention it.

MR. SMITH: I do think the transcript or review of the transcript --

MS. SOMMERS: Yeah. We can very, very easily have any part of that reread.

A JUROR: Are you trying to say they have a difference of opinion and we're here to figure out which one? I mean --

A JUROR: I don't think it was a difference of opinion.

MR. SMITH: To the extent to which their opinions even differ, I think, again, it is explained or clear in the words of the testimony. And again, that can be read back at any time. But, you are the arbitrators of the facts, not us. So, your recollection controls, and you are the ones that make those decisions. And again, transcripts are there to be reviewed. But, I would submit that both Dr. [redacted] and Dr. [redacted] were asked their conclusions and asked to explain them. So, I just -- again, we are not your legal advisors -- or, we are your legal advisors, but we are not determining the facts. That's for you to decide whether or not they're in disagreement in the first place, it's up to you how to resolve it.

MS. SOMMERS: If -- if [redacted] is right outside, we could bring her back, finish her questioning, and then take the break and that might be more appropriate.

A JUROR: [redacted] may I make a suggestion?

MS. SOMMERS: Of course.

A JUROR: Maybe we can ask you the questions before she comes in. That way, we can --

MS. SOMMERS: You know what, that's actually a great idea.

A JUROR: [redacted] been patiently waiting and I don't want to make her wait another hour.

MS. SOMMERS: [redacted], could you peak your head out and just tell Mike to hold [redacted] outside for a moment?

So, what we're going to do is people -- the remaining people that had questions for [redacted] Why don't you ask them now. I'll kind of write them down and then I'll ask her. So, who had questions that had not been answered? I know there were.

A JUROR: The question for the witness is, if she arrives on site and notes or witnesses an issue, does she have the authority to say anything?

MS. SOMMERS: To the police?

A JUROR: Just in general. Yeah, because it

was regarding restraining. If she sees anything that looks like it can be causing the patient distress, does she have the authority to say something and if she does, as a follow-up question, did you see anything on site that looked a little off and do you wish you would have said something?

MS. SOMMERS: Yeah, I can definitely ask that. So, that's of course a different question than whether the people that she is asking to do things, to listen to her. But, is there anything precluding her from saying anything?

A JUROR: When she arrived on site, does she take charge essentially, based on the patient's condition probably the most important thing.

MS. SOMMERS: Understood.

A JUROR: Don't know if you have to write this down.

MS. SOMMERS: Believe me, I do.

A JUROR: Her Supervisor was called and asked about using the ketamine. Did she give an answer on how long it would take the Supervisor to get there?

MS. SOMMERS: Okay.

A JUROR: I have a follow-up question to her now that it just jogged my memory. She was talking

about how she had two vials. She was just loading up the second vial. It wasn't clear to me whether any sedative was administered.

A JUROR: It was not.

MS. SOMMERS: Well, let's ask her.

A JUROR: She said so.

A JUROR: Okay. Fine.

MS. SOMMERS: Are you okay with that?

A JUROR: That's fine.

MS. SOMMERS: Anyone else? All right. Let's bring her in.

(Whereupon, the witness entered the Grand Jury room at a time of 1:24 p.m.)

[redacted] after having been previously called and duly sworn testified further as follows:

EXAMINATION BY MS. SOMMERS:

Q. For the record, we have recalled [redacted] following the testimony of Dr. [redacted] just recall that you're still under oath.

A. I am.

Q. So, [redacted], just a couple of questions from the grand jurors. If you arrive on a scene, is there anything prohibiting you from indicating when you see things that are not up to your, what you believe should be done?

A. Not necessarily, no. Unless it's a safety concern for myself.

Q. Okay. When you arrived on scene, did you see anything that you did not approve of?

A. The position that he was being held in was not ideal, but from my vantage point, it was not necessarily a concern that needed to immediately be addressed.

Q. If it was a concern that you felt immediately needed to be addressed, did you have the authority to say something?
A. I could have said something. I have no authority to force them to listen.
Q. Okay. In any event, did you saying anything?
A. I did not.
Q. In terms of contacting your Supervisor in order to get ketamine on scene, did you get any indication as to how long that was going to take?
A. While I was on the phone with her, she indicated that she was probably about a minute to two minutes out from my location at that time.
Q. And, what happened while you were on the phone with her?
A. At that point, my partner called over and said he needed my help and I ended the conversation and hung up.
Q. So, it was at the point where your partner -- and I believe you said his name was [redacted]?
A. Yes.
Q. It was at the point that he called you over that you were on the phone with your Supervisor?
A. I had been on the phone for the minute before that, yes.

Q. Okay. So you had been on the phone with her, and were you still on the phone with her?
A. I was still on the phone with her.
Q. And, what, if anything, did you indicate when your partner called you over?
A. I don't remember my exact words. I believe it was something along the lines of, we may have a cardiac arrest and I hung up.
Q. Okay. Is a cardiac arrest in the EMS or the pre-hospital care universe known by a number?
A. Medical 5 or surgical 5.
Q. Is it also ever known as 500?
A. Yes.
MS. SOMMERS: Did I answer your question? Do any grand jurors have any follow-up questions based on that?
A JUROR: What concern might there have been about the position that he was in?
THE WITNESS: We don't like to hold an excited delirium patient's face down. It's not ideal. It can sometimes restrict them taking those deep breaths. But, when I first walked up, it appeared he was still able to move around, so it was not an immediate concern.
MS. SOMMERS: Does that answer the

questions?

A JUROR: Absolutely.

MS. SOMMERS: Thank you. Anyone else?

A JUROR: At the point where he was vomiting up liquids, was that the point where they decided that it would do no good to do anything else because the heart has stopped?

MS. SOMMERS: So, let me stop you for a moment because I'm not sure if this witness --

A JUROR: I'm sorry.

MS. SOMMERS: No, no. You're fine.

BY MS. SOMMERS:

Q. So, let me ask you this. Were you present at the time that Mr. Prude vomited?

A. I was not. It was, I believe, just after that my partner called me. I was not made aware of that until later on in the call.

Q. So, you were not present at that moment?

A. I was not.

MS. SOMMERS: Okay. Does that answer your question?

A JUROR: Yes.

MS. SOMMERS: Any others?

GRAND JURY POOL: (All jurors indicating a negative response.)

MS. SOMMERS: All right. Thank you. I apologize that you had to wait. Thank you.

THE WITNESS: That's okay.

MS. SOMMERS: Thank you. You're all set.

(Whereupon, the witness left the Grand Jury room at a time of 1:29 p.m.)

MS. SOMMERS: So, it's 1:30. How about -- do you want to say -- 2:00 o'clock would be great. And, we can then just finish. I think we have two witnesses left. So, if you could get back at 2:00. We won't be here until 5:00. That would be great. Thank you.

(Whereupon, the Grand Jury broke for lunch.)

(Proceeding reconvened.)

MR. SMITH: Ladies and gentlemen, we have two witnesses left this afternoon. Ladies and gentlemen, hopefully they go quick. We're going to call [redacted].

MS. SOMMERS: All set?

MR. SMITH: Yes.

(Whereupon, the witness entered the Grand Jury room at a time of 2:03 p.m.)

[redacted] after being duly called and sworn, testified as follows:

EXAMINATION BY MR. SMITH:

Q. Good afternoon, sir.

A. Hello.

Q. Could you state and spell your first and last names for the record, please?

A. I am [redacted]

Q. Are you currently employed, Mr. [redacted]

A. I am not. I'm a full time graduate student.

Q. Where are you a graduate student?

A. Quinnipiac University.

Q. Where is that, sir?

A. It's in -- my campus is in North Capen, Connecticut.

Q. What kind of program is it?

A. It's a physician's assistant program, Masters Degree.

Q. Congratulations, sir. Prior to physician's assistant school, were you employed?

A. I was.

Q. Where were you employed, sir?
A. AMR Ambulance.
Q. Where were you employed by AMR Ambulance?
A. Rochester, New York.
Q. What was the timeframe you worked for AMR?
A. August 2018 to April 2020.
Q. What was your position at AMR, Mr. [redacted]
A. I was an emergency medical technician.
Q. Could you just briefly describe for the Grand Jury, please, sir, the grand jurors, what an emergency medical technician is?
A. So, it's a first responder position. You're trained to administer life saving interventions, basic life saving interventions, that are not overly invasive in an attempt to help people in an acute emergency event, all the way down to more non-emergent events as well, to bring people to the hospital safe.
Q. And, Mr. [redacted] what's the level of education or specific training that you have that you need to become an EMT?
A. So, it's like a course, the way I took it was, it was a three month course over the summer that involved going to class four -- four days a week for about four hours each class session. Then, you had to take a clinical skills exam, as well as a book type of exam,

like a standard exam.
Q. And, you passed all that?
A. Yes.
Q. Did you work as an EMT anyplace else besides AMR?
A. I did. I had -- initially, I was hired to a small private ambulance company in Central New York, in Rome, New York. That's where I first worked as an EMT. I also worked as an EMT at my undergraduate university, at St. Lawrence University, way up north near Canada. So, I had a little previous experience there. And then, I became the EMT at AMR.
Q. So, how many years total did you have as an EMT before school, Mr. [redacted]
A. Before I left, I had about three and a half years.
Q. I'm drawing your attention to March 23rd of this year, 2020, Mr. [redacted]. Were you working as an EMT for AMR on that date?
A. Yes.
Q. Do you recall what shift you were working on that day?
A. I worked 5:30 p.m. to 5:30 a.m.
Q. Were you working with anybody?
A. Yes, I had a partner.
Q. Who was your partner?

A. [redacted].
Q. Is [redacted] an EMT?
A. She is a Paramedic.
Q. And, the grand jurors got some testimony, Mr. [redacted], but can you just briefly describe the difference between an EMT and a Paramedic and the different levels of care?
A. Yeah. So, an EMT naturally, is a basic life support provider. A Paramedic is an advanced life support provider. So, when I do more life saving interventions, it's very non-invasive or as least invasive as it can be. Paramedics do much more invasive things. Their learning is a lot longer than what an EMT is and their, kind of, gauge of what they can do in an acute emergency is much wider than mine.
Q. So, Ms. [redacted] is at a higher level of care than you are?
A. Correct.
Q. And, as an EMT, Mr. [redacted], are you able to perform CPR?
A. Yes.
Q. Chest compressions?
A. Yes.
Q. Are you able to administer sedatives?
A. No.

Q. I want to direct your attention to around 3:00 a.m., a little after 3:00 a.m., Mr. [redacted] again, on March 23rd, 2020. Did you receive a dispatch directing you to the vicinity of 435 Jefferson Avenue in the City of Rochester?
A. Yes.
Q. How were you made aware of that dispatch, sir?
A. It came in over the radio. It's standard that dispatch gets the 911 call. They code it, and then they dispatch the ambulance that is closest to that call. We were the closest ambulance, so they called our rig number. We responded. They said, go to XYZ address for this call.
Q. What was the nature of that call, Mr. [redacted] if you recall?
A. It was a psychiatric call.
Q. Is a psychiatric call a common call for an AMR EMT crew in the City of Rochester?
A. Extremely common, yes.
Q. What does that mean to you as an EMT when you get that call?
A. When you hear that, your idea of what's going on is still very broad. Dispatch information isn't always spot on and what's happening on the scene is not always directly correlating to what the patient's

condition is. So, you always take the information with a grain of salt. But, when you hear a phychiatric event, you know, you prepare yourself for the types of calls in which someone's in more of a mental or emotional distress, and less of a physical distress. Some of those things, you know, overlap a bit, if it's, you know, something like a suicide attempt or things of that nature. But, your mind shifts away from the harder more intervention driven medicine, such as like, a heart attack or trouble breathing call. So, you kind of paint the picture to be ready to respond to someone who's in some distress or is emotional.

Q. Is it fairly common, sir, that one of these types of calls, as a psych call, when you respond, you end up transporting the patient to the hospital?

A. Correct.

Q. Where were you when you received this dispatch?

A. We were on the west side of the City. I can't remember exactly where we were, whether or not we were at a post or if we were actually driving somewhere to a post. But, I remember we were, kind of, heading south on the west side of the City.

Q. Now, did you respond directly to 435 Jefferson Avenue or did you stage?

A. We staged beforehand.
Q. Where did you stage?
A. We staged just north of Main Street, like, literally, probably two blocks away from the call, which is pretty standard practice for any kind of psychiatric caller or any kind of a call of that nature.
Q. Why is that, Mr. [redacted]
A. It's mostly for our own protection. To make sure that the police are there, have the scene under control before we go in.
Q. Eventually, were you cleared to enter the scene?
A. Correct.
Q. Did you then proceed to the area of 435 Jefferson?
A. Yes.
Q. From where you were to 435 Jefferson Avenue, Mr. [redacted] how long did it take to get there?
A. I would say no more than three minutes.
Q. From the time you initially got that dispatch, from the time you initially arrived on scene, was that call updated at all, did you receive any additional information?
A. When we get dispatched for things, we get the notes that the dispatchers get, and that gets sent to

a phone that's part of our equipment on the ambulance. And, in some of those notes, there's sometimes things of -- of, you know, noteworthy there, and it did, you know, say that there was a naked, bloody man on the ground.

Q. Did you draw any conclusions when you heard that updated information, Mr. [redacted]

A. Again, you kind of have to take everything with a grain of salt because you're not there yet. You can play around with the idea of well, why is this happening or why is this occurring, and you absolutely should do that, but you also still have to be prepared for, you know, anything else to happen. You know, you can only speculate so much. But, to be told that there's someone naked and bloody on the ground, you know, your mind immediately starts asking the questions, well, why is someone in that position and what is -- what is making someone to be in that type of position.

Q. So, based on that information that you and Ms. [redacted] received, Mr. [redacted], did you two, sort of, on the way over to 435 Jefferson Avenue; or, before you exited the ambulance, was there any kind of plan of who was going do to what discussed? Or, what was the plan?

A. [redacted] and I work very well together and that's why I've worked with her for so long. I actually chose to only work with her when I could have worked with many only people, but I only felt comfortable working with her. And, because we worked so well together, there wasn't always a lot of need for overt communications. We both understood what our roles were going from call to call. It was always very clear, you know, she has, you know, final say over things, as she should. And, I'm there to help her with anything that she needs going from it. In a call like this, that could go -- because a Paramedic doesn't always take the call, if the call is not requiring of advanced life support interventions, then the EMT can take the call.

A psychiatric event is one of those calls that can go either way. Calls that cannot go either way are calls like cardiac events. So, if you get called for someone whose heart rate is 150, that's always going to be the Paramedic's job to handle that because they are at a higher level of care that can deal with that. That, I will never be able to deal with.

But, for psych calls, going into it, you always know it can either be a BLS or an ALS call.

And then, what you find on the scene determines what level of care they need. So, going into it, we both understood, you know, it could be BLS, it could be ALS, depending on what the nature of the call is. But, you never assume that, hey, this is always, you know, a BLS providers action. But -- so, we understood that.

When we get on scene we have to determine that and we have to gauge the situation. And, so was there overt conversation being had if -- hey, if it's X then I'll take it and if it's, you know, Y, I'll take it no, because we both have a pretty good understanding of this is ALS criteria and this is BLS criteria, and we know who can handle what.

So, there's not ever -- there's questions in terms of why is this individual naked in the street when it's cold out. That's a question that you always ask, you know, to the crowd. But, there's a very limited amount of true pre planning that you can do.

Q. I don't want to put words in your mouth, Mr. [redacted] but, it's fair to say then, sort of, pending on the situation at the scene and the evaluation of the patient, there's not a specific plan?

A. Yeah. You come in very broad and able to handle, kind of, everything. You rule out life threats, you

address life threats and then you dictate care from there.
Q. Did there come a point then, sir, that you arrived on the scene at 435 Jefferson Avenue?
A. Yes.
Q. Did you make any observations when you arrived at that location?
A. Yeah. So, pulling up to the scene, it caught my eye, the level of police presence that -- you know, just seeing the number of police cars there.
Q. Do you recall how many cars you saw?
A. I would say at least four or five.
Q. Was that unusual to you, sir, on a psych call?
A. It's not unusual but it tells me that something is happening. Something is requiring more than a few officers to be there. Because for a cooperative psychiatric call, someone who needs to go to the hospital who needs help, is not resisting in any kind of way, there wouldn't be a true need to have more than two or three officers.
Q. Did you see any police officers outside of their patrol cars at that scene?
A. Yes.
Q. How many?
A. I saw at least five, I believe.

Q. Did you see a patient?
A. Yes.
Q. Where was the patient located?
A. So, the patient was in a prone position with his hands restrained behind his back with -- with handcuffs. This was another thing that -- that stuck out to me was the way -- way that the officers were restraining him. Working in Rochester, I've seen many individuals being restrained, but I've never quite seen somebody be restrained in this manner.
Q. What -- in what way was it different, Mr. [redacted]
A. There was one officer who -- who seemed to be, kind of, like tri-podding on the patient's, you know, neck and head. I had never seen that before. I had no idea police were allowed to do that or anything of that nature. And, as I said, I've seen multiple people being restrained, but never seen someone, I guess, who needed that level of restraint to that patient.
Q. Let me ask you this, Mr. [redacted] are you familiar or aware of the Rochester Police training techniques?
A. I am generally aware. I'm not aware of the specific techniques or training. But, I've seen, in general, some of their techniques being done.
Q. How many officers were hands on with this

patient?
A. I believe at least three.
Q. And, where were they located?
A. One was towards the head. There was another one on the back torso. And then, I believe, one on the legs.
Q. The thing that you just described that you hadn't seen before, where was that being done and by whom, which officer, where was he located?
A. He was towards the head. So, it quite literally looked like he was, you know, kind of, bracing with his back legs and taking his other two hands and really supporting most of his weight on the -- on the back of the patient's head and he was shaded towards the -- the front of the -- the patient towards the head of the patient.
Q. You said previously, the head and neck. So, I want to be clear, if you can tell us, tell the Grand Jury, if you saw that officer's hands, sort of, near the neck or if they were on the head?
A. I could not differentiate if it was on the head or if it was on the neck. I just could see that it was near that -- that area. And, I could -- I could tell that there was some amount of force being put either on the neck or on the back of the head.

Q. Could you tell how much force was being used?
A. I couldn't. I mean, I know you could stand on your legs and just put a little bit of pressure or you could put your entire body weight. But, from the way he was positioned and how I was seeing it, I don't think I could ever tell how much pressure.
Q. And, at that point, Mr. [redacted], could you tell what you were just describing, whether or not the patient was moving?
A. The patient was moving at that point, yes.
Q. Could you describe what kinds of movements?
A. It was kind of a jerking, resisting kind of movement. There's, you know, classic, like, medical induced movements, things, you know, like seizure activity, you know, they call it tonoclonic movement. That is not what this looked like. This looked like purposeful controlled movement to try to get out of the situation of having being restrained. That's how I would kind of describe the movement.
Q. Was that patient verbal, saying anything, Mr. [redacted]?
A. He was verbal but not really comprehensible speech. You could hear, you know, kind of, you know, garbled words of that nature, and/or him trying to say words, but -- but you could not hear anything.

Q. Did you make any other observations about that patient being restrained?
A. He had a spit sock over his head. He was naked, true to the details of the dispatch note.
Q. What was the weather like at that -- at that time, Mr. [redacted]?
A. It was cold. I don't know if it was exactly below freezing, but there was snowfall. When it landed it melted, it did not stick. So, it was -- it was relatively cold. He was covered in, you know, like, moisture. He was damp.
Q. Did you observe any blood, Mr. [redacted]?
A. He had some abrasions over his body spread about.
Q. Based on all those observations that you just made and just described for the Grand Jury, Mr. [redacted] including the nudity, the blood, the incomprehensible speech, the original nature of the call being psychiatric, did you draw any conclusions about what was go on with the patient?
A. I could draw the conclusion that this man needed help and that we needed to get him to the hospital. Without any further information, just objectively, I don't think I could fully speculate what would be the issue without having more of a background or kind of information from others or from the patient himself.

Q. Did you perceive any more information from the officers at the scene about the patient?
A. Yes.
Q. What was that, Mr. [redacted]
A. The officers informed us that this was a man who was reported missing by his family and that he -- he ran off earlier and the family reported that he could have been doing drugs and the drugs could have included PCP. And then, someone called 911 for a man that was breaking windows, or something of that nature, running down -- down the street that we were dispatched to. And, I guess, that is how the police officers initially found him, was by responding to this 911 call.
Q. Now, I don't want you to guess, Mr. [redacted] let me ask you this question. Are you familiar with the effects and symptoms of PCP intoxication?
A. I know very generally. I do not know every side effect, no.
Q. Did this patient's presentment, including some of the things that you just described, is that consistent with what is known about PCP use?
A. I know that it can make people agitated.
Q. Did this person appear agitated?
A. Yeah.

Q. Mr. [redacted], did you later learn that that patient's name was Daniel Prude?
A. Yes.
Q. What is that you do -- based on these observations, Mr. [redacted], what is that you decided to do as an EMT?
A. Regardless of what was going to happen, he needed to go to the hospital. And -- so, I knew that and I said well, I don't know the exact steps that we need to take, but right now I need to be concerned with how to safely get him into the back of the ambulance to effectively bring him to the hospital. So, I made the steps to, you know, get the stretcher, position the stretcher next to the patient, undo all the straps and get it ready to then move the patient onto the stretcher to bring him to the hospital.
Q. Did you then do all those things, Mr. [redacted]
A. Yes.
Q. And, while you were doing that, where was [redacted]?
A. [redacted] was talking to police officers, getting more of the story. And, after she did that, while I was pulling the stretcher around, she made the decision that she was going to sedate him for his safety as well as our own. Her, you know, protocol is

that she had as a Paramedic, she was going to sedate him. She also wanted to administer a higher level sedative agent that only the Supervisors carried. So, as she was drawing up the initial sedative, she called our Supervisor for a -- possibly giving the higher level sedative as well. And, that was while I was pulling the stretcher next to the patient. She was towards the back of the ambulance actually making the phone call.

Q. Now, while you were getting the stretcher ready I believe you just testified to, Mr. [redacted] were you next to the patient?

A. Yes.

Q. And. While you were getting the stretcher ready, were you able to observe the patient?

A. I was able to see.

Q. Okay. And, at some point while you were getting the stretcher ready, sir, were you alerted to a change in the patient's condition?

A. Yes. One of the officers had mentioned that it seemed like he stopped moving as much and that he may have thrown up.

Q. Do you know which officer said that?

A. No. It was one of them behind him.

Q. And, do you know when they made that statement,

the officer made that statement, Mr. [redacted], whether or not the officers were still hands on with Mr. Prude?

A. I believe there was no longer anyone on his head, but there were people behind him, kind of, you know, I don't think using as much force as before, but they were still hands on.

Q. Do you know whether or not they were using any force at all?

A. I don't know.

Q. Now, Mr. [redacted] what did you do when you were alerted to that change in condition?

A. Well, naturally, I check -- as an EMT, you're taught your ABC's of, you know, anything that's airway breathing circulation. So, you know, I look at the patient. I checked for a pulse on the wrist just to see if there was one, and I couldn't find one. So, I said to myself, well, he's handcuffed with his hands behind his back, maybe that's not the best place to get it. I removed the spit sock. I instructed the police to roll him over because I noticed at that point there was little to no movement, if none at all, in the patient. So, I asked them to roll him over and I removed the -- the spit sock and noticed that there wasn't any breathing, noted no chest rise or fall and

then I felt for a carotid pulse and he did not have one.

Q. So, initially, Mr. [redacted], when you checked the radio pulse, Mr. Prude was still prone?

A. Yes.

Q. You asked the officers -- it was you who asked the officers to turn over Mr. Prude?

A. Yes.

Q. They turned him over?

A. Yes.

Q. And, you removed the spit sock?

A. Mm-hmm.

Q. You checked for a carotid pulse?

A. Mm-hmm.

Q. Did he have a pulse?

A. No.

Q. What did you then do?

A. I call for [redacted]

Q. Where was [redacted]

A. Just to the back of the ambulance.

Q. Okay. Then what happened?

A. I was very alarmed and I was initially very shocked because anyone in emergency medicine knows that one of the scariest positions to be in is to have a patient who goes into a cardiac arrest with

handcuffs behind their back.
Q. Why is that, Mr. [redacted]
A. Any time you place an object or -- or anything behind someone's back, that will prop them up. For CPR, to be adequate, it has to be against a hard flat surface. If you're laying on something like that and then you're trying to do compressions, you're not really compressing the heart, but you're compressing the whole object. And, you're not effectively pumping the heart. So, doing chest compressions with someone who's handcuffed behind their back isn't very effective. That, initially, was what ran through my head at that moment, was saying to myself was, well, geeze, I -- I don't -- I don't know what to do and I called for [redacted] and I asked her, do you want me to do CPR with the handcuffs? She was like, yes, we don't have any other choice. So, that's what I did. I did CPR for, you know, a couple rounds as they were looking for the handcuff key.
Q. Did it appear to you, Mr. [redacted] that there was a delay for the key?
A. There was. It seemed odd that there were multiple police officers near us but no one had a handcuff key and that someone had to go to their cruiser -- their patrol car to get a key.

Q. How many rounds of CPR did you do while Mr. Prude was handcuffed?
A. I did at least two. So, I would say anywhere around, you know, a couple of minutes, two or three.
Q. Eventually, was Mr. Prude un-handcuffed?
A. Yes.
Q. And, placed on the stretcher?
A. Yes.
Q. Was the stretcher moved into the ambulance?
A. Correct.
Q. Did you con -- did you -- let me withdraw that. Did you continue CPR in the ambulance?
A. Yes. We continued CPR, you know, brief pauses while we moved him onto the stretcher, continued CPR while we were moving the stretcher towards the back of the ambulance, briefly stopped CPR again to lift the stretcher into the ambulance. I then continued CPR inside the ambulance.
Q. At some point, Mr. [redacted], were you able to get a pulse back for Mr. Prude?
A. We did.
Q. After how long, if you can say, sir?
A. I would guess somewhere between 15 and 20 minutes of our arrival. I'm not exactly sure exactly what time the cardiac arrest began. But, I would suspect

about 15 minutes from our time when we got pulses back.

Q. Could you just briefly describe for the grand jurors, what happened from there, Mr. [redacted], after you got the pulse back?

A. It's pretty straight forward protocol that -- that once we get pulses back, we've stabilized the patient enough to get them to the hospital quickly to then have them, you know, perform the high level of care that the patient needs. So, I always, in any of our cardiac arrests, as soon as we get pulses back, I know it's my job to get out of the back of the ambulance and go drive the ambulance now. So as soon as I heard we got pulses back, I just knew to open the door, hop out and get into the front seat.

Q. Where did you transport Mr. Prude to?

A. To the U of R Hospital, Strong Memorial.

Q. And, what was his condition when you got him to Strong, Mr. [redacted] Had it improved at all?

A. I would say it was unchanged from the point of when we got pulses back on scene. It was still that he had pulses, but he was still, you know, unconscious, intubated, all of that.

Q. Did that -- once you got to Strong, did that end your care of the patient, Mr. [redacted]?

A. Yeah. We -- we brought him into the trauma bay, moved him onto the hospital bed, [redacted] gave them a report, and that's pretty much where our part of the job ends.

Q. Mr. [redacted] I just want to go back and ask you a couple of questions about what you said when you arrive on scene. Was it just the -- withdraw that. Was it only the actions of the officer that was near or at a head of Mr. Prude that you described as sort of a technique or action that you hadn't seen before?

A. Yes.

Q. Did -- did what you were seeing concern you, Mr. [redacted]

A. It left me questioning, like, because naturally, I don't know very much about what the police officers are taught to do and how they're taught to restrain people. It left me wondering, is that something they're taught or something of that nature? Did I immediately say, hey, like, that's not a very great thing to be doing to someone? Yes. But, I don't -- I don't know if they were taught to do it or not.

Q. And, did you express any concern at the time to anybody at the scene, Mr. [redacted]

A. No.

MR. SMITH: I have no further questions for

Mr. [redacted] Do any of the grand jurors have any questions?

MS. SOMMERS: Can I ask a question? I'll ask you.

BY MR. SMITH:

Q. I do just have a couple more questions, Mr. [redacted]. I'm wondering about the drive from the scene of the staging to the scene at 435 Jefferson. And, I believe, and I don't want to put words in your mouth, or mis-characterize your testimony, but I believe you stated that you and [redacted], Ms. [redacted] have an understanding, sort of, the difference between the EMT and a higher level Paramedic, and what she's going to do and what you're going to do. I guess my question, based on all of that, Mr. [redacted] specifically, is whether or not during that drive from, again, the staging area to 435 Jefferson, whether or not you had any specific conversations with Ms. [redacted] based on the information and the dispatch and the call about excited delirium?

A. About excited delirium, specifically, I do not believe so. I believe that it probably was mentioned that he could have been on drugs. But, specifically, the phrasing of excited delirium, I don't believe was ever immediately brought up.

A JUROR: I actually have a question, two part question.

MR. SMITH: Okay.

A JUROR: First of all, has he ever seen any of the actual training videos from the police officers at the RPD? And, when he started CPR on Daniel, he didn't question that either. When he was told what to do, was he concerned about that harming him more knowing it wasn't right?

MR. SMITH: Okay. I can ask those questions. Sure.

BY MR. SMITH:

Q. As you've heard, Mr. [redacted], one of the grand juror's first question is whether or not you've ever had the opportunity or occasion to review the Buffalo Police Department's --

A JUROR: Rochester.

Q. -- the Rochester Police Department's training policies or training videos respective to defensive tactics?

A. No.

Q. And then, secondly, Mr. [redacted] one of the grand jurors wanted to know whether or not you had a concern about performing CPR while Mr. Prude was handcuffed? And, I guess, I'm going to break that down into a

couple of questions and make sure it answers the grand juror's question. Is it ideal, and I think you answered this, but is it ideal to do CPR, chest compressions while someone is handcuffed behind their back?

A. Absolutely not.

Q. Is it better than no CPR at all?

A. I would assume, yes.

Q. Is the concern with the handcuffing behind the back that it's ineffective or that it could hurt the person?

A. More that it's ineffective.

MR. SMITH: Did that answer your question. Do any of the grand jurors have further questions for Mr. [redacted]?

MS. SOMMERS: I have just -- I apologize. I'm not -- there seems to be kind of, watching the video, just a -- a lack of sort of, swiftness or appreciation of the gravity maybe or the potential gravity of the situation, and I'm just wondering, were you -- because you mentioned that you were alarmed and shocked when you arrived on scene, and I'm just wondering perhaps, why you didn't sort of move a little bit faster?

THE WITNESS: Well, we're taught to handle

emergencies by remaining calm. And, if you're not calm, you're not ever going to be effective. You can -- and, this is how I would handle things. Is you can internally say, well, that's alarming, but you have to remain with a poker face and you have to be able to address these things. Running around and -- and doing things of that nature, I don't think will help anyone. It would most likely increase the, you know, amount of risk tied with what you're doing and the likelihood of some sort of adverse outcome associated, you know, with making a mistake.

The gravity of the situation is never lost with me in these types of situations. It's -- it's ever apparent that these are people's lives that many times have been lost and that's why it's such a pressing event. The gravity of that's never lost on me. But, would I ever rush or try to move with an increased haste because of that, no, because I can trust my training and I know what to do in -- in situations when -- when I'm presented with them. And, if I rush, it's only going to be more dangerous for me and less advantageous to the patient.

So, if you thought that I wasn't moving with regard, I -- I would question that because I think much of what I do is well thought out and calculated

from the beginning. I try to always keep my -- my hands busy whenever I was an EMT. I always felt that -- that if I wasn't doing something, most of the time I felt like I was doing something wrong, but I never did something, you know, crazy aggressive fast because of the situation itself. So, yeah.

BY MR. SMITH:

Q. Mr. [redacted], is transporting a 941, mental health arrest psych patient, an acute medical emergency?

A. Well, I think you need a little bit more information about what that is because a 941 can be very broad.

Q. Let me ask it another way. Prior to the cardiac arrest, was the scene that you arrived at, did you perceive that to be an acute medical emergency, Mr. [redacted]?

A. A medical emergency, yes. Acute, as in needing direct interventions, specific to ensure, you know, life, I would say no.

Q. Did that change after Mr. Prude's change in condition.

A. Yes.

MR. SMITH: Any further questions?

MS. SOMMERS: I have one more.

Are you aware, based on your own training

and experience, that individuals who are suffering from or appear to perhaps be suffering from excited delirium syndrome can rapidly devolve into cardiac arrest? Were you aware of that back in March?

THE WITNESS: I would say I was aware that, you know, a lot of these psychiatric events that are tied to -- to drugs can divulge into, you know, some sort of life threatening event. I was not as well versed that excited delirium itself could rapidly change into something like a cardiac arrest.

MS. SOMMERS: Thank you.

MR. SMITH: [redacted]?

A JUROR: I don't know. Was there actually foam on the stretcher; and, if so, why would be doing CPR on the foam stretcher different than anything else.

THE WITNESS: You're entirely correct. There is a mattress on the stretcher and it does impede our, you know, CPR to some ability. The same way, a hospital stretcher has a mattress and, in some way that does impede it. But, to -- if you put your hands behind your back, you can feel that you're -- you're kind of putting all that pressure on your shoulder blades and if you press down on your chest, it will move your chest as itself, so it will move

your chest like this, but you want, when you're doing CPR, to naturally do like this so your back doesn't move. So, the bigger issue of, it's not a flat, a firm surface, is a greater issue than, you know, it being a softer surface, if you understand what I'm saying.

MR. SMITH: Did that answer the question?

A JUROR: Yes.

MR. SMITH: Do any of the other grand jurors have any other questions for Mr. [redacted] Seeing as there are none, you are excused. Thank you.

THE WITNESS: Thank you.

(Whereupon, the witness left the Grand Jury room at a time of 2:44 p.m.)

(Discussion off the record.)

(Proceeding reconvened.)

MR. Smith: Everybody, we're going to call Sergeant [redacted].

(Whereupon, the witness entered the Grand Jury room at a time of 2:47 p.m.)

S G T. [redacted] [redacted] after being duly called and sworn, testified as follows:

EXAMINATION BY MR. SMITH:

Q. Good afternoon, sir.

A. Good afternoon.

Q. Could you state and spell your first and last names for the record, please?

A. [redacted]

Q. How are you employed, Sergeant [redacted]?

A. As a Sergeant with the City of Rochester Police Department.

Q. And, how long been employed with the Rochester Police Department?

A. 24 years, two months.

Q. How long as a Sergeant?

A. 12 years.

Q. What is your current assignment, sir?

A. I'm the Sergeant assigned to the Research and Evaluation Section.
Q. Could you just explain for the grand jurors what the Research and Evaluation Section does?
A. Primarily we deal with departmental policy, some training and I oversee our New York State Division of Criminal Justice Services Accreditation Program, along with a variety of other tasks.
Q. Do you have any other roles or duties at the Rochester Police Department, sir?
A. Yes, sir.
Q. What are those?
A. I'm the Commander of our Hostage Negotiation Team, Commander of our Crisis Intervention Team and Commander of our Domestic Abuse Response Team.
Q. I want to ask you some questions, Sergeant [redacted] about the Crisis Intervention Team?
A. Yes, sir?
Q. What is it first of all?
A. It is an abbreviated version of the definition of the team of specially trained officers that voluntarily participate and the primary purpose is to respond to calls involving people in crisis based on primarily mental health, substance abuse or emotional distress.

Q. We'll break that down a little bit. I'm just wondering if you could explain for the grand jurors, give them a sense of, briefly, how the CIT Team came to be in the Rochester Police Department; how it was formed, when and by whom?

A. In 2002, Rochester Police had several in-custody deaths that were primarily considered to be people that were in an emotional or mental health crisis. So, the command at that time formed a fairly large committee composed of law enforcement, social service agencies, medical professionals, hospitals, probation, et cetera, and the court system. They met, they decided that more training was needed. They based a lot of their recommendations on something called the Memphis Model, which is where crisis intervention began back in the 80's and came up with the concept for what was then called the Emotion and Disturbed Person Response Team. That team still exists, we just changed the name about three years ago to Crisis Intervention Team.

Q. What is the end goal or the purpose of the Crisis Intervention Team?

A. The end goal is to -- for -- ensure the safety of the members, officers, the public and the, what we call them, the ED, the emotionally disturbed person

that in any incident which resolved safely and preferably with no harm to anybody involved.
Q. How does an officer in the CIT Unit differ -- or how would they handle an incident than just a regular patrol officer, sort of, what's the difference in the training between the outcomes?
A. CIT Officer. First, you said the CIT Unit, we do not have a Unit. At least in the Police Department, we are not allowed to call it a Unit.
Q. Your secret is safe here, sir.
A. A Unit would be a full-time assignment. CIT is a part-time assignment and we do --
Q. We'll get to that.
A. -- during normal duties. CIT has -- a CIT member volunteers and then goes through a 40 hour training, we give then additional tools when dealing with people in crisis.
Q. What are some of those tools?
A. One is knowledge to recognize symptoms of a person in crisis. An example being what symptoms of someone that might be a schizophrenic might exhibit. Those are usually verbal, physical and environmental clues. They are -- they interact with individuals that have mental health issues. During this school for family members of those people to give a better

idea of what their interactions with law enforcement have been. We bring in the medical professionals, or mental health professionals to get more information about hospital procedures, resources that are available in the community and we teach de-escalation or communication tools.

Q. What is de-escalation, Sergeant [redacted]

A. De-escalation is a -- a tool to preferably, peacefully, resolve an intense situation.

Q. What does it involved; what is the tactic or technique?

A. We base it on what is called the FBI behavioral modification stairway which, in essence, is we try to build a rapport with the individual. For lack of a better term, by making small talk. And there are some things that we teach, questions to ask, things to say, things not to say, and how to say things. But, there's also things like, body language, things of that type that help us to, kind of, form a relationship with the individual that's in crisis. But, doing that we -- again, I apologize for saying this again, for lack of a better term, we are able to establish control over that person, not physical. And, to get them to do what we want so that we can resolve the situation without force.

Q. That's the goal?
A. Yes.
Q. I believe you had said some of this stuff, Sergeant [redacted] I'm probably going to be a little repetitive here, but do members of the CIT Team receive any specialized training?
A. We call it the -- the 40 hour basic course.
Q. What are the contents of the 40 hour course, generally?
A. The first day covers diagnoses. So, we go through in a broad scope, the various mental health diagnoses; schizophrenia, depressions, personality disorders, psychosis, things of that nature. And, as I mentioned before the characteristics to look for when you're dealing with somebody, they're not taught to diagnose, they're taught to recognize symptoms. They're taught a lot on excited delirium, dealing with veterans, on dealing with juveniles, on dealing with senior citizens.
Q. Is there any specific training on de-escalation, Sergeant [redacted]
A. The block -- it's not called de-escalation, it's called communication skills. But, yes.
Q. You mentioned excited delirium?
A. Yes, sir.

Q. The CIT Team members are given some specialized training on excited delirium?
A. There is one block on it.
Q. Tell us what is in the block, Sergeant [redacted]?
A. It's a half hour to 45 minutes class. It -- it covers what to look for with someone that potentially is suffering from excited delirium. The -- the way they're speaking, obviously, the physical behaviors, some of the things that the individual might do, and how to interact with them safely in a nutshell.
Q. That's -- that's training extra and above, again, what's given to them, them being the officers in the Academy?
A. Yes, sir.
Q. And, again, this specific CIT training in awareness and identifying psychiatric conditions, drugs, excited delirium, again, over and above what's given in the Academy to the recruits?
A. Yes, sir.
Q. Sergeant [redacted] I think it follows then to receive these trainings, you have to be a member of the CIT Team?
A. Yes, sir.
Q. How does one become a member of the CIT Team?
A. Our procedure -- I can't speak to other law

enforcement agencies. But, our procedure is that I will, usually once a year, we call it posting, put out our announcement saying we're going to conduct this school and anybody that meets some loose criteria, number of years on the job, internal affairs history, we call it PSS history, sick time, and Supervisor recommendations. As long as they meet those things that I review, and as long as they can be spared personnel wise from their assigned platoon, they -- they can go to the school.

Q. Voluntary?

A. Yes, sir.

Q. Okay. I just want to ask you about some specific officers, Sergeant [redacted] Is Officer, Rochester Police Office, [redacted] on the CIT Team?

A. No, sir.

Q. Is Officer [redacted] on the CIT Team?

A. No, sir.

Q. Is Officer [redacted] --

A. No, sir.

Q. -- on the CIT Team.

A. No, sir.

Q. [redacted]?

A. No, sir.

Q. Sergeant [redacted]

A. No, sir.
Q. So, is it fair to say that some of that training, that special training that you had just discussed, those officers would not have received?
A. They have not.
Q. I want to ask one more question about the excited delirium training, Sergeant [redacted] Do the CIT Team members, when they're trained about excited delirium, received any special training regarding the vulnerability of people who may be experiencing these symptoms to certain things, like, positional asphyxia?
A. Briefly. Part of it is the medical aspect of it.
Q. Sort of, what generally is that training?
A. Primarily, that we teach that if someone is potentially suffering from excited delirium, get medical treatment as soon as possible, if not, immediately. It is vital due to the body overheating, and that can result in cardiac issues.
Q. Sergeant [redacted] how does the CIT Team get activated; how is it that a CIT Team member comes to respond to an incident?
A. There's two or three different ways. The primary way is that we have a general order that covers the Team, and that general order specifies that and working with the 911 call Center, that if a person is

actively threatening or attempting to commit suicide, that a CIT Team officer should be dispatched by 911. But, there are other ways. Someone could call and request a CIT Team officer. Or, I frequently get requests from various agencies, mental health providers and so on, that if a CIT Team officer is available to go by with one of our facet workers, one of the FIT Team or any of the other agencies that go out in the field with them to check on a person, or to complete their paperwork, which is for a 945 or a 960 mental hygiene detention.

Q. Sergeant [redacted] do the CIT Team, Crisis Intervention Team, operate 24 hours a day, 7 days a week?

A. Kind of.

Q. Tell me?

A. Because it is a voluntary assignment, we cannot dictate where the officer can work. So, if I trained an officer that currently works on the first platoon, our midnight shift, and three months later he transfers to days, I can't say that he cannot do that. That's by contract, we're not allowed to do that. So, in theory, yes, but in practice, we can't guarantee. And, also, you have to toss in sick time, vacation time, things like that, where it might take people off

their normal shifts.
Q. Is it fair to say, Sergeant [redacted] that there's certainly not a question that there could be shifts at the Rochester Police Department where there is no CIT Team member on duty?
A. Correct.
Q. And, do you know, specifically, sir, if you know, whether or not there was any Crisis Intervention Team members on duty in the vicinity of 3:00 a.m. to 3:30 a.m. on March 23rd of 2020?
A. I never looked.
Q. You mentioned the FIT Team, sir?
A. Yes, sir.
Q. And, could you tell the grand jurors what the Erie County FIT Team is?
A. That one I don't know, but I know the Monroe County one.
Q. I just realized the problem. The Monroe County?
A. Monroe County FIT Team is a subset of the Monroe County Office of Mental Health. It consists currently of five mental health clinicians who work on the road with law enforcement. They only go to calls or houses after being requested by law enforcement. They operate throughout the County. So, what might happen is, I might go on a call, if I think the person

probably needs more services but maybe didn't have to go to the hospital, I would call the FIT Team, say, can you come visit this person and do a better evaluation, as they're a mental health clinician and I'm am not. And, they can then track that then with further appointments with a mental health provider or any of the social services that are out there that we don't have the capacity to do so.

Q. Are you aware, sir, of when the Monroe County FIT Team operates?

A. Yes, sir.

Q. When?

A. Monday through -- currently, Monday through Friday from approximately 8:00 a.m. to 10:00 p.m.

Q. So, with that in mind, do you know whether or not the FIT Team was available at 3:30 in the morning on March 23rd, 2020, which was the early morning hours on a Monday?

A. They would not have been.

Q. Now, sir, based on all your multiple roles at the Rochester Police Department, do you also have the occasion to teach at the Police Academy?

A. Yes, sir.

Q. And, what sort of subjects do you teach on?

A. Obviously, mental health related topics, hostage

negotiations topics, communication skills, domestic violence and officer willingness.

Q. And, Sergeant [redacted], when you teach the new recruits about emotional distress and psychiatric issues, is there any training about excited delirium during that portion?

A. Yes.

Q. How much?

A. One power point slide.

Q. Sir, showing you what's been marked as Grand Jury Exhibit 51, which is a nine page document that's double sided. I want to ask if you recognize that?

A. Yes, sir.

Q. What do you recognize that to be?

A. This is one lesson from the recruit curriculum.

Q. And, is this the lesson that you give to the recruits at the Police Academy?

A. Yes, sir.

Q. And, is this a curriculum that you created, sir?

A. No, sir.

Q. Who created that curriculum?

A. The Department of Criminal Justice Services.

Q. And, this Exhibit again, Grand Jury Number 51, this is an exact copy of the power point that you give to the new recruits in the Academy on emotional

distress?
A. Yes, sir.
MR. SMITH: At this time, I'm going to offer Grand Jury Number 51.
(Whereupon, Grand Jury Exhibit Number 51 was then received into evidence.)
BY MR. SMITH:
Q. I'm now going to publish for the Grand Jury, Grand Jury Exhibit Number 51, specifically -- display specifically, page 4. Direct your attention, sir, once this is on, and the Grand Jury's attention to slide number 22, do you recognize what's on the screen, Sergeant [redacted] -- or, can you see it?
A. Yes, sir.
Q. And, it this the slide that grand -- that the new recruits get in the Academy as it relates to excited delirium?
A. Yes, sir.
Q. And, is this the only training that the recruits get in the Academy as it relates to excited delirium?
A. I go into a little bit greater detail, but it's not part of the actual curriculum.
Q. And, this is the part of the curriculum that you teach?
A. Yes, sir.

Q. Can you read what's on the screen on slide 21, Sergeant [redacted]?
A. The state of extreme mental and physiological excitement characterized by extreme agitation, hypothermia, hostility with exceptional strength and endurance without fatigue. Many similarities from an emotionally distressed person. The significant difference is that they may be under the influence of an unknown substance or synthetic drug.
Q. Is there any indication on that slide, Sergeant [redacted] that individuals experiencing this condition or these symptoms may be particularly vulnerable to suffer sudden death or cardiac arrest?
A. No.
Q. One final question, Sergeant [redacted] I understand that there's training that relates to identification and awareness and de-escalation that the CIT Team members get. But, sir, is the goal, even when a CIT Team member responds or maybe especially to one of these incidents, is the goal notwithstanding de-escalation, still to get the individual medical treatment as soon as possible?
A. If necessary, yes, sir.
MR. SMITH: I have no further questions for Sergeant [redacted]. Do any of the grand jurors have any

questions?

A JUROR: Just one. They're trained in mental health issues, who trains them?

THE WITNESS: The New York State Department, Division of Criminal Justice Services conducts a trained to trainer that you have to successfully complete before you can teach pretty much any subject at the recruit level in the Academy.

A JUROR: Trained by a physician?

THE WITNESS: DCJS personnel.

MR. SMITH: Could you just explain, Sergeant [redacted] for to the grand jurors what DCJS is.

THE WITNESS: State agency that oversees law enforcement training. As to their credentials, I couldn't tell you. I apologize for that. I know the curriculum was developed with medical and mental health professionals, but in terms of the trained to trainer instructors, that I don't know.

BY MR. SMITH:

Q. I guess, Sergeant [redacted] a follow up would be regarding, specifically, excited delirium, where did you learn, sort of, what -- what is it that you teach to the recruits in the Academy?

A. Personal experience.

Q. How about in terms of the underlying medical

information, sort of, related to excited delirium?
A. Between the class, my teaching partner, reading articles on it.

MS. SOMMERS: Do you ever attend training with or sponsored by the New York Association for Mental Illness or NAMI or any of those types of agencies?

THE WITNESS: I have been to trainings across the country. Primary organization is the Crisis Intervention Team International Organization. That's an umbrella organization of law enforcement, mental health professionals and groups like NAMI that you mentioned. So, it's a conference on a variety of topics and almost every one that I've attended, I've sat through a class or a seminar on excited delirium.

MS. SOMMERS: Thank you.

A JUROR: Why does the block or topic get added to the CIT training?

THE WITNESS: I'm sorry, I couldn't hear you.

A JUROR: Why does the block or topic get added to the CIT training?

THE WITNESS: Primarily, either my co-teacher or myself decided that it's something missing from the curriculum. Whether it be because an

event that's occurred or that we've researched or something of that nature.

A JUROR: So, excited delirium has come up in the daily routine of a police officer and is incorporated into the CIT training, was thought to be important?

THE WITNESS: Primarily, because my experience with it is why I thought it was important.

BY MR. SMITH:

Q. Sergeant [redacted] what was your experience with it that you referred to?

A. In 2002, I responded to a call with someone who was later diagnosed or described as suffering from excited delirium, where the individual died in our custody.

Q. That was the impetus for you to get involved with this, Sergeant [redacted]?

A. That, and a -- a family member with extensive mental health issues.

MR. SMITH: Do any of the grand jurors have any further questions?

MS. SOMMERS: To your knowledge, Sergeant [redacted], was the 2002 incident the last one that you are aware of, where an individual was manifesting symptoms of excited delirium and died?

THE WITNESS: Yes, ma'am.

MS. SOMMERS: Is it your understanding that these incidents are relatively, and by -- I'm -- I'm air quoting relatively, for the record, rare?

THE WITNESS: Extremely.

MS. SOMMERS: Okay. But, significant enough to be taught in CIT training?

THE WITNESS: For a variety of reasons, yes.

MS. SOMMERS: Is primary among them wanting to try to do everything to avoid a loss of life or injuries to everybody involved?

THE WITNESS: Yes.

MS. SOMMERS: Anybody --

MR. SMITH: Do any one of the grand jurors have any other questions? Seeing as there are none, you are excused. Thank you.

(Whereupon, the witness left the Grand Jury room at a time of 3:13 p.m.)