

**Special Investigations and  
Prosecutions Unit**

**Report on the Investigation into  
The Death of Troy Hodge**



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## EXECUTIVE SUMMARY

On July 8, 2015, Governor Andrew Cuomo signed Executive Order 147 (the “Executive Order”), appointing the Attorney General as a special prosecutor “to investigate, and if warranted, prosecute certain matters involving the death of an unarmed civilian . . . caused by a law enforcement officer.” On June 16, 2019, Troy Hodge (“Mr. Hodge”) became unresponsive and subsequently died following an encounter with multiple officers of the City of Lockport Police Department (“LPD”) and, to a lesser extent, the Niagara County Sheriff’s Office (“NCSO”). On October 17, 2019, Governor Cuomo issued Executive Order 147.29, expressly conferring jurisdiction on the Office of the Attorney General (“OAG”) to investigate any potential unlawful acts or omissions by law enforcement related to Mr. Hodge’s death.<sup>1</sup>

The review and investigation into this matter by the OAG included:

- Review of NCSO body worn camera footage from scene;
- Review of civilian cell phone video;
- Review of all reports and audio recordings of police and dispatch communications, including all communications to, from, and between LPD, NCSO, Twin Cities Ambulance, and the Lockport Fire Department (“LFD”);
- Review of all LPD and NCSO paperwork, reports, and depositions generated in connection with this incident;
- Interviews with all LPD, NCSO, and LFD members at the scene during the incident;
- Interviews with the ambulance personnel involved in the incident;
- Interviews with all identified civilian witnesses;
- Review of forensic reports, including DNA analysis;
- Review of relevant medical records and history, including the records from Twin Cities Ambulance and Eastern Niagara Hospital related to the incident;
- Review of autopsy and toxicology report from the County of Erie Office of the Medical Examiner; and
- Consultation with a private forensic pathology expert to review the autopsy report and findings.

On the night of June 16, 2019, LPD officers were dispatched to the home of Mr. Hodge’s mother after she called 911 and reported that her son was exhibiting erratic behavior. LPD Officer Daniel Barrancotta (“PO Barrancotta”) was the first officer to arrive on scene, followed shortly thereafter by LPD Officer Marissa Bonito (“PO Bonito”). Mr. Hodge was in the driveway and as PO Barrancotta approached him, Mr. Hodge stated he did not believe that PO Barrancotta was a real officer. Mr. Hodge then announced that people were after him and he needed to get his shotgun, before moving quickly towards the side entrance door of his mother’s home. When PO Barrancotta stepped in to prevent Mr. Hodge from entering the home and retrieving a gun, he observed a knife in Mr. Hodge’s hand. According to the officers, Mr. Hodge freed himself from PO Barrancotta’s grasp and grabbed PO Bonito, holding her in a headlock and attempting to move the knife toward her head. POs Barrancotta and Bonito were eventually able to dislodge the knife

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<sup>1</sup> Executive Order 147.29 is attached as Exhibit 1.

from Mr. Hodge's hand using physical force, but they were not able to restrain Mr. Hodge until other LPD officers, and eventually NSCO deputies, arrived on scene to assist.

Following a lengthy struggle, Mr. Hodge was eventually handcuffed. He initially remained vocal, although his words continued to appear confused, paranoid, and delusional. Minutes later, however, as Mr. Hodge remained on the ground and the ambulance was arriving on scene, Mr. Hodge was found to be unresponsive. Despite lifesaving efforts performed by the ambulance personnel and officers at the scene, Mr. Hodge could not be resuscitated. He was transported to a hospital, where he was ultimately pronounced dead.

The medical examiner subsequently identified the cause of Mr. Hodge's death as: "[s]udden death associated with acute cocaine intoxication and prolonged physical altercation." While the medical examiner took note of "multiple blunt force injuries of the skin, subcutaneous tissues, and muscles on the head torso, and extremities," she opined that those injuries did not contribute to Mr. Hodge's death. The medical examiner deemed the manner of death to be "homicide," because the responding officers were involved in a physical interaction with Mr. Hodge; she explicitly noted, however, that the homicide designation did not imply that there was an intent to cause injury or that excessive force was used. The OAG retained and consulted with a private forensic pathology expert to review the autopsy report and findings, and upon review, that expert agreed with the cause of death as determined by the medical examiner.

Having completed its investigation of this incident, the OAG has concluded that there is insufficient evidence to establish that a crime was committed by any of the officers involved. Beyond not being able to prove beyond a reasonable doubt that the actions of the responding officers specifically caused Mr. Hodge's death in light of the autopsy findings, the OAG has concluded that it cannot prove beyond a reasonable doubt that the force employed against Mr. Hodge was unreasonable under the circumstances.

Although the OAG does not find criminal liability, this incident did raise significant concerns about certain aspects of the police response, and we offer recommendations to address them. First, we recommend that the LPD strongly consider abandoning its dispatching operations and allowing the NCSO's dispatch center to cover all 911 calls in the city of Lockport. Notably, the ambulance was significantly delayed in its arrival at the scene due to communications issues between the LPD and NSCO dispatchers. Second, we recommend that all law enforcement officers, dispatchers, and emergency medical personnel be trained to recognize the constellation of symptoms Mr. Hodge displayed as a potential medical emergency and to respond accordingly. Finally, we recommend that LPD modify its use of force policy. Although we cannot know whether these recommendations could have saved Mr. Hodge's life if they had been implemented before this incident, they can reduce the likelihood that similar tragedies might occur in the future.

## BACKGROUND

### Initial Communications with Law Enforcement

Troy Hodge was a 39-year-old resident of Lockport, New York, with a history of substance abuse, stemming from a vehicle accident and the subsequent prescription of opioids.<sup>2</sup> He lived with his longtime girlfriend and their 14-year-old daughter; his mother lived nearby. Shortly after 11:00 pm on June 16, 2019, after a day in which his girlfriend described his demeanor as increasingly paranoid in nature, Mr. Hodge went to the home of his mother, Fatima Hodge (“Ms. Hodge”) at 217 Park Avenue in Lockport. There, according to his mother, Mr. Hodge was hallucinating and insisting that people were at her home and coming for him.

At 11:36:47 pm,<sup>3</sup> the NCSO 911 system (“NC-911”)<sup>4</sup> received a call from Mr. Hodge’s cell phone. The dispatcher, Jennifer Ketch (“Disp. Ketch”), answered and could hear some sort of argument between, based on what she could discern from audio cues, a mother and son; however, nobody spoke into the phone. The connection was lost at 11:38:00 pm, but seconds later another call came in from Mr. Hodge’s cell phone.<sup>5</sup> This call was shorter than the first. During both calls, Disp. Ketch repeatedly asked for the address of the emergency, but nobody ever spoke into the phone. After the second hang-up from Mr. Hodge’s phone, Disp. Ketch reverse-called the number and received Troy Hodge’s voice mail. Using technology available at NC-911, Disp. Ketch was able to pinpoint the location of the cell phone caller as 213-217 Park Avenue in Lockport.

In the meantime, Mr. Hodge had walked out of his mother’s house and into her driveway. At that point, Ms. Hodge called 911 from her landline; that call, however, was not routed to the NC-911 system (where Disp. Ketch worked), but to a separate 911 system operated by the Lockport Police Department (“LPD-911”).<sup>6</sup> The existence of these dueling 911 systems would ultimately prove to be a major cause of the flawed emergency response in this case. Ms. Hodge’s call reached an LPD-911 dispatcher, Police Officer Aric Morgan (“PO Morgan”), at 11:38:55 pm. Ms. Hodge repeatedly implored PO Morgan to send someone to her home, saying that her son was not himself and was experiencing an issue with his medicine. As PO Morgan spoke to Ms. Hodge, another LPD-911 dispatcher, Police Officer Brent Russell (“PO Russell”), broadcast over the radio that an officer was needed at 217 Park Avenue for “some type of medical condition.” He did not indicate that the matter reportedly involved an issue with medication.

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<sup>2</sup> Tragically, Mr. Hodge was referred to a pain management specialist after a 1998 motor vehicle accident; that physician was subsequently prosecuted by the United States Attorney’s Office for the gross over-prescription of opioids (see <https://www.wkbw.com/news/local-news/dr-gosy-trial-takes-surprise-turn-with-plea-deal>). Mr. Hodge struggled with intermittent substance abuse from that time on.

<sup>3</sup> All times referenced in this report have been calibrated to the Niagara County Sheriff’s Office’s 911 time-stamp.

<sup>4</sup> The NCSO maintains the County Communications/911 Center (NC-911) through which nearly all emergency calls in Niagara County are processed.

<sup>5</sup> It is unclear how these two 911 calls came to be made from Mr. Hodge’s cell phone, whether or not they were intentional, or (if intentional) what prompted them.

<sup>6</sup> The LPD maintains LPD-911, a separate dispatch center, within the police department. If a person in the City of Lockport calls 911 from a landline phone, the call is routed to LPD-911. However, if that person calls 911 from the same location using a cell phone, the call is routed to and processed by NC-911, because LPD-911’s outdated technology cannot process cellular data.

At the same time, Disp. Ketch had been in the process of calling LPD-911 herself, to ask that an officer be dispatched to the area of 213-217 Park Avenue for what appeared to her (based on the calls from Mr. Hodge's cell phone) to be a domestic dispute. As she was waiting for LPD-911 to answer her call, she heard PO Russell over the radio asking for a car to respond to 217 Park Avenue for a medical condition.<sup>7</sup> PO Morgan then answered Disp. Ketch's call and the two engaged in the following dialogue:

Disp. Ketch: Did I just hear you guys give something out on Park Ave.?

PO Morgan: 217. Yeah. 217 Park Avenue. We're trying to get information. Some type of medical condition. So start rescue [ambulance] to that location.

Disp. Ketch: OK. Alright. Do you want them staged or right to the scene?

PO Morgan: Just respond to the location.

Disp. Ketch: OK. 217 Park Ave.?

PO Morgan: Yes.

PO Morgan then appeared to hang up the phone.

In a subsequent interview with OAG staff, Disp. Ketch said that she had intended to advise PO Morgan that she had received cell phone calls from the location and believed the incident to involve a domestic dispute, but before she could do so PO Morgan hung up on her. Nonetheless, because she was aware that the incident might involve a domestic dispute, and therefore a potentially unsafe scene, she took it upon herself to dispatch Twin City Ambulance (TCA), as well as the Lockport Fire Department ("LFD")<sup>8</sup> with directions to "stage" in the area of 217 Park Avenue.<sup>9</sup>

At 11:40:49 pm, unaware that Disp. Ketch had directed fire and ambulance to "stage" near the scene, rather than respond to the scene directly, PO Morgan advised the first responding LPD officer that fire and ambulance would be "responding" to the call as a precautionary measure.

Just over four minutes later, Disp. Ketch contacted LPD-911 (again) and notified PO Russell that the ambulance was "staged" in the area of 217 Park Avenue, thereby advising LPD-911 (albeit indirectly) that she had disregarded PO Morgan's directions to have the ambulance respond to the scene. However, PO Russell did not pass that information on to the on-scene

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<sup>7</sup> While NSCO and LPD maintain separate 911 dispatch centers, NCSO-911 dispatchers have access to the same police radio frequency as the LPD-911 dispatchers, However, LPD-911, not NCSO-911, is exclusively responsible for dispatching LPD police officers.

<sup>8</sup> Members of the LFD are routinely dispatched to calls that may involve medical treatment. LFD members are equipped to provide life support measures and often assist police and ambulance personnel. However, the LFD rig is a firetruck, and not an ambulance.

<sup>9</sup> "Staging" is the standard practice of having EMTs and other responders wait outside of a potential zone of danger (rather than respond directly to the scene) until law enforcement confirms that it is safe to enter.

officers or to PO Morgan, later noting that it had been overlooked due to the chaos occurring at the time.

The result of these miscues was that the TCA ambulance was staging .2 miles from Ms. Hodge's driveway awaiting directions from the on-scene officers to enter the scene.<sup>10</sup> However, the on-scene officers, believing that the ambulance and LFD had been instructed to respond directly to the scene, and their beliefs reinforced by LFD's presence at the scene, were unaware that the ambulance was nearby and waiting for word that the scene was safe to enter.

### Encounter with First Responding Officers

LPD Patrol Officer Daniel Barrancotta was on routine road patrol when he received a dispatch from LPD-911 requesting that he respond to 217 Park Avenue for "some type of medical condition." At approximately 11:40:49 pm, as PO Barrancotta was arriving at Ms. Hodge's home, PO Morgan advised him that Twin City (Ambulance) and LFD were also responding.

Ms. Hodge's home (217 Park Ave.) shares a driveway with 213 Park Avenue.<sup>11</sup> A photograph of both houses (217 is on the left), with the shared driveway running between them, is below.



In a later interview with OAG staff, PO Barrancotta said that the extent of his knowledge of the call when he arrived on scene was that a person at the location needed medical assistance, which generally meant some sort of heart condition or other physiological problem, that fire and ambulance were responding to the scene, and that Patrol Officer Marissa Bonito would also be responding.<sup>12</sup> As he made his way up the driveway, PO Barrancotta saw a female (later determined

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<sup>10</sup> It was emblematic of the confused nature of the emergency response that, although NC-911 directed LFD to stage along with the ambulance, the two-member LFD rig disregarded NC-911's directions to stage and proceeded directly to the scene.

<sup>11</sup> The residents of 213 Park Ave., B.L. and A.L., were present in their home on the night of the incident. These neighbors heard, but did not see, the events of that evening, and provided sworn statements to OAG staff to that effect.

<sup>12</sup> PO Bonito had been at LPD assisting with a booking matter when Lieutenant David Pytlik ("Lt. Pytlik") called LPD dispatch to ask about the medical issue at 217 Park Avenue; one of the dispatchers told him (for reasons unclear) that

to be Ms. Hodge) and a younger male (later determined to be Mr. Hodge) at the back of the driveway near the garage. PO Barrancotta said that the female was visibly upset and appeared to be trying to calm the younger male; at that point, he assumed (wrongly) that the pair was awaiting medical assistance for, and concerned about, someone inside the home.

According to PO Barrancotta, Ms. Hodge approached him and said that Mr. Hodge was her son and needed help, because he believed someone was after him. At that point, PO Barrancotta, who had, in 2017, successfully completed Crisis Intervention training aimed at teaching verbal de-escalation tools for use in situations involving people in emotional crisis, tried to obtain more information from Ms. Hodge; he did not approach Mr. Hodge, saying he intended to keep space between them in order to gain time, formulate a plan, and avoid further agitating Mr. Hodge.<sup>13</sup>

At that point, PO Barrancotta said he observed that Mr. Hodge had a flashlight in his left hand, and appeared to be looking for something; Mr. Hodge also appeared to be holding something in his right hand, although PO Barrancotta could not, at that point, determine what it was.<sup>14</sup> Mr. Hodge then grew more upset and told his mother that PO Barrancotta was a “fake police [officer],” prompting PO Barrancotta to shine his flashlight on himself to illuminate his uniform; PO Barrancotta said he then told Mr. Hodge that he was a real officer who was there to help him.

At this time, approximately 11:42:25 pm, PO Bonito, who had been dispatched from the LPD station house approximately half a mile away, arrived on scene. In a later interview with OAG staff, she said that as she walked up the driveway, she saw Mr. Hodge and heard him making statements about “fake police,”<sup>15</sup> and that PO Barrancotta appeared to be trying to verbally de-escalate the situation without success.

According to PO Barrancotta, Mr. Hodge began to make statements indicating that other people were there, and that he needed to get his shotgun, before moving quickly toward the landing and side door of 217 Park Ave. PO Bonito likewise recounted that Mr. Hodge then said words to the effect of, “I need to get [my shotgun],” and ran toward the side door of the home. Not wanting Mr. Hodge, in what appeared to be a delusional condition, to retrieve a shotgun or any other type of weapon from inside the home, PO Barrancotta said he intercepted and grabbed Mr. Hodge by the back of his sweatshirt to prevent him from entering the house.

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a person at the residence had taken an unknown quantity of pills. At that point Lt. Pytlik directed PO Bonito to join PO Barrancotta on the call.

<sup>13</sup> A hallmark of communications-based de-escalation programs is “the strategic slowing down of an incident in a manner that allows officers more time, distance, space, and tactical flexibility during dynamic situations.” <https://www.justice.gov/opa/pr/justice-department-applauds-adoption-police-department-wide-tactical-de-escalation-training>.

<sup>14</sup> In an interview with OAG staff, Ms. Hodge said that when he initially arrived at her house minutes before the police encounter, Mr. Hodge was holding his cell phone – with the flashlight on – in his hand. Ms. Hodge further said that Mr. Hodge was still holding his cell phone in his left hand when the encounter with PO Barrancotta began, while holding his keys in his right hand.

<sup>15</sup> In her account, Ms. Hodge also stated that when PO Barrancotta identified himself as a police officer to Mr. Hodge, Mr. Hodge told her the officers were not the “real police” and were “fake police.”

There is no body-worn camera (“BWC”) footage of PO Barrancotta’s and PO Bonito’s interaction with Mr. Hodge.<sup>16</sup> However, starting at 11:43:21 pm, approximately one minute after PO Bonito’s arrival on scene, J.S. – a neighbor who lived across the street from the Ms. Hodge’s house – began to record the encounter on his cell phone.<sup>17</sup> Although the officers and Mr. Hodge are not visible on J. S.’s footage, due primarily to the angle of J.S.’s vantage point relative to the location where the officers and Mr. Hodge were, it does capture audio.<sup>18</sup>

This recording in large measure tracks the account provided by PO Barrancotta and PO Bonito. In the opening seconds, Mr. Hodge can be heard yelling, “Mom don’t let them kill me.” He also references getting into the house and says that “they” have shotguns.<sup>19</sup> During this time, the officers can be heard yelling “stop,” and Ms. Hodge says, “Stop, Troy.” In her own account, provided in an interview with OAG staff, Ms. Hodge’s description of the initial stage of the police encounter is consistent with the narratives provided by PO Barrancotta and PO Bonito – although it does, in connection with the altercation to follow, diverge in one particularly meaningful respect.

According to both PO Bonito and PO Barrancotta, just as PO Barrancotta first put his hands on Mr. Hodge to keep him from entering the house, Mr. Hodge brandished a knife, and their focus abruptly turned to wresting it from him. Based upon the available evidence, it appears that the knife was likely the item that PO Barrancotta noticed in Mr. Hodge’s right hand earlier but had not been able to identify. The officers said that as they tried to take the knife from Mr. Hodge, he attempted to bring it toward PO Barrancotta who prevented Mr. Hodge from stabbing him by grasping Mr. Hodge’s right wrist with both of his hands.

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<sup>16</sup> Pursuant to LPD’s then-existing BWC policy, the only time officers were required to activate their cameras was during traffic stops. Recording of all other events was discretionary, although use of force incidents were to be recorded “where possible.” POs Barrancotta and Bonito believed they were responding to a medical call, not a use of force incident. Furthermore, PO Bonito did not have a functioning BWC, a fact she had previously brought to the attention of the LPD. Patrol Officer Patricia Burdick, who responded after the initial altercation between Mr. Hodge and the officers, was wearing her BWC, but did not turn it on; in any event, she said that Mr. Hodge knocked off her BWC during subsequent efforts to restrain him. (A NCSO deputy retrieved it from the driveway later in the incident.) Lt. Pytlik’s body camera fell off as he was running up toward 217 Park Avenue; he is seen on later footage retrieving the items he dropped. We note that, on October 8, 2019, LPD updated its BWC policy and broadened the scope of required recording to include nearly all police civilian encounters, except when the officer is in locations where there is a reasonable expectation of privacy (such as bathrooms), or situations where individuals are expressing their first amendments rights and not violating any law. The Prior and Updated Body Worn Camera policies are attached (Exhibits 2 and 3)

<sup>17</sup> J.S. provided a signed statement describing the incident during an interview with OAG staff. In it, he said his attention was first drawn to his window when he heard a male voice scream and then yell “don’t let them kill me.” He said he also heard a male voice yelling “drop the knife” and a female voice yelling “stop.” At some point, he eventually heard both the male and female voices yelling, “stop resisting.” The only other thing he recalled hearing was a male voice saying, “they have the shotgun ma, don’t let them kill me.”

<sup>18</sup> The video may be accessed [here](#).

<sup>19</sup> The audio recording also corroborates the account of B.L. and A.L. (the residents of 213 Park Avenue), who informed OAG staff that during the incident, they heard Mr. Hodge repeatedly yelling “don’t let them kill me” and “don’t let them hurt me.” They also reported hearing Mr. Hodge state “he got a shotgun.... he’s got a gun,” and described hearing police officers telling Mr. Hodge to “stop” and to stop reaching into his pockets (offering that it did not sound as if Mr. Hodge was “listening” to the police).



According to the officers, Mr. Hodge then wrapped his left arm around PO Bonito's neck, catching her in a headlock.<sup>20</sup> PO Bonito said that while in the headlock, she was unable to see what Mr. Hodge was doing with the knife; PO Barrancotta, however, said that Mr. Hodge was trying to bring the knife toward PO Bonito's head but that PO Barrancotta prevented his doing so by holding tightly onto Mr. Hodge's right wrist. PO Bonito described significant pressure on her neck, saying she needed to drop down and rotate her head to keep her airway open. PO Bonito began kicking Mr. Hodge's leg at that point and PO Barrancotta was able to take Mr. Hodge to the ground; during this time, PO Bonito said she was able to free herself. With PO Barrancotta and Mr. Hodge now on the ground, Mr. Hodge still retained his hold on the knife and according to both officers, continued to fight and flail – despite the officers' strenuous efforts to restrain him.

PO Bonito, who had remained on her feet when Officer Barrancotta took Mr. Hodge to the ground, removed her taser from her belt and discharged it in dart-probe mode.<sup>21</sup> According to PO Bonito, she issued a single, five-second burst. But while PO Bonito assumed her deployment was successful, it is not clear that her belief is borne out by the available evidence;<sup>22</sup> in any event, the taser deployment did not have any discernable effect upon Mr. Hodge.

During this portion of the incident, PO Barrancotta said Mr. Hodge tried to bite him. Still holding Mr. Hodge's right hand with his own left hand, PO Barrancotta punched Mr. Hodge in the face with his right hand, but Mr. Hodge still did not release the knife and continued to struggle. PO Bonito said that, in an effort to dislodge the knife, she stomped on Mr. Hodge's hand, at which point he grabbed her leg, tried to bite it, and nearly took her to the ground. Only after PO Bonito kicked Mr. Hodge in the head did he release her leg. PO Barrancotta said that the knife came free from Mr. Hodge's hand at that point, and PO Barrancotta grabbed it and put it into his back pants pocket, where it remained during the remainder of the encounter. The recovered knife is depicted below:

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<sup>20</sup> PO Bonito is approximately 5 feet 1 inch tall and weighs approximately 115 pounds. Mr. Hodge was approximately 6 feet tall and weighed approximately 159 pounds. Every officer interviewed in connection with this incident described Mr. Hodge's strength as extraordinary.

<sup>21</sup> Taser® is the brand name of the electronic control weapon originally sold by Taser International and now sold by Axon. The devices used during this incident (Model X26) can be used in two modes. In "dart-probe" mode, darts are released from the instrument, pierce the skin, and, upon deployment, can cause temporary neuromuscular incapacitation, during which an individual will be unable to move. In "drive-stun" mode two electrodes are pressed directly against the suspect. While drive-stun mode delivers an electric shock, it is a pain compliance technique and does not cause the override of an individual's central nervous system or potential neuromuscular incapacitation.

<sup>22</sup> The tasers used by the LPD at the time of this incident were the Model X26 instruments, which have not been sold by Taser International since 2014. Further, the taser records maintained at the LPD were produced by outdated software, and the instrument assigned to PO Bonito the night of this incident apparently experienced a hardware glitch (related to the records it generates) in or about December of 2017; taken together, those factors made interpreting the taser data challenging. PO Bonito's taser record appears to confirm that she fired her instrument, but it is unclear whether the deployment was successful – i.e., whether the two prongs penetrated Mr. Hodge's skin and conducted electrical current. Although PO Bonito assumed her taser deployment was successful, the ambulance personnel who arrived later in the incident noted that no taser prongs were found in Mr. Hodge's skin. Further, the medical examiner did not reference findings consistent with taser prong penetration in the autopsy report. Based on the totality of the evidence, the OAG cannot determine whether PO Bonito successfully deployed her taser and it had no effect on Mr. Hodge or whether her deployment itself was unsuccessful. No other officer deployed his or her taser.



Again, although it captured no images of the altercation, the civilian cell phone audio captures the sound of PO Bonito's taser deployment at 11:43:55 pm, immediately after which, for about 20 seconds, PO Barrancotta and PO Bonito can be heard repeatedly calling for Mr. Hodge to drop the knife.

While Ms. Hodge, in her account, describes a physical struggle following PO Barrancotta's attempt to keep Mr. Hodge from entering the house, as well as Mr. Hodge being tasered by a female officer after he resisted being handcuffed, she denied that those actions were prompted by Mr. Hodge's brandishing of a knife.<sup>23</sup> Rather, she said the knife PO Barrancotta recovered (which Ms. Hodge acknowledged did belong to Mr. Hodge, and which, she said, he always carried for fishing or work) first appeared when it fell from Mr. Hodge's left side or pocket – after the struggle had already begun. However, the civilian cell phone recording, which captured the contemporaneous, repeated calls by the officers for Mr. Hodge to drop the knife, indicates that Ms. Hodge's account regarding the knife is not accurate.

Once the knife was secured, PO Barrancotta said he tried to use his radio to request additional assistance. At 11:44:27 pm, he can be heard on a recorded radio transmission saying, "Send more cars here asap." LPD-911 was unable to decipher the transmission and asked PO Barrancotta to repeat it. At 11:44:40 pm, PO Barrancotta said, "Get us some cars." These calls for backup are also captured in the cell phone recording.

Although Mr. Hodge was still not restrained, PO Barrancotta said he was physically exhausted by this time and knew he and PO Bonito would not be able to get Mr. Hodge into handcuffs alone. Instead, he said he stayed on top of Mr. Hodge, in an attempt to maintain control of him, until others arrived to help them. PO Barrancotta said that during this time, Mr. Hodge continued trying to roll and get up, and trying to bite him any time his arms or hands were near Mr. Hodge's face. PO Bonito said that Mr. Hodge again grabbed her leg and tried to bite her during this time, and that she kicked him.

At 11:45:38 pm, LPD Patrol Officer Patricia Burdick ("PO Burdick") advised that she was on-scene, followed shortly thereafter by LPD Lieutenant David Pytlik ("Lt. Pytlik"). The civilian

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<sup>23</sup> In her account, Ms. Hodge indicated that Mr. Hodge was holding his cell phone in his left hand and his keys in his right hand before and during the initial police encounter. However, body-worn camera footage, which shows keys being removed from Mr. Hodge's pocket well after he was handcuffed, appears to refute her assertion that Mr. Hodge was holding his keys in his right hand.

cell phone recording does capture images of each of these two officers making their way up the driveway as they arrive. Members of the Niagara County Sheriff's Office began to arrive at approximately 11:48:15 pm.

### Restraint of Mr. Hodge and Aftermath

PO Burdick later told OAG staff that as she ran up the driveway, she heard yelling and then saw PO Barrancotta lying (face down) on top of a man who was lying on the ground, also face down; she said PO Bonito was trying to grab Mr. Hodge's arms, which PO Burdick described as flailing. Despite having PO Barrancotta on top of him and then PO Burdick kneeling on him, PO Burdick said Mr. Hodge continued to lift himself up with his arms. The three officers working together still could not restrain Mr. Hodge. At one point, PO Burdick said Mr. Hodge grabbed her vest and she punched him in the arm; he then grabbed her body camera, which she said she feared he would use as a weapon. PO Burdick said that Mr. Hodge was trying to bite PO Barrancotta and that she struck him in order to get him to stop; Lt. Pytlik arrived at this time.

Working together, the four LPD officers, joined near the end of the process by NCSO deputy Christopher Pino ("Dep. Pino"), were finally able to restrain Mr. Hodge with handcuffs behind his back, although he continued to struggle. By 11:49:19,<sup>24</sup> Mr. Hodge was finally restrained.

Under standard LPD practice, once an individual is in handcuffs, officers on-scene will request that a staging ambulance enter the scene; and indeed, in this case, there was an ambulance at the ready, staging approximately one minute away. However, due to the communications miscue described previously, the on-scene officers were unaware that an ambulance was staged nearby and therefore did not make that request. Rather, believing that an ambulance had been dispatched directly to the scene, they kept awaiting its arrival and ultimately wondered why it was taking so long to arrive.<sup>25</sup>

At 11:49:19 pm, NCSO Deputy Joshua Austin ("Dep. Austin") arrived on the scene, followed at 11:50:20 pm by NCSO Deputy Edward Finley ("Dep. Finley"). Both NCSO deputies were equipped with body-worn cameras and much of the subsequent interaction with Mr. Hodge is therefore captured in video footage ["The BWC footage"]<sup>26</sup> and may be accessed [here](#).

At the time of the deputies' arrival, the officers were outside the door of 213 Park Ave. with Mr. Hodge lying in the prone position in the driveway, hands restrained behind his back. Dep. Pino and PO Burdick were at Mr. Hodge's lower body (Dep. Pino essentially at Mr. Hodge's

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<sup>24</sup> Since this portion of the incident was not captured on video, determining the exact time of restraint is impossible. However, Mr. Hodge was restrained by the time the NSCO BWC footage begins at 11:49:19 pm.

<sup>25</sup> If contacted immediately, the staging ambulance would have been on scene at least three minutes before the time that Mr. Hodge stopped making noise. An on-scene ambulance with a stretcher and crew focused on Mr. Hodge's health, would likely have meant that live-saving measures would have commenced sooner had Mr. Hodge become unconscious; he would also have reached the hospital faster. It is not unreasonable to suggest that but for the miscues brought about by the competing 911 systems, this tragic outcome may have been avoided.

<sup>26</sup> The OAG synchronized the footage from Deputy Austin's and Dep. Finley's BWCs so that they could be viewed simultaneously; the video was also lightened, to aid in viewing. Note that the time stamps on the BWC footage are different from the NC-911 times, which are used throughout this report.

feet), PO Bonito and Lt. Pytlik by his trunk area, and PO Barrancotta near Mr. Hodge's head. Mr. Hodge was still vocal and was generally moaning "no" and other comments. Over the course of the next few minutes, the officers were primarily strategizing how to search Mr. Hodge's pockets for additional weapons.

At 11:51:20 pm, Lt. Pytlik advised that he was turning Mr. Hodge toward him so that other officers could check his waistband. Although Mr. Hodge cannot be seen clearly on the BWC footage during this time, the officers' statements on video – between 11:51:20 pm and 11:53:14 pm, when officers can be heard telling Mr. Hodge to "stop," "stop moving," "stop resisting," and "stop fighting" – indicate that he continued to struggle as they searched him. The officers removed keys, a pill bottle, and money from Mr. Hodge's person. At the direction of Dep. Austin, a defensive tactics instructor, the officers then crossed Mr. Hodge's legs and brought his feet toward his buttocks in an apparent attempt to keep Mr. Hodge still. As the officers were taking these steps, Mr. Hodge grew quieter and less frequently vocal.

Similarly, Mr. Hodge's struggling decreased dramatically by this time. At 11:53:42 pm, Mr. Hodge began to move his arms again, and Lt. Pytlik told him to relax his hands and that they were trying to help him. Mr. Hodge began to move again at 11:53:59 pm, and Dep. Austin told him to leave his hand where it was. At 11:54:19 pm, Mr. Hodge began to move his arms, and again the officers directed him to stop moving.

At this point, PO Bonito can be seen on the video putting her foot on the area of Mr. Hodge's neck and shoulder as Mr. Hodge remained face down on the ground. PO Bonito's foot remained there, with some adjustments, until 11:55:44 pm. During the one minute and 25 second period of time her foot was on Mr. Hodge, he can be heard on the body-worn camera footage saying his girlfriend Nicole's name (faintly) at 11:54:29 and then faintly and intermittently moaning until 11:54:58 pm.

In a subsequent interview, PO Bonito told OAG staff that she consciously did not place her foot on Mr. Hodge's neck, but rather on his shoulder, and that at no time did she apply any meaningful pressure. PO Bonito insisted that she was well aware that applying pressure to a person's neck was potentially dangerous to that person and she would not – and did not – do so.<sup>27</sup> Rather, PO Bonito said, because her left foot was on the door stoop, she placed her right foot on Mr. Hodge's shoulder primarily as a manner of keeping her balance. It is impossible to gauge the accuracy of this statement from the video footage. Below are photographs displaying PO Bonito's foot in Mr. Hodge's shoulder / neck area as well as a photograph taken in the immediate aftermath of the incident, illustrating the space involved.

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<sup>27</sup> Although PO Bonito stated she knew that putting pressure on a person's neck was potentially dangerous, the LPD did not ban such moves pursuant to its then-existing Use of Force Policy. We address LPD's Use of Force Policy below in Recommendation III. The former and current Use of Force Policies are attached (Exhibits 4 and 5).



By this time, although the LFD members were on scene<sup>28</sup> and trained in Advanced Life Support (“ALS”), they were focused on calming Ms. Hodge, and assumed that the ambulance personnel would provide direct patient care when the crew arrived. Additionally, the LFD rig was not an ambulance and did not contain a stretcher. However, at 11:55:13 pm, the officers began to question where the ambulance was and strategize how they would transport Mr. Hodge to the hospital. The firefighters, PO Barrancotta, and Lt. Pytlik each contacted their dispatchers to clarify the status of the ambulance. At 11:55:51, after being contacted by the officers on scene, PO Morgan at LPD-911 called NC-911 asking the estimated time of arrival of the ambulance and (again, believing it had been originally dispatched to the scene) requested that the ambulance expedite its response. It was this call that led to the staging ambulance finally being notified (by NC-911) that it was clear to enter the scene. One minute and 19 seconds later, the TCA ambulance was at Ms. Hodge’s home.

Shortly before the ambulance arrived, at approximately 11:56:16 pm, Lt. Pytlik placed his hand on Mr. Hodge’s back; he later told OAG staff that he could feel Mr. Hodge breathing at that point. Dep. Austin, who was also on the ground with Mr. Hodge, can be heard on the video saying that Mr. Hodge was breathing. At 11:57:21 pm, Ms. Hodge asked the officers if Mr. Hodge was dead. Lt. Pytlik, who appears to have kept a hand on Mr. Hodge’s back throughout this period of time, advised her that, “He’s fine. He’s doing fine over here. He’s breathing. We’re going to get him some medical attention now.” At 11:57:30 pm, Ms. Hodge asked, “He’s not dead, is he?” and the officers around Mr. Hodge replied, “No. He’s not dead. He’s fine.”

At approximately 11:57:49 pm, the ambulance lights can be seen on the BWC video and it backs into the driveway shortly thereafter. At 11:58:43 pm, Lt. Pytlik pulled on Mr. Hodge’s shirt and called his name in an apparent attempt to rouse him, but Mr. Hodge did not move. At 11:59:25 pm, just as the officers are preparing to place Mr. Hodge on a stretcher, Lt. Pytlik can be seen checking Mr. Hodge’s carotid (neck) pulse. In a subsequent interview with OAG staff, Lt. Pytlik said at this point he thought Mr. Hodge may have stopped breathing, but because Lt. Pytlik was wearing gloves he could not feel a pulse when he checked Mr. Hodge’s neck. Lt. Pytlik then began to shake Mr. Hodge and call his name.

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<sup>28</sup> As noted, LFD had disregarded Disp. Ketch’s direction to stage and went straight to the scene; Twin City Ambulance followed Disp. Ketch’s directions.

The officers turned Mr. Hodge over at 11:59:38 pm, and a few seconds later Dep. Austin performed a sternum rub.<sup>29</sup> Mr. Hodge was nonresponsive. At approximately 11:59:50 pm, Mr. Hodge was lifted onto a stretcher where LFD firefighter (and paramedic) Mark White (“LFD White”) checked for a pulse. LFD White later told OAG staff he believed he was initially able to discern a pulse; however, one of the TCA crew members then felt for a pulse and said she could not feel one.

LFD Firefighter Timothy Lundquist (“LFD Lundquist”) ran to the LFD vehicle to obtain a bag valve mask (to perform ventilations) and an automatic external defibrillator to analyze Mr. Hodge’s heart rhythms. In the meantime, the TCA medic directed officers to remove Mr. Hodge’s handcuffs from behind his back, which they did, affixing one cuff to the stretcher. Because at that point nobody knew what type(s) of drugs Mr. Hodge had ingested (including the possibility of opioids), officers retrieved Naloxone,<sup>30</sup> although an LFD medic had already administered his own. The officers and members of the LFD and TCA loaded Mr. Hodge into the ambulance and began performing cardio pulmonary resuscitation (CPR). PO Barrancotta and PO Bonito alternated performing chest compressions on Mr. Hodge during the short trip to the hospital, while LFD Lundquist performed ventilation with a bag mask.

The ambulance backed out of Ms. Hodge’s driveway at 12:03:37 am and arrived at Eastern Niagara Hospital less than three minutes later. Hospital personnel continued CPR and rescue efforts in the emergency room for approximately thirty minutes, but Mr. Hodge never regained a pulse. At 12:40:00 am, Mr. Hodge was pronounced dead.

### Medical Examiner Findings

Alexandra Hart, M.D., a forensic pathologist at the Erie County Medical Examiner’s Office, performed a post-mortem examination of Mr. Hodge later that morning (June 17).<sup>31</sup> She identified numerous blunt force injuries to Mr. Hodge’s head, neck, torso, and extremities that were consistent with an extended physical altercation. Those injuries consisted primarily of abrasions (tearing of the superficial layer of the skin), lacerations (skin tearing, deeper than the superficial layer), and internal hemorrhages (internal bleeding). Mr. Hodge had no broken bones.

Toxicological analysis of Mr. Hodge’s blood confirmed the presence of cocaine, buprenorphine<sup>32</sup>, and their metabolites.

Prior to issuing her findings, Dr. Hart reviewed the records from the LFD, TCA, and Eastern Niagara Hospital. OAG staff also provided her with all available video footage of the incident. Ultimately, Dr. Hart concluded that Mr. Hodge suffered a cardiac arrest (heart attack)

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<sup>29</sup> A sternum rub is the application of painful stimulus with the knuckles of closed fist to the center chest of a patient who is not alert and does not respond to verbal stimuli. The sternum rub is one of the most common means by which EMTs and paramedics determine whether a person is asleep, unconscious, or not responsive.

<sup>30</sup> Naloxone, otherwise known as Narcan, is an opioid receptor antagonist and can reverse the effects of an opioid overdose; it has no effect on people who are experiencing non-opioid induced drug overdoses such as those caused by cocaine.

<sup>31</sup> A portion of Dr. Hart’s autopsy report is attached as Exhibit 6.

<sup>32</sup> Buprenorphine is a prescribed substance used to treat opioid dependence.

“in the setting of acute cocaine intoxication and a physical altercation with the police.” She deemed the Cause of Death: “Sudden Death Associated with Acute Cocaine Intoxication and Prolonged Physical Altercation,” and deemed the Manner of Death: “Homicide.” Dr. Hart went on to note that the homicide designation meant that other people (in this case, police officers) contributed in some measure to his death through their use of force, but that the classification “[did] not imply that there was intent to cause injury or that excessive force was used.”

Notably, while Dr. Hart found and described blunt force injuries to Mr. Hodge’s neck area, she specifically found that the placement of PO Bonito’s foot on or around Mr. Hodge’s shoulder and neck played no role in his death. Regarding specific injuries to Mr. Hodge’s neck area, Dr. Hart noted that the hyoid bone was not fractured (an injury commonly found in asphyxial deaths), and that the tracheal & laryngeal cartilages were intact. Dr. Hart did note the presence of blunt force injuries to Mr. Hodge’s neck, specifically “hemorrhage of the lateral aspect of the right sternocleidomastoid muscle and hemorrhage of the superior aspects of the bilateral sternohyoid muscles.” Dr. Hart also noted the presence of “focal hemorrhage of the mucosa of the posterior wall of the larynx.”

While those injuries are consistent with some amount of pressure being applied to neck area (at some point during the encounter), Dr. Hart declined to find that these injuries, which she described as superficial in nature, were the cause of Mr. Hodge’s death. During subsequent conversations with the Erie County ME’s Officer regarding Mr. Hodge’s autopsy, Deputy Chief Medical Examiner Katherine Maloney told OAG staff that she agreed with Dr. Hart’s autopsy findings; Dr. Maloney said that even assuming, for the sake of argument, that PO Bonito’s foot had caused the above-referenced injuries to Mr. Hodge’s neck, and, for the further sake of argument, that pressure and/or those resulting injuries had restricted blood flow through the carotid body on the right side of Mr. Hodge’s neck, the carotid body on the left side of Mr. Hodge’s neck would have allowed for the free exchange of air and blood sufficient to allow Mr. Hodge to remain conscious for the amount of time involved.<sup>33</sup>

In order to ensure that Mr. Hodge’s cause of death had been properly assessed, the OAG retained Dr. Kunjlata Ashar, an independent forensic pathologist and the former (now-retired) chief Medical Examiner of Westchester County, to review all of the available materials (including video footage) as well as Dr. Hart’s findings.

Dr. Ashar came to the same conclusion as did Dr. Hart with respect to Mr. Hodge’s cause of death. Moreover, she agreed that PO Bonito’s foot placement played no role in Mr. Hodge’s death.<sup>34</sup>

In reviewing the records, Dr. Ashar, like Dr. Hart, noted the presence of several blunt force injuries to Mr. Hodge’s head, neck, torso, and extremities. Dr. Ashar attributed these injuries to Mr. Hodge’s altercation with police, as well as their efforts at subdual and resuscitation; Dr. Ashar, as had Dr. Hart, found the injuries to be external in nature and to not involve the internal organs.

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<sup>33</sup> This point was also made by Dr. Ashar in assessing the potential significance of presence of PO Bonito’s foot on or around Mr. Hodge’s neck.

<sup>34</sup> Dr. Ashar did not designate a specific manner of death (i.e. homicide).

As it relates to Mr. Hodge’s neck, Dr. Ashar specifically noted the presence of blunt force injuries to the right sternocleidomastoid muscle and both sides of the sternohyoid muscle. Like Dr. Hart, however, Dr. Ashar found those to be “external” injuries that played no role in Mr. Hodge’s death, which she agreed was caused by cardiac arrest associated with cocaine intoxication and a prolonged physical struggle.

Further, while Dr. Ashar indicated that there was some potential indication of asphyxia due to the presence of petechial hemorrhages and lung congestion, she noted that Mr. Hodge’s “normal breathing” would have been hampered by his cocaine intoxication, which she specifically designated as the cause of certain autopsy findings, including pulmonary emphysema and hemorrhages. According to Dr. Ashar, those underlying conditions potentially led to Mr. Hodge experiencing dyspnea<sup>35</sup> when the encounter with police began.

## LEGAL ANALYSIS

### Colorable Offenses

All of the crimes for which any of the officers might arguably be culpable<sup>36</sup> – reckless manslaughter, criminally negligent homicide, and reckless endangerment – contain elements that render them highly unlikely to be proven beyond a reasonable doubt, based upon our review of the admissible evidence. Both reckless manslaughter<sup>37</sup> and criminally negligent homicide<sup>38</sup> demand proof that “(1) [the officers’] actions were ‘an actual contributory cause of death,’ in the sense that they ‘forged a link in the chain of causes which actually brought about the death’ and (2) that ‘the fatal result was reasonably foreseeable.’”<sup>39</sup> In addition to the two-prong causation analysis, reckless manslaughter would require the officers to have been affirmatively aware of the risk of death created by their conduct, but nevertheless chose to engage in that conduct anyway. Criminally negligent homicide would essentially require establishing that the officers *should have known* the risk of death created by their conduct.

There is simply no affirmative evidence that the LPD officers – aside from PO Bonito, whose conduct is addressed separately below – were conscious of the possibility that the force they used to restrain Mr. Hodge would create a risk of Mr. Hodge’s death; nor is there proof from which

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<sup>35</sup> Difficult or labored breathing.

<sup>36</sup> This list of such crimes does not include murder (PL 125.25(1)), which would require an intent to cause Mr. Hodge’s death, or intentional manslaughter (PL 125.20(1)), which would require an intent to cause “serious physical injury” (as defined by New York law), because there is simply no affirmative evidence whatsoever of any such intent on the part of any of the officers involved.

<sup>37</sup> A person is guilty of reckless manslaughter (manslaughter in the second degree, PL 125.15(1)) when he or she “recklessly causes the death of another person.” Under PL 15.05(3), “A person acts recklessly with respect to a result or to a circumstance described by a statute defining an offense when he is aware of and consciously disregards a substantial and unjustifiable risk that such result will occur or that such circumstance exists.”

<sup>38</sup> A person is guilty of criminally negligent homicide (PL 125.10) when, “with criminal negligence, he [or she] causes the death of another person.” Under PL 15.05(4), “A person acts with criminal negligence with respect to a result or to a circumstance described by a statute defining an offense when he fails to perceive a substantial and unjustifiable risk that such result will occur or that such circumstance exists. The risk must be of such nature and degree that the failure to perceive it constitutes a gross deviation from the standard of care that a reasonable person would observe in the situation.”

<sup>39</sup> See *People v Davis*, 28 NY 294, 300 (2016) (citations omitted).



to conclude that such a risk would or should have been readily inferred from Mr. Hodge's appearance or behavior. Mr. Hodge remained strong and vocal until, quite suddenly, he was no longer making noise or moving. None of the officers, including those in the best position to observe Mr. Hodge throughout this incident (POs Bonito and Barrancotta), had ever received training about the unique characteristics he was displaying – and how individuals manifesting those characteristics might rapidly change from displaying strength and vigor to a state of unconsciousness, and that they are uniquely vulnerable to sudden death. In the absence of evidence that any officers consciously disregarded a substantial and unjustifiable risk that their conduct might result in Mr. Hodge's death, or that they failed to perceive such a risk, their conduct cannot be proven to constitute reckless manslaughter or criminally negligent homicide.

PO Bonito is the only officer who, during the portion of the incident captured on video (post-restraint), could potentially be said to have engaged in conduct that could foreseeably carry the risk of causing serious injury or death to Mr. Hodge. Not only did PO Bonito (potentially) apply pressure to Mr. Hodge's neck, but she acknowledged knowing that putting pressure on a person's neck could cause that person serious injury; indeed, she said that it was that very knowledge that led her to avoid applying any such pressure to Mr. Hodge's neck. Accordingly, if it could be proven that (1) PO Bonito's foot was actually on Mr. Hodge's neck in such a way that it impeded his carotid arterial blood flow and (2) this act caused or contributed to Mr. Hodge's death, reckless manslaughter charges would be possible against PO Bonito; after all, awareness of a risk (the danger of applying pressure on the neck) and engaging in that very behavior nonetheless (placing one's foot on the neck) is the very essence of recklessness.

But while the BWC video appears to show PO Bonito with her foot in the area of Mr. Hodge's neck, her statement about her awareness of the damage such conduct could cause was coupled with her denial that she had actually put pressure on Mr. Hodge's neck. In other words, PO Bonito denied putting pressure on Mr. Hodge's neck, because she said she knew better than to do so, creating a factual issue that would be nearly impossible to overcome beyond a reasonable doubt; her explanation appears plausible, but in any event, it cannot be refuted with other evidence. In any event, even if that issue could be resolved, the apparent impossibility of establishing causation – given that two separate medical examiners concluded that even if PO Bonito's foot was on Mr. Hodge's neck, it did not cause or contribute to his death<sup>40</sup> – would stand as a barrier to prosecution.

The non-homicide crime of reckless endangerment in the second degree<sup>41</sup> would not require proof that the officers caused Mr. Hodge's death, but would still require proof that the officers were aware of and consciously disregarded the risk that their conduct would result in "serious physical injury"<sup>42</sup> to Mr. Hodge. There is at least a colorable argument to be made – though perhaps not a particularly strong one – that the officers were aware that repeatedly striking and kicking Mr. Hodge

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<sup>40</sup> As noted above, this issue was of such concern that after receipt of the first Medical Examiner's report, a second, wholly independent Medical Examiner was retained for the purpose of determining what, if any, were the possible effects of PO Bonito's foot in the area of Mr. Hodge's neck. Dr. Ashar, like Dr. Hart before her, concluded that PO Bonito's foot in the area of Mr. Hodge's neck did not contribute to his death.

<sup>41</sup> A person is guilty of reckless endangerment (PL 120.20, reckless endangerment in the second degree) when he or she "recklessly engages in conduct which creates a substantial risk of serious physical injury to another person."

<sup>42</sup> Under Penal Law § 10.00(1), "serious physical injury" is defined as "physical injury which creates a substantial risk of death, or which cause death or serious and protracted disfigurement, protracted impairment of health or protracted loss or impairment of the function of any bodily organ."

as they were trying to restrain him created a substantial risk of serious physical injury to Mr. Hodge, regardless of whether they realized that his condition rendered him uniquely vulnerable to serious injury, including death. That said, regardless of whether the officers' conduct in interacting with Mr. Hodge actually created a risk of serious physical injury to him – again, both medical examiners said that the injuries Mr. Hodge sustained during the altercation were not serious and would not have resulted in the death of an otherwise healthy individual – there is simply no evidence that any of the LPD officers (the only officers who used hands-on force) were aware that their conduct created any such risk.

Again, we address PO Bonito's conduct separately, because there is certainly an argument to be made that if she had applied sufficient pressure to Mr. Hodge's neck with her foot, she would indeed have created a substantial risk of serious physical injury to Mr. Hodge. However, as noted above, there is no direct evidence that PO Bonito actually placed any meaningful pressure on Mr. Hodge's neck. Instead, PO Bonito specifically denied placing pressure on Mr. Hodge's neck, asserting that she had her foot on Mr. Hodge's shoulder with the majority of her weight on her other foot. While body camera video footage shows PO Bonito's foot in the area of Mr. Hodge's neck, there is simply no way to determine, from that video, the exact location of her foot or the amount of pressure, if any, that was being applied. Because the exact location of, and the amount of pressure being applied by, PO Bonito's foot cannot be determined by the video, there is simply not sufficient evidence to sustain our burden of proving, beyond a reasonable doubt, that PO Bonito's conduct with respect to Mr. Hodge's neck area "created a substantial risk of physical injury" to Mr. Hodge.

But even if the elements of the above-referenced crimes could be established, they would be negated if the officers' conduct was justified by law.

### Justification

Under Penal Law § 35.30(1), "[A] police officer..., in the course of effecting...an arrest...of a person whom he or she reasonably believes to have committed an offense, may use physical force when and to the extent he or she reasonably believes such to be necessary to effect the arrest...."<sup>43</sup> When such a defense is raised, it must be disproven beyond a reasonable doubt in order to establish the officer's criminal culpability. Although the Court of Appeals has not directly addressed the meaning of the "reasonably believe" language in Penal Law § 35.30, it has interpreted identical language in the context of another subsection of the justification statute, Penal Law § 35.15. In *People v Goetz* (68 NY2d 96 [1986]), and then later in *People v Wesley* (76 NY2d 555 [1990]), the Court of Appeals held that the phrase "reasonable belief" has both a subjective component and an objective component. The subjective component is satisfied if the defendant in fact actually believed, "honestly and in good faith," that physical force was being used or was about to be used against him (or a third person) at the time he used physical force, and that the use of physical force

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<sup>43</sup> Penal Law § 35.30(1) sets a significantly higher threshold for the use of "deadly physical force," essentially permitting such force only when the officer reasonably believes it necessary to defend himself from "the use or imminent use of deadly physical force." Penal Law § 10.00(11) defines deadly physical force as "[p]hysical force which, under the circumstances in which it is used, is readily capable of causing death or other serious physical injury." But while the officers' collective conduct may well have been a contributory cause of Mr. Hodge's death, unlike the use of a firearm, the law would almost certainly not regard the application of punches and kicks to an individual armed with a knife, resisting arrest and trying to bite the officers, as force "readily capable of causing death or serious physical injury."

was necessary in order to repel the danger, regardless of whether that belief was accurate or not (*see Goetz*, 678 NY2d at 114). The objective component is satisfied if a “reasonable person” under the same “circumstances” could have held those beliefs (*see id.* at 115).

To negate the justification defense in this incident, it would be necessary to prove either that the officers did not subjectively believe the use of force was necessary or that the use of force was not objectively reasonable (or both).

Almost from his arrival on scene, PO Barrancotta was authorized to take Mr. Hodge into custody pursuant to §9.41 of the Mental Hygiene Law [“MHL”].<sup>44</sup> After Mr. Hodge brandished the knife and began fighting with PO Barrancotta and other arriving officers, his arrest for additional criminal offenses would have also been justified.<sup>45</sup> In taking Mr. Hodge into custody, the officers were authorized to “use physical force when and to the extent they ... reasonably believe[d] such to be necessary to effect the arrest.” The use of physical force would only be criminal if, and to the extent that, it exceeded what the officers reasonably believed was necessary to effect the arrest.

PO Barrancotta, PO Bonito, and (later) PO Burdick acknowledged punching and kicking Mr. Hodge before he was restrained. PO Barrancotta and PO Bonito said these efforts were initially aimed at getting Mr. Hodge to drop his knife; the audio captured by the civilian witness’ video corroborates their statements in this regard. After PO Barrancotta obtained the knife, PO Bonito said she kicked Mr. Hodge when he grabbed and tried to bite her leg, and PO Burdick said she punched Mr. Hodge as he grabbed the BWC off her vest (fearing he would use it as a weapon) and in an effort to stop Mr. Hodge from trying to bite PO Bonito. All officers indicated that nothing they did seemed to have had an effect on Mr. Hodge, who continued to fight with them.

The officers did not use their batons or weapons of any sort in order to restrain Mr. Hodge. And after PO Bonito’s one taser deployment, which as noted above, may not have been effective, Mr. Hodge was not tasered again. Further, unlike the involved officers, Mr. Hodge did not appear to grow tired or lose his strength until after he was restrained.

After Mr. Hodge was in handcuffs – setting aside PO Bonito’s conduct (which is addressed in detail above) – he was not punched, kicked, or subjected to any manner of physical force other than being held down.

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<sup>44</sup> MHL 9.41 provides, “Any ... police officer who is a member of the state police or ... a sheriff’s department may take into custody any person who appears to be mentally ill and is conducting himself in a manner which is likely to result in serious harm to himself or others. “Likelihood to result in serious harm” shall mean (1) substantial risk of physical harm to himself as manifested by ... conduct demonstrating that he is dangerous to himself, or (2) a substantial risk of physical harm to other persons as manifested by ... violent behavior by which others are placed in reasonable fear of serious physical harm. Such officer may ... remove [such person] to [a] hospital ...” Further, MHL § 1.03(20) defines “Mental Illness” as “affliction with a ... mental condition which is manifested by a disorder or disturbance in behavior, feeling, thinking, or judgment to such an extent that the person afflicted requires care, treatment and rehabilitation.” The law does not distinguish between organic mental conditions and those induced by drug intoxication.

<sup>45</sup> Pursuant to the BWC footage, after the ambulance departed on its way to the hospital, Lt. Pytlik advised Ms. Hodge that after Mr. Hodge was released from the hospital, he would be arrested for his conduct relative to biting and fighting with the officers.

Under these circumstances, it would be nearly impossible to prove beyond a reasonable doubt, that the officers' conduct in taking Mr. Hodge into custody, or holding him after he was in custody, was not justified pursuant to the New York Penal Law.

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

Because it appears from a thorough and detailed analysis of all the available evidence that it would not be possible to prove beyond a reasonable doubt that any officer engaged in any legally unjustifiable conduct in taking Mr. Hodge into custody, homicide or any other charges would not be appropriate. For these reasons, and pursuant to our ethical obligations, the OAG has elected not to seek charges against any of the officers involved in this case.

## RECOMMENDATIONS

### I. The Lockport Police Department should consider abandoning its 911 dispatching operations.

As the United States moves toward the largest technological overhaul of its emergency communications systems since the inception of 911,<sup>46</sup> Lockport maintains an antiquated, in-house dispatch center (LPD-911) that needlessly, wastefully, and (most importantly), inadequately duplicates services that Niagara County is readily capable of providing to the citizens of Lockport. Those inadequacies were on full display in this case. We therefore recommend that LPD thoughtfully consider relinquishing all dispatching in the city of Lockport to the Niagara County Communications / 911 Center (NC-911).

As noted above, when a person in the City of Lockport calls 911, the single factor determining which entity processes the call is what type of phone the caller uses. If a person calls 911 from a landline phone, the call is routed to LPD-911; if the same person standing in the same location calls 911 from a cellular phone, the call is routed to NC-911. Using civilian dispatchers, NC-911 processes nearly all emergency calls in Niagara County. The LPD, on the other hand, pays as many as two sworn police officers each shift to process the city of Lockport's landline calls.<sup>47</sup>

LPD apparently retains this system because eliminating it would take positions from LPD officers and would therefore constitute a mandatory subject of negotiation.<sup>48</sup> Further, the union representing LPD members indicated that removing the LPD-911 would present a "safety hazard" to both LPD officers and city residents.<sup>49</sup> To the contrary, and as detailed more fully above, we found that the ineffective interplay between LPD-911 and NC-911 actually caused issues in this case and may well have affected the ultimate outcome.

The dispatch related issues included but were not limited to confusion about the nature of the 911 call,<sup>50</sup> and a critical misunderstanding as to whether the ambulance was responding directly to the scene or staging nearby to await clearance. The cumulative result of these miscues and misunderstandings was that a TCA ambulance was staging .2 miles (~ 1 minute) away from Ms. Hodge's driveway awaiting directions from the on-scene officers to enter the scene. However, the on-scene officers, believing that the ambulance had been instructed to respond directly to the scene,

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<sup>46</sup> See <https://www.policeforum.org/assets/EmergencyCommunications.pdf>

<sup>47</sup> The night of this incident, one of the two LPD officers working in LPD-911 did so on overtime, having worked the immediately preceding shift as a road patrol officer. The other worked LPD-911 as his preferred assignment, since seniority permitted him to choose where he worked.

<sup>48</sup> See e.g., <https://buffalonews.com/2020/01/29/911-emergency-in-lockport/>;  
<https://buffalonews.com/2019/06/30/editorial-lockport-needs-to-let-niagara-county-handle-its-911-call-system/>

<sup>49</sup> [https://buffalonews.com/news/local/lockport-likely-to-keep-police-dispatching-911-call-answering-in-house/article\\_c1f85908-b862-5ad5-a099-55bdc9e11c43.html](https://buffalonews.com/news/local/lockport-likely-to-keep-police-dispatching-911-call-answering-in-house/article_c1f85908-b862-5ad5-a099-55bdc9e11c43.html)

<sup>50</sup> It appears, based on the OAG's review of the telephonic communications between LPD-911 and NC-911, that PO Morgan did initially hang up on Disp. Ketch as she said she was planning to advise him about the 911 calls received from Mr. Hodge's cell phone. There was, however, nothing preventing Disp. Ketch from calling LPD-911 back and advising that there was evidence of a domestic incident at the location as well as a medical issue. Arming officers with as much information as possible before they enter scenes is critical to improving police responses. See, <https://www.policeforum.org/assets/30%20guiding%20principles.pdf> [Recommendation 29]. And see [RECOMMENDATION 2 of this report.](#)

were unaware that the ambulance was awaiting clearance and they instead grew frustrated that the ambulance was taking so long to respond.

It is impossible to reconcile this incohesive response with the assertion that eliminating 911 operations at LPD would somehow place officers and the public in harm's way. Clearly, a centralized dispatch system would have avoided many of the miscues that plagued this case - miscues that ultimately delayed the ambulance's arrival at Mr. Hodge's side by at least six minutes. Notably, Mr. Hodge remained conscious during the first five of those six minutes. Had the ambulance arrived in a timely manner, Mr. Hodge's chances for survival may have improved.<sup>51</sup>

Finally, the future of dispatching will inevitably expand beyond simply dialing 911 and speaking with a dispatcher. The next wave of emergency communications, commonly referred to as Next Generation 911 (NG911), will augment voice calls with photos, videos, and text messages, thereby allowing for enhanced services.<sup>52</sup> Implementation of this technology is an investment and not all communities have been able to move at the same pace. New York City has an NG911 implementation plan; Niagara County does not.<sup>53</sup> In any event, other than investing in an entirely new system, LPD-911 and its outdated technology will remain behind - and completely incompatible with - the type of multi-media communications platform the rest of the country is moving toward.

The OAG therefore recommends that the LPD strongly consider eliminating its in-house 911 system.

II. Law Enforcement Officers, Dispatchers, and EMS Personnel Must be Trained to Recognize that When People Display a Unique Constellation of Symptoms, it Can Signal Potential, Imminent Medical Distress; Response Protocols and Training must be Structured Accordingly.

According to Ms. Hodge, this incident began when Mr. Hodge arrived at her home believing people were after him. Ms. Hodge in turn called 911 and asked for help, because her son was "not himself" and was having an issue with "medication or something." When PO Barrancotta arrived on scene, he observed that Mr. Hodge was "sweating profusely." Despite seeing PO Barrancotta's uniform, and his mother telling him that the police were there to help him, Mr. Hodge insisted that PO Barrancotta was part of the "fake police" who had come to kill him. Mr. Hodge then brandished a knife and began fighting with PO Barrancotta and PO Bonito, but the two officers were not able to restrain him. PO Barrancotta and PO Bonito both said that Mr. Hodge did not fatigue, and they were startled by his strength. It was only after PO Burdick, Lt Pytlik, and Dep Pino arrived that the officers were collectively able to apply handcuffs to Mr. Hodge. Thereafter, Mr. Hodge continued to move and speak in an incoherent and delusional manner for a period of time. Mr. Hodge appeared to be intolerant to pain, prompting one officer to note that he was "not feeling a thing," to which another replied, "I know, nothing." After the initial resistance and struggle, Mr. Hodge stopped

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<sup>51</sup> Cardiopulmonary Resuscitation (CPR) is an emergency lifesaving procedure performed when the heart stops beating; the immediate provision of CPR can enhance one's chances of survival after cardiac arrest. <https://cpr.heart.org/en/resources/what-is-cpr>

<sup>52</sup> See e.g., [https://www.911.gov/issue\\_nextgeneration911.html](https://www.911.gov/issue_nextgeneration911.html)

<sup>53</sup> See [https://www1.nyc.gov/assets/doitt/downloads/pdf/2018\\_doitt\\_ng911\\_1178\\_annual\\_report.pdf](https://www1.nyc.gov/assets/doitt/downloads/pdf/2018_doitt_ng911_1178_annual_report.pdf);

moving and the officers believed he had fallen asleep. In fact, Mr. Hodge had gone into cardiac arrest and would never again regain consciousness.

Not one responding officer had been trained to recognize that individuals displaying the unique combination of features Mr. Hodge displayed, are disproportionately vulnerable to cardiac arrest and sudden death during restraint. The lack of training for, recognition of, and coordinated response to these medical emergencies must change.

Since Executive Order 147 was issued in 2015, all deaths in New York that have occurred during the course of or following restraint by law enforcement (with or without additional force other than the restraint itself), have been investigated by a single office – the OAG. If those cases had instead remained with local prosecutors, a comprehensive, aggregate view of this issue would not have been possible; this is particularly true in light of the variation among Medical Examiners as to how they classify the cause and manner of restraint-related deaths. Simply put, since Executive Order 147 was issued, the OAG has repeatedly observed cases throughout the state with strikingly similar factual characteristics and we cannot ignore this.

The most common type of presentment this office has observed involves individuals under the effect of a stimulant drug – most commonly cocaine. The individuals have generally been observed to be in a condition indicating some sort of detachment from reality and police have been summoned because of bizarre and/or violent and erratic behavior. Further, the individuals involved in our cases have often been highly sweaty or attired in clothing inappropriate for the existing weather conditions and/or surroundings. After police restrain these individuals, they have resisted the restraint and fought, seeming not to tire until, quite suddenly, they have become silent. The death is nearly always attributed to cardiac arrest or acute drug intoxication.<sup>54</sup>

In Mr. Hodge’s case, the responding officers did not know that he had ingested cocaine, but they knew some type of illicit substance was involved and they repeatedly asked Mr. Hodge what he had consumed. Had they been trained to recognize the constellation of symptoms Mr. Hodge displayed, they would also have known that his panicked and bizarre behavior (i.e. behavior seemingly detached from his present reality), coupled with his strength, sweating, and lack of fatigue, rendered him vulnerable to sudden death by cardiac arrest, particularly when restrained.

This is not simply a law enforcement issue. Responding to this type of event must involve coordination between dispatchers, law enforcement, paramedics, and emergency department medical staff. For instance, dispatchers should be trained that certain 911 calls (such as calls indicating that a person is naked or inappropriately clothed and acting in a bizarre and/or aggressive manner) should result in the immediate dispatch of an ambulance to stage in the area and continuous coordination with other first responders. Law enforcement officers *must* attempt to de-escalate for as long as possible, while awaiting the arrival of EMS (ideally, not restraining at all until EMS is ready). If the subject must be restrained, officers should be taught the best technique for doing so; they must also be taught to vigilantly monitor the subject, armed with knowledge that the person under their care, custody and control may become unconscious without notice. EMS should respond to these calls with full knowledge of the circumstances involved and have a planned response ready

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<sup>54</sup> In one case, the Medical Examiner attributed the death to “asphyxia,” noting that by asphyxia, she meant a lack of oxygen in the blood, which, she said, could have been due to cardiac arrest.

to execute swiftly. Law enforcement and EMS should work together as a team, and since these are *medical* emergencies, once EMS is present, the EMS assessment of how to treat the patient must be accorded weight. Likewise, hospital personnel should know in advance that a person being transported to their facility, whether conscious or not, appears to have been manifesting this unique constellation of characteristics. Since all of this requires a high degree of coordinated response, we recommend that each of the stake-holders mentioned above (dispatchers, law enforcement, EMS, and hospital emergency personnel) work together to develop a community-wide response policy, disseminate it to their respective organizations, and conduct trainings together.<sup>55</sup>

There was no coordinated response policy in Lockport at the time of this incident. As noted previously, the dispatch coordination was inept, the officers had never been trained about the unique constellation of symptoms that Mr. Hodge displayed, and they failed to recognize that he was in medical peril and might quickly become unresponsive; once LFD members (trained in CPR and advanced life support) arrived, they stayed with Ms. Hodge instead of monitoring Mr. Hodge; and the ambulance personnel, despite asking for information about the call, arrived on scene equipped with the knowledge that they were needed quickly, but with no other information about the call whatsoever.

Trained officers armed with the knowledge that Mr. Hodge was at a heightened risk of cardiac arrest would likely not have waited as long (or any length of time at all) to question why the ambulance had yet to arrive. Additionally, the officers may have implemented different restraint tactics, and then remained vigilant about watching Mr. Hodge, knowing that his condition might rapidly deteriorate. Moreover, the officers would likely have insisted that after the LFD crew arrived on scene, they remain at Mr. Hodge's side, monitoring him and ready to provide CPR if necessary, instead of taking up the task of calming Ms. Hodge.

In addressing this issue, we are not suggesting that restraint does not contribute to the death of individuals experiencing this condition. To the contrary, our experience with cases over which we have had jurisdiction has informed us that individuals exhibiting these symptoms are particularly vulnerable to the stress and rigor of restraint, particularly when they struggle against it, are largely impervious to pain, and do not fatigue normally.

Of course, the challenge lies in the fact that people in this condition need medical intervention, and restraint may be necessary to provide that intervention. It stands to reason that law enforcement officers, who will be called upon to respond to, interact with, and potentially restrain individuals during these circumstances, should be trained to recognize the safest way to manage them.

Not only can training and a coordinated response policy potentially save lives, they can also promote police accountability. When an officer is properly trained, and does not act in accordance with that training, that failure obviously weighs into the determination of whether the officer's conduct was "objectively reasonable."<sup>56</sup> And as noted above (Legal Analysis) the risk of death

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<sup>55</sup> For an example of training leading to the deployment of best response techniques, *see* [https://www.youtube.com/watch?v=OL\\_K6XAix6Q](https://www.youtube.com/watch?v=OL_K6XAix6Q)

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



inherent in this (or any) situation, as well as an individual's knowledge of that risk, are an elements of potential homicide charges.

We therefore recommend that LPD and all police organizations work with their local communications/911 offices, EMS partners, and medical facilities to develop and implement policies for how best to recognize and respond to these types of critical incidents. Specifically, officers should be trained, consistent with best standards, on how to reduce the likelihood of death in these situations, including when and how to restrain people exhibiting these characteristics - in order to minimize harm to themselves and others.

### III. The LPD Should Modify its Use of Force Policy

As noted above, PO Bonito said she did not place her foot on Mr. Hodge's neck because, essentially, she knew not to do so. The Use of Force policy in effect at the time of this incident (Exhibit 4) was silent regarding that type of action. On June 24, 2020, LPD issued an updated Use of Force Policy (Exhibit 5). There are some general improvements to the old policy contained in the new one, such as reference to de-escalation and a duty to intercede when another officer uses unreasonable force, neither of which existed in the previous policy.

However, the new policy expressly permits the use of the "Carotid Control Hold," under circumstances "where deadly force is authorized." In an effort to underscore the danger of these types of restraint techniques and the potential criminal penalties for such use, as indicated by the passage of Penal Law Penal Law § 121.13-a (Aggravated Strangulation), the OAG recommends removing those provisions. Instead, we recommend that LPD expressly prohibit officers from using chokeholds or other applications of pressure to the throat, windpipe, neck (or blocking the mouth or nose) in a manner that may hinder an individual's breathing or obstruct the circulation of blood.

Inasmuch as we recommend changing the Use of Force policy as reflected above, we also suggest that LPD take the opportunity to review its entire Use of Force policy and consider placing a greater emphasis on using de-escalation whenever safe and feasible as well as narrowing the description of circumstances under which deadly force is authorized; in particular, LPD should consider refining its definition of what constitutes an "imminent" threat or danger.<sup>57</sup>

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<sup>57</sup> The OAG makes this recommendation because we are otherwise recommending modification of LPD's Use of Force Policy, not because the force employed during this incident was deadly force.

# EXHIBIT 1



# State of New York

## Executive Chamber

No. 147.29

### EXECUTIVE ORDER

In view of the request of Attorney General Letitia James, my order and requirement, embodied in Executive Order Number one hundred and forty-seven, dated July 8, 2015, is hereby amended to include an additional paragraph to the penultimate paragraph as amended by Executive Order Numbers 147.1 - 147.28 to read as follows:

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

(cc) of any and all unlawful acts or omissions or alleged unlawful acts or omissions by any law enforcement officer, as listed in subdivision 34 of section 1.20 of the Criminal Procedure Law, arising out of, relating to or in any way connected with the death of Troy Hodge on June 17, 2019, in Niagara County.



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

BY THE GOVERNOR

A handwritten signature in black ink, appearing to be "M. C.", written over a horizontal line.

Secretary to the Governor

A handwritten signature in black ink, appearing to be "Andrew Cuomo", written over a horizontal line.

# EXHIBIT 2



# CITY OF LOCKPORT POLICE DEPARTMENT

## OFFICE OF THE CHIEF OF POLICE

ONE LOCKS PLAZA  
LOCKPORT, NEW YORK 14094  
PHONE 716-439-6633  
FAX 716-439-6777

CHIEF STEVEN PREISCH  
spreisch@lockportny.gov

The City of Lockport Police Department currently has a total of 40 body cameras. All 40 cameras are of the same make and type (Safety Vision, Prima Facie). Each officer and Lieutenant assigned to the Patrol Division is assigned their own body camera (total of 36, as of 07/25/2019). In addition to the Patrol Division, our K9 officer, Detective Lieutenant and Detective Captain are also assigned a body camera making a total of 39 body cameras issued and 1 spare backup camera. Each camera that is assigned is programmed to show the specific officer/lieutenants name and badge number along with a current time stamp.

Each officer is responsible for the care and safe keeping of their issued body camera. The cameras are not issued at the start of each shift and they are not turned in at the completion of their shift. Each officer is responsible for ensuring that their camera is charged and ready for service prior to the start of their shift and for plugging it into the data transfer dock in a timely manner (typically at the end of each tour of duty). When the officer plugs their camera in to transfer the data they are responsible to ensure that the data transfers without errors. Each officer is responsible for checking the status of their camera each shift and reporting any malfunctions, damage or other problems to the body camera administrator as soon as they occur (body cameras are currently administered by PO Kaufman).

In the event that a body camera is damaged or becomes inoperable Safety Vision is notified and the camera is sent back for repair or replacement. The officer is issued a new body camera if available with their credentials programmed into it. When the repaired body camera returns they are stored as backups and used as needed.

A handwritten signature in blue ink, appearing to be "DK" with a long, sweeping underline.

PO Daniel Kaufman

**Overview**[Send Link](#) [Help](#)

Order Number	Date	Title	Category
P-164	02/23/2015	BODY CAMERA RECORDER	GENERAL ORDERS

TO: All Personnel

INDEX/SUBJECT: P-164 Body Camera Recorders

AUTHORITY: Chief of Police

EFFECTIVE DATE(S): 2/23/2015, Reviewed 1/7/2016, Reviewed 1/23/2017

**I. PURPOSE:**

To establish policy regarding the use of Body Camera Recorders worn by Officers of the Lockport Police Department.

A. This order is to establish uniform guidelines for the use of the On-Officer Video Recording System to be referred to as the B

B. The system will be used to document various events and at the end of the user's shift the captured data will be preserved o

**II. POLICY:**

The Lockport Police Department has adopted the use of an On-Officer Video Recording System primarily for the Patrol Division

A. It is the policy of the City of Lockport Police Department that officers will use the Body Camera equipment to record video and audio transactions, in their entirety, that occur between officers and the public a

1. To protect officers safety and acknowledge that recording may not be possible in every situation, recordings will not be requ

1a When ever possible, all use of force will be recorded on the Body Camera Recorder. If a video of a use of force incident

B. All controls regarding time and recording quality have been pre-set. No changes shall be made without the authorization of

C. Any portion of a video/audio recording that contains events surrounding a violation of the law is considered a record of a cr

D. Video/audio recordings are the property of the City of Lockport Police Department and are not to be duplicated without the written authorization of the Chief of Police.

E. No privately owned body cameras are authorized for use.

F. The objectives of utilizing On-Officer Body Camera are:

1. To enhance officer safety
2. To accurately capture statements and events during the course of an incident.
3. To enhance the officer's ability to document and review statements and actions for both internal reporting and for courtro
4. To capture visual and audio information for use in current and future investigations.
5. To enhance the public trust by preserving factual presentations of officer-citizen interactions through video and audio rec
6. To protect officers from the potential of false claims arising from officer-citizen interactions.

**III. PROCEDURES****A. Police Officer Responsibilities**

1. Whenever a unit is available it will be taken on patrol by Officers assigned to the Patrol Division. Whenever it is possible circumstance where the Officer believes the recording of the event will benefit the investigation can be recorded at the Of
2. At the end of their shift, officers will place the body camera and battery into any open slot on the body camera docking st
3. Officers will have the ability to review their recordings to insure accurate written reports only prior to upload to the police
4. The system will not be intentionally activated to record conversations of fellow employees without their knowledge during
5. Officers shall not activate the system to record informants, undercover officers, or sex crime victims
6. Officers will test the system, according to training and manufacturer's guidelines, prior to utilizing the equipment. Problem
7. Officers will immediately report any loss of, or damage to, any part of the system equipment to a supervisor.
8. The body camera equipment issued to an Officer is the responsibility of the officer assigned to maintain in good working o
9. The camera unit must be manually activated by an activation button located on the front of the body camera.
10. The officer controls the deactivation by use of the "stop button" located on the camera unit.

11. When the recorded event ends, the officer should manually stop the recording.
12. The camera unit must be deactivated when not being used for a specific police purpose.
13. Officers are required to inform their supervisor of any recorded sequences that need to be saved.
14. Officers will ensure that body camera unit, audio/video equipment is activated and operating properly and the video recording is saved.

A. Traffic Stops – Audio and video equipment will be used to record the entire duration of all traffic stops. If possible, officers

B. Prisoner Transports – Video and audio Body Camera equipment will be used during prisoner transports when:

- i. The prisoner is argumentative and/or combative;
- ii. The prisoner has been involved in a use of force;
- iii. The prisoner is injured or claims to be injured.

C. Officer may also use their Body Camera equipment to:

- a. Record any DWI arrest, including performance tests or interviews with the suspect;
- b. Record the actions and/or statements of suspects for use later judicial proceedings;
- c. Record the circumstances at crime and accident scenes or other events such as the confiscation and documentation of evidence;
- d. Record the audio portion of a conversation with a citizen when appropriate;
- e. Community related activities as desired.

15. When an incident has ended and is noteworthy, the officer will notify their supervisor and note in the case or blotter report.
16. Officers are not authorized and will not attempt to erase, alter, or tamper with

Body Camera recordings.

17. Officers will ensure that the Body Camera has an adequate amount of free recording space to complete their tour of duty.
18. Officers will note in the narrative of the related report when video/audio recordings were made during an incident in queue.
19. Officers are encouraged to inform their supervisor of any recorded sequences that may be of training value.

B. Supervisor Responsibilities

1. Ensure that all officers follow established procedures for the use and maintenance of the Body Camera equipment and the camera.
2. Ensure that he or she issues Body Cameras out to patrol officers prior to the start of their duty shift each day.
3. Ensure that he or she verifies that all Body Cameras issued out to patrol officers are returned at the end of the shift and placed in the designated location.
4. Ensure that repairs or replacement of damaged or nonfunctional Body Camera equipment is addressed.
5. Ensure that for each arrest the system administrator is notified to mark video and to retain the video record for the court case.

6. Notify a Body Camera Administrator of any recording needed to be saved to DVD.

a. The Body Camera Administrators include:

- i. Chief of Police;
- ii. Administrative Captain;
- iii. Detective Captain;
- iv. Patrol Captain;
- v. Designated Body Camera Administrator.

b. Authorized Body Camera Administrators designated by the Chief of Police as listed above will not delegate their responsibilities.

7. When an incident arises that requires immediate retrieval of recorded media (ex. serious crime scenes, dep:)
- C. Body Camera Administrator Responsibilities
1. Ensure the Body Camera system is functioning to manufacturer's specifications.
  2. Ensure that data contained in the Body Camera system is downloaded and saved to the departmental dedicated police video server.
  3. Record and save any designated event recorded in the Body Camera system.
    4. Prepare recordings/copies of recordings to District Attorneys Office as needed.
    5. Review recordings for quality control as per this General Order.

IV. Record Retention, and Media Duplication

1. Once a recording has been saved to the video server, ALL appropriate security restrictions and chain of custody requirements shall be implemented.
2. All video and audio recordings will be retained for a period of 365 days after its creation.
3. Recordings marked as evidence will be saved to DVD and retained on the police video server until completion of any court proceedings.
4. Once the case is closed, either by court disposition or determined to be closed in any other way, the retention period will begin.
5. Release of, or facilitation of viewing of any video to an unauthorized person, media entity or other non-law enforcement entity is prohibited.
6. All released video/audio or any permitted viewing shall be appropriately documented in an IMPACT Blotter or the associated file.

V. Random MVR Review for Proper Maintenance

A. Review Procedures

1. The Administrative Captain will conduct a monthly random review of five (5) Body Camera videos from the police video server.
2. Should a problem be found during review, the Administrative Captain will notify the Body Camera administrator.
3. The Body Camera Administrator will be responsible for repair and maintenance of the server and all Body Camera units.
4. Minor infractions (not criminal in nature) discovered by the Administrative Captain during routine review should be viewed



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**Order #:** P-164      **Date:** 02/23/2015  
**Category:** GENERAL ORDERS  
**Title:** BODY CAMERA RECORDERS

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TO: All Personnel

INDEX/SUBJECT: P-164 Body Camera Recorders

AUTHORITY: Chief of Police

EFFECTIVE DATE(S): 2/23/2015

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**I. PURPOSE:**

To establish policy regarding the use of Body Camera Recorders worn by Officers of the Lockport Police Department.

A. This order is to establish uniform guidelines for the use of the On-Officer Video Recording System to be referred to as the Body Camera.

B. The system will be used to document various events and at the end of the user's shift the captured data will be preserved on the department's digital video storage server.

**II. POLICY:**

The Lockport Police Department has adopted the use of an On-Officer Video Recording System primarily for the Patrol Division but does not preclude Officers assigned to the Detective, Support Services, or Training Divisions from utilizing the system for operations deemed necessary.

A. It is the policy of the City of Lockport Police Department that officers will use the Body Camera equipment to record video and audio transactions, in their entirety, that occur between officers and the public as described in this General Order. To maximize the use of this equipment, officers will follow the procedures for the body camera equipment use as set forth in this directive.

1. To protect officers safety and acknowledge that recording may not be possible in every situation, recordings will not be required if it would be unsafe, impossible or impractical to operate said body camera.

1a When ever possible, all use of force will be recorded on the Body Camera Recorder. If a video of a use of force incident is recorded then said video will be retained for a period of 365 days.

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B. All controls regarding time and recording quality have been pre-set. No changes shall be made without the authorization of the Chief of Police.

C. Any portion of a video/audio recording that contains events surrounding a violation of the law is considered a record of a criminal investigation.

D. Video/audio recordings are the property of the City of Lockport Police Department and  
are not to be duplicated without the written authorization of the Chief of Police.

E. No privately owned body cameras are authorized for use.

F. The objectives of utilizing On-Officer Body Camera are:

1. To enhance officer safety
2. To accurately capture statements and events during the course of an incident.
3. To enhance the officer's ability to document and review statements and actions for both internal reporting and for courtroom presentation.
4. To capture visual and audio information for use in current and future investigations.
5. To enhance the public trust by preserving factual presentations of officer-citizen interactions through video and audio recording.
6. To protect officers from the potential of false claims arising from officer-citizen interactions.

**III. PROCEDURES**

**A. Police Officer Responsibilities**

1. Whenever a unit is available it will be taken on patrol by Officers assigned to the Patrol Division. Whenever it is possible to do so, All traffic stops will be recorded. All other events such as enforcement activities where practical, any Police/citizen interaction or any other circumstance where the Officer believes the recording of the event will benefit the investigation can be recorded at the Officers judgment and discretion. Once the system has been activated, it shall not be deactivated until the

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event has concluded and the Officer drives away from the scene.

2. At the end of their shift, officers will place the body camera and battery into any open slot on the body camera docking station. Data will then be transferred from the unit to the Police video server automatically and stored for 120 days.

3. Officers will have the ability to review their recordings to insure accurate written reports only prior to upload to the police video server. A 710.30 notice must be prepared if the officer intends to use any of the defendant's statements for prosecution.

4. The system will not be intentionally activated to record conversations of fellow employees without their knowledge during non-enforcement related activities.

5. Officers shall not activate the system to record informants, undercover officers, or sex crime victims

6. Officers will test the system, according to training and manufacturer's guidelines, prior to utilizing the equipment. Problems will be reported to the officer's immediate supervisor and the unit will be taken out of service.

7. Officers will immediately report any loss of, or damage to, any part of the system equipment to a supervisor.

8. The body camera equipment issued to an Officer is the responsibility of the officer assigned to maintain in good working order.

9. The camera unit must be manually activated by an activation button located on the front of the body camera.

10. The officer controls the deactivation by use of the "stop button" located on the camera unit.

11. When the recorded event ends, the officer should manually stop the recording.

12. The camera unit must be deactivated when not being used for a specific police purpose.

13. Officers are required to inform their supervisor of any recorded sequences that need to be saved.

14. Officers will ensure that body camera unit, audio/video equipment is activated and operating properly and the video recorder is positioned properly to record events in the following circumstances:

A. Traffic Stops – Audio and video equipment will be used to record the entire duration of all traffic stops. If possible, officers will activate the camera equipment when following a vehicle

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they intend to stop. The camera equipment will only be deactivated after the traffic stop has ended and the violator/officer has left the scene.

B. Prisoner Transports – Video and audio Body Camera equipment will be used during prisoner transports when:

- i. The prisoner is argumentative and/or combative;
- ii. The prisoner has been involved in a use of force;
- iii. The prisoner is injured or claims to be injured.

C. Officer may also use their Body Camera equipment to:

- a. Record any DWI arrest, including performance tests or interviews with the suspect;
- b. Record the actions and/or statements of suspects for use later judicial proceedings;
- c. Record the circumstances at crime and accident scenes or other events such as the confiscation and documentation of evidence or contraband;
- d. Record the audio portion of a conversation with a citizen when appropriate;
- e. Community related activities as desired.

15. When an incident has ended and is noteworthy, the officer will notify their supervisor and note in the case or blotter report. The system Administrator will be contacted by department Impact email by the squad supervisors to mark said event. The recording will then be saved for a 365 days.

16. Officers are not authorized and will not attempt to erase, alter, or tamper with Body Camera recordings.

17. Officers will ensure that the Body Camera has an adequate amount of free recording space to complete their tour of duty.

18. Officers will note in the narrative of the related report when video/audio recordings were made during an incident in question. Officers must note the start time of the recording in such reports. A 710.30 notice must be prepared when using any recording for prosecution.

19. Officers are encouraged to inform their supervisor of any recorded sequences that may be of training value.

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B. Supervisor Responsibilities

1. Ensure that all officers follow established procedures for the use and maintenance of the Body Camera equipment and the completion of Body Camera documentation;
2. Ensure that he or she Issue Body Cameras out to patrol officers prior to the start of their duty shift each day.
3. Ensure that he or she verifies that all Body Cameras issued out to patrol officers are returned at the end of the shift and placed in their docking cradles for video upload and battery charging prior to leaving after the completion of their duty shift each day.
4. Ensure that repairs or replacement of damaged or nonfunctional Body Camera equipment is addressed.
5. Ensure that for each arrest the system administrator is notified to mark video and to retain the video record for the court cases.

6. Notify a Body Camera Administrator of any recording needed to be saved to DVD.

a. The Body Camera Administrators include:

- i. Chief of Police;
- ii. Administrative Captain;
- iii. Detective Captain;
- iv. Patrol Captain;
- v. Designated Body Camera Administrator.

b. Authorized Body Camera Administrators designated by the Chief of Police as listed above will not delegate their responsibilities. Further, they will not allow unauthorized access to the police video server to any other member of the Lockport Police Department for any reason.

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Title: BODY CAMERA RECORDERS

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7. When an incident arises that requires immediate retrieval of recorded media (ex. serious crime scenes, departmental shootings, department vehicle accidents), the shift supervisor shall respond to the scene and ensure that the recorded Media is properly retrieved. The supervisor then will follow the steps listed in step 3 above.

### C. Body Camera Administrator Responsibilities

1. Ensure the Body Camera system is functioning to manufacturer's specifications.
2. Ensure that data contained in the Body Camera system is downloaded and saved to the departmental dedicated police video server.
3. Record and save any designated event recorded in the Body Camera system.
  4. Prepare recordings/copies of recordings to District Attorneys Office as needed.
  5. Review recordings for quality control as per this General Order.

### IV. Record Retention, and Media Duplication

1. Once a recording has been saved to the video server, ALL appropriate security restrictions and chain of custody requirements must be followed.
2. All video and audio recordings will be retained for a period of 365 days after its creation.
3. Recordings marked as evidence will be saved to DVD and retained on the police video server until completion of any court proceedings. Court proceedings include both criminal as well as civil proceedings. Further retention may be required at the discretion of the Chief of Police.
4. Once the case is closed, either by court disposition or determined to be closed in any other way, the retention period will begin on that date.
5. Release of, or facilitation of viewing of any video to an unauthorized person, media entity or other non-law enforcement entity is prohibited unless authorized in writing by the Chief of Police.
6. All released video/audio or any permitted viewing shall be appropriately documented in an IMPACT Blotter or the associated Blotter/Case. Documentation shall include the reason for the release and the attached written authorization of the Chief of Police.

### V. Random MVR Review for Proper Maintenance

**DEPARTMENT ORDER**

Page #: 7

**Order #:** P-164      **Date:** 02/23/2015  
**Category:** GENERAL ORDERS  
**Title:** BODY CAMERA RECORDERS

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A. Review Procedures

1. The Administrative Captain will conduct a monthly random review of five (5) Body Camera videos from the police video server for the purpose of reviewing video and audio quality.
2. Should a problem be found during review, the Administrative Captain will notify the Body Camera administrator.
3. The Body Camera Administrator will be responsible for repair and maintenance of the server and all Body Camera units.
4. Minor infractions (not criminal in nature) discovered by the Administrative Captain during routine review should be viewed as a training opportunity and not as routine disciplinary actions. Should the behavior or action become habitual after being formally addressed, the appropriate disciplinary or corrective action should then be taken.

# EXHIBIT 3



## Body-Worn Cameras

### 424.1 PURPOSE

To establish uniform guidelines for the use of the Axon On-Officer Video Recording System. The system will be mandatory for all Road Patrol Officers/Canine Unit and will be used to document various events, and at the end of the user's shift, the captured data will be preserved in a web-based digital storage facility, Evidence.com. Once captured, these recordings cannot be altered in any way and are protected with multiple layers of encryption.

### 424.2 PROGRAM OBJECTIVES

The Lockport Police Department has adopted the use of the On-Officer Video Recording System to accomplish the following objectives:

- (a) To enhance officer safety.
- (b) To accurately capture statements and events during the course of an incident.
- (c) To enhance the officer's ability to document and review statements and actions for both internal reporting requirements and for courtroom preparation/presentation.
- (d) To provide an impartial measurement for self-critique and field evaluation during recruitment and new officer training.
- (e) To capture visual and audio information for use in current and future investigations.
- (f) To enhance the public trust by preserving factual representations of officer-citizen interactions in the form of video and audio recording.

### 424.3 TRAINING

Officers will not utilize the system until they have received proper training.

Training will consist of, but will not be limited to:

- (a) A review of the system, its functions, its usage and its activation and deactivation.
- (b) A review of the user manual and agency policy.
- (c) A hands-on review of the system.
- (d) The retention and storage of the video and the procedures for placing them into evidence.

Normal (Buffering) Mode - The AXON continuously loops video recording for up to 120 seconds (actual loop time for our office to be established as 30 seconds). Records video only (no audio) while buffering.

Event Mode - In the Event Mode, the AXON saves the buffered video and continues recording audio and video for up to eight (8) hours. Continuously pressing the Event button turns the recording off and on and also places markers on the media segment for later viewing in Evidence.com.

# Lockport Police Department

## Policy Manual

### *Body-Worn Cameras*

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#### **424.4 OPERATIONAL PROTOCOLS**

Whenever it is possible to do so, it is required that the AXON be utilized to record the following types of events: traffic stops, pursuits, vehicle searches, confrontational citizen contacts, use of force situations, statements made by subjects, victims and witnesses, advising an individual of their Miranda Rights, during interrogations or other legitimate law enforcement contacts.

To respect the dignity of others, employees will try to avoid recording videos of persons who are nude or when sensitive human areas are exposed.

The AXON Camera shall not be used to record personal activity.

The AXON Camera will not be activated in places where a reasonable expectation of privacy exists, such as dressing rooms or restrooms.

The AXON Camera will not be intentionally activated to record conversations of fellow employees without their knowledge during routine, non-enforcement related activities.

Employees shall not record informants or undercover officers.

Employees will avoid recording individuals who are picketing or engaged in a protest or First Amendment demonstration, unless an obvious violation of criminal law is occurring.

Officers will test the equipment to ensure it is operating properly. If problems are encountered with any component of the system, the AXON camera will not be used. The employee will immediately notify a supervisor and the malfunction will be documented. The supervisor will then notify the program administrator of the malfunction and it will be the administrators responsibility to reassign a new camera and to send the inoperable camera to AXON for repair/replacement.

Whenever an officer obtains a video statement it will be documented in the Incident Report.

When the AXON Camera is used in any investigation or during a traffic stop, this fact will be documented on any citation and/or report generated regarding the contact.

Officers will utilize the provided AXON Taser signal batteries. The signal batteries will activate the recording function of body worn cameras when the officers taser is turned on or deployed.

Patrol vehicles will use a signal device that will activate the recording function of body worn cameras when the over head lights are activated or the gun lock is released. Officers will test the function of the signal device at the start of each shift and report any malfunctions to a supervisor.

#### **424.5 EVIDENTIARY PROTOCOLS**

At the end of their shift, officers shall place the AXON camera into any open slot on the ETM (docking station). This will allow the data to be transferred from the AXON Camera through the ETM to Evidence.com.

Officers will not allow citizens to review the recordings.

The release of information requested through a public records request will be subject to the same statutory exemptions from disclosure as any other departmental records.

# Lockport Police Department

## Policy Manual

### Body-Worn Cameras

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Officers will not make copies of any recording for their personal use and are prohibited from using a recording device (such as a telephone camera or secondary video camera) to record media from Evidence.com or the AXON Camera unit.

Officers will immediately report any loss of, or damage to, any part of the AXON Camera equipment to a supervisor. The supervisor will document the loss or damage and then notify the program administrator. It will be the administrator's responsibility to reassign a new camera and to send the inoperable camera or related equipment to AXON for repair/replacement.

All digital media collected using the AXON Camera is considered a record of the Lockport Police Department. Accessing, copying or releasing any media for other than official law enforcement purposes is strictly prohibited, except as required by law or authorized by the authority of the Chief of Police.

Recordings will be automatically deleted from Evidence.com at the preset retention levels based on category. It will be the responsibility of the employee issued a body worn camera to tag and set the category for each recording after it is completed. The following is the retention schedule for body worn camera recordings:

- (a) Uncategorized - Until manually deleted. This category will be the default category if no category is select by user.
- (b) Arrest - 180 days
- (c) Citizen Contact/Non Incidental - 30 days
- (d) Evidence/Investigation - 180 days
- (e) Interview/Statement - 180 days
- (f) Pending Review - Until manually deleted. To be used by Supervisors only.
- (g) Traffic Stop, un issued - 60 days
- (h) Traffic Stop, Warning Issued - 30 days
- (i) Training - Until manually deleted. To be used by Supervisors only.
- (j) Use of Force - 1 year

# EXHIBIT 4

**Overview**[Send Link](#) [Help](#)

Order Number	Date	Title	Category
A-085	12/31/2017	Use Of Force	GENERAL ORDERS ▾

TO: All Sworn Personnel

INDEX/SUBJECT: A-085 Use of Force

AUTHORITY: Chief of Police

EFFECTIVE DATE(S): 3/21/2008, rev. 8/18/2010, reviewed 2/10/2014, reviewed 1/17/2015, reviewed 1/22/2016, reviewed 1/1

## I. PURPOSE

To set policy for the use of force by Officers of the Lockport Police Department

## II. POLICY

A. It shall be the policy of the Lockport Police Department that the level of physical force used by an Officer in the performance duties be within the limits established by Article 35 of the New York State Penal Law, and consistent with training given by this department and training provided at the Police Academy. Such force will be necessary, reasonable and not reckless based upon totality of the circumstances and information known to the Officer at the time such force is required.

## III. PROCEDURE

A. Only department approved equipment, weapons and ammunition will be carried on duty and used when applying physical for except in an emergency when the Officer may use other resources at his disposal, to the extent justified by law. The carrying of weapon is required by all Officers while on duty, except under certain circumstances approved by a superior Officer.

### B. Confrontational Continuum

1. The Confrontational Continuum should be relied upon as a guide for action.
2. A Police Officer encountering resistance is not required to strictly follow each step of the Continuum as listed.
3. Should a situation arise where a Police Officer must immediately use OC, Taser, impact weapons, etc., it is not necessary to follow each step in the Continuum as it will be the defendant's actions that will determine the proper defensive techniques or devices.
4. Steps in the Confrontational Continuum
  - a. Officer's presence
  - b. Verbalization;
  - c. Oleoresin Capsicum (OC) Aerosol Restraint
  - d. Control Techniques (wrist locks, escort holds, etc.);
  - e. Taser (X26);
  - f. Focused Strikes (closed hand, kicks, etc.);
  - g. Impact Instrument (straight baton, expandable baton);
  - h. Deadly Physical Force;

### C. Subject Resistance Report

1. Subject Resistance Reports (SRR) will be filed with the Chief's Office where a subject fails to comply with a lawful order of and the officer is forced into a physical confrontation with a subject where Oleoresin Capsicum (OC) aerosol, Taser, physical rest strikes, baton, or firearm is used as a result of the subjects actions.

2. A SRR will be filed whether or not an arrest was made and if an arrest was not made, the SRR will include a detailed explanation setting forth the reasons for the use of force.

a. Resistance countermeasures used against crowds or unknown persons will still be documented, recording all possible information.

#### D. Restraining Devices

1. Use of restraining devices is mandatory on all prisoners unless, in the Officer's judgement, unusual circumstances exist where the use of restraining devices impossible or unnecessary (ie: prisoner is very elderly, handicapped, etc.).

2. Discretion may be used to allow for the hands of the prisoner to be cuffed in the front, due to physical or other conditions. In such case, it will remain the responsibility of the Officer in contact with the prisoner to ensure control of such prisoner.

3. The mere placing of handcuffs on a prisoner will not require a SRR.

#### E. Use of Oleoresin Capsicum (OC) Aerosol Restraint

##### 1. Resisting Subjects

a. OC may be used to gain control of a resisting subject or to effect a lawful arrest.

b. If an arrest is not made, or a subject is not taken into custody, explain in the narrative of the SRR.

#### F. Prisoners

1. If, after given an opportunity to comply with a lawful direction or order, the subject verbally or physically resists, OC may be used to effect compliance.

#### G. Crowd Control

1. OC may be used to disperse a group or crowd, if after verbalization to disperse, resistance is encountered.

2. If an arrest is not made, explain in the narrative of the SRR.

#### H. Juveniles

1. Consistent with the limits established in Article 35 of the New York State Penal Law and Departmental training, a Taser or OC may be used to restrain or control a resisting juvenile, if, due to the extent and nature of the circumstances surrounding the incident, the use of OC is justified.

2. Thoroughly explain in the SRR why the level of force was necessary, including Officer/Subject factors and special circumstances.

#### I. Animals

1. A Taser or OC may be used to distract or disable any animal which is attacking, or presenting an imminent danger to any person or to another animal.

2. Document this use in a blotter report.

#### J. Use of Tasers

1. Will only be deployed by department personnel who have been certified in the use of the X26 Taser device.

2. Such use will be in accordance with the department policy and training.

#### K. Impact Instrument (straight baton, expandable baton)

1. Impact weapons are those that are either used to strike or to effect a block from a subject that is actively aggressive.
2. The decision to use an impact weapon must be made with consideration to the severity of the resistance and the level of t
  - a. All impact weapons are to be used in accordance with the techniques taught in training.
  - b. In any case, the head, neck and spine shall not be targeted in a physical force situation.

#### L. Use of a Firearm

1. Warning Shots
  - a. No Officer shall fire so called "warning shots".

#### M. Vehicles

1. No Officer shall fire at a vehicle or conveyance, when the identity of the occupants is not known to him, except in defense or others as permitted by law.

#### N. Animals

1. The killing of an animal by firearm is justified for self-defense, or to prevent substantial harm to the Officer or another per
2. When the animal is so badly injured or sick that compassion requires its relief from further suffering and there is a need fo immediate action.
3. A seriously sick or injured animal may be destroyed after reasonable efforts have been made to request assistance from th or agency responsible for the disposal of animals.
4. The destruction of vicious animals should be guided by the same directives set forth for self-defense and to ensure the saf others.
5. The indiscriminate and reckless use of firearms is strictly prohibited.

#### O. Off-Duty Weapons

1. The carrying of the department weapon or a personal weapon off-duty is not required by the Lockport Police Department.
2. The department assumes no responsibility for the proficiency training or use of non-department weapons.
3. Officers are required to obey Federal, State and local laws and ordinances regarding the use and carrying of a handgun.

#### P. Off-Duty Arrest Resistance

1. Any off-duty Officer encountering resistance pursuant to his duty as a Police Officer, shall immediately notify an on-duty s Officer of the incident, or, if outside the City of Lockport, shall notify the law enforcement agency of jurisdiction.

#### Q. Medical Treatment

1. After resistance countermeasures are used and the situation at hand is considered controlled and safe, an Officer shall eva need for medical attention or treatment for the person upon whom the techniques were used and arrange for such treatment wh
  - a. That subject has a visible injury requiring medical attention; or
  - b. Subject complains of sustaining an injury or complains of illness.
  - c. If in fact a need for medical treatment exists by either the person whom the resistance countermeasures were used on Officer, the platoon supervisor will be notified.

- d. The platoon supervisor will investigate and document the injuries, photograph the existence or non-existence of said injury deemed necessary, investigate the circumstances surrounding the injury and forward any documentation to the Chief of Police for review.
- e. In the event that the use of resistance countermeasures result in a person's death, the supervisor will:
  - i. Notify the Chief of Police and Chief of Detectives
  - ii. Initiate an investigation as directed;
  - iii. The supervisor will respond to the scene and protect the scene pending an investigation;
  - iv. The supervisor shall insure any injured parties receive prompt medical treatment;
  - v. The shift commander shall complete a report including statements from all witnesses and all parties involved and submit to the Chief of Police;
  - vi. The shift commander shall insure the involved Officers do not discuss the incident with anyone not directly involved in the incident or the investigation thereof;
  - vii. It will be the responsibility of the supervisor at the scene to insure the proper notifications are made.
  - viii. The incident shall be reviewed to determine if the countermeasures were used lawfully and in accordance with the department rules, regulations and directives. The review shall also address the need for further training and the adequacy of the equipment and ammunition used.



**DEPARTMENT ORDER**

Page #: 1

**Order #:** A-085      **Date:** 02/15/2001  
**Category:** GENERAL ORDERS  
**Title:** USE OF FORCE

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TO: All Personnel

INDEX/SUBJECT: A-085 Use of Force

AUTHORITY: Chief of Police

EFFECTIVE DATE(S): 3/21/2008, rev. 08/18/2010, reviewed 2/10/2014

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I. PURPOSE

To set policy for the use of force by officers of the Lockport Police Department.

II. POLICY

A. It shall be the policy of the police department that the level of physical force used by an officer in performance of his/her duties be within the limits established by Article 35 of the New York State Penal Law, and consistent with training given by this department and the training academy. Such force will be necessary, reasonable and not reckless based upon the totality of the circumstances and information known to the officer at the time such force is required.

III. PROCEDURE

A. Only department approved equipment, weapons, and ammunition will be carried on duty and used when applying physical force, except in an emergency when the officer may use other resources at his disposal, to the extent justified by law. The carrying of a service weapon is required by all officers while on duty, except under certain circumstances approved by a superior officer.

B. Confrontational Continuum

1. The Confrontational Continuum should be relied upon as a guide for action.
2. A police officer encountering resistance is not required to strictly follow each step of the Continuum as listed.

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**Order #:** A-085      **Date:** 02/15/2001  
**Category:** GENERAL ORDERS  
**Title:** USE OF FORCE

---

3. Should a situation arise where a police officer must immediately use OC, Taser, impact weapons, etc., it is not necessary to exactly follow each step in the Continuum as it will be the defendants actions that will determine the proper defensive techniques or devices.

4. Steps in Confrontational Continuum

- a. Officer's Presence;
- b. Verbalization;
- c. Oleoresin Capsicum (OC) Aerosol Restraint;
- d. Control Techniques (wrist locks, escort holds, etc.);
- e. Taser (X26);
- f. Focused Strikes (closed hand, kicks, etc.);
- g. Impact Instrument (straight baton, expandable baton);
- h. Deadly Physical Force;

C. Subject Resistance Report

1. Subject Resistance Reports (SRR) will be filed with the Chief's Office where a subject fails to comply with a lawful order of an officer and the officer is forced into a physical confrontation with a subject where Oleoresin Capsicum (OC) aerosol, Taser, physical restraint or strikes, baton, or firearm is used as a result of the subjects actions.

2. A SRR will be filed whether or not an arrest was made and if an arrest was not made, the SRR will include a detailed explanation setting forth the reasons for the use of force.

a. Resistance countermeasures used against crowds or unknown persons will still be documented, recording all possible information.

**DEPARTMENT ORDER**

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**Order #:** A-085      **Date:** 02/15/2001  
**Category:** GENERAL ORDERS  
**Title:** USE OF FORCE

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D. Restraining Devices

1. Use of restraining devices is mandatory on all prisoners unless, in the officer's judgment, unusual circumstances exist which make the use of restraining devices impossible or unnecessary (ie: prisoner is very elderly, handicapped, etc.).

2. Discretion may be used to allow for the hands of the prisoner to be cuffed in front, due to physical or other conditions. In either case, it will remain the responsibility of the officer in contact with the prisoner to ensure control of such prisoner.

3. The mere placing of handcuffs on a prisoner will not require a SRR.

E. Use of Oleoresin Capsicum (OC) Aerosol Restraint

1. Resistive Subjects

a. OC may be used to gain control of a resistive subject or to effect a lawful arrest.

b. If an arrest is not made, or a subject is not taken into custody, explain in narrative of SRR.

F. Prisoners

1. If, after given an opportunity to comply with a lawful direction or order, subject verbally or physically resists, OC may be used to effect compliance.

G. Crowd Control

1. OC may be used to disperse a group or crowd, if after verbalization to disperse, resistance is encountered.

2. If an arrest is not made, explain in narrative of SRR.

H. Juveniles

**DEPARTMENT ORDER**

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**Order #:** A-085      **Date:** 02/15/2001  
**Category:** GENERAL ORDERS  
**Title:** USE OF FORCE

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1. Consistent with the limits established in Article 35 of the New York State Penal Law and Departmental training, a Taser or OC may be used to restrain or control a resistive juvenile, if, due to the extent and nature of the circumstances surrounding the incident, the use of OC is justified. u

2. Thoroughly explain in the SRR why the level of force was necessary, including Officer/Subject factors and special circumstances. O

I. Animals

1. A Taser or OC may be used to distract or disable any animal which is attacking, or presenting an imminent danger to any person or to another animal.

2. Document this use in a Blotter report.

J. Use of Tasers

1. Will only be deployed by department personnel who have been certified in the use of the X26 Taser device.

2. Such use will be in accordance with the department policy and training.

K. Impact Instrument (straight baton, expandable baton)

1. Impact weapons are those that are either used to strike or to effect a block from a subject that is actively aggressive.

2. The decision to use an impact weapon must be made with consideration to the severity of the resistance and the level of the threat.

a. All impact weapons are to be used in accordance with the techniques taught in training.

b. In any case, the head, neck, and spine shall not be targeted in a physical force situation.

**DEPARTMENT ORDER**

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**Order #:** A-085      **Date:** 02/15/2001  
**Category:** GENERAL ORDERS  
**Title:** USE OF FORCE

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L. Use of a Firearm:

1. Warning Shots

- a. No officer shall fire so-called 'warning shots'.

M. Vehicles

1. No officer shall fire at a vehicle or conveyance, when the identity of the occupants is not known to him, except in defense of himself or others as permitted by law.

N. Animals

1. The killing of an animal by firearm is justified for self-defense, or to prevent substantial harm to the officer or another person.

2. When the animal is so badly injured or sick that compassion requires its relief from further suffering and there is need for immediate action.

3. A seriously sick or injured animal may be destroyed after reasonable efforts have been made to request assistance from the owner or agency responsible for the disposal of animals.

4. The destruction of vicious animals should be guided by the same directives set forth for self-defense and to ensure the safety of others.

5. The indiscriminant and reckless use of firearms is strictly prohibited.

O. Off-Duty Weapons

1. The carrying of the department weapon or a personal weapon off-duty is not required by the department.

2. The department assumes no responsibility for proficiency training or use of non-department weapons.

3. Officers are required to obey Federal, State, and local laws and ordinances regarding the use and carrying of a handgun.

**DEPARTMENT ORDER**

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**Order #:** A-085      **Date:** 02/15/2001  
**Category:** GENERAL ORDERS  
**Title:** USE OF FORCE

---

P. Off-Duty Arrest Resistance

1. Any off-duty officer encountering resistance pursuant to his duty as a police officer, shall immediately notify an on-duty supervising officer of the incident, or, if outside the City of Lockport, shall notify the law enforcement agency of jurisdiction.

Q. Medical Treatment

1. After resistance countermeasures are used and the situation at hand is considered controlled and safe, an officer shall evaluate the need for medical attention or treatment for the person upon whom the techniques were used and arrange for such treatment when:

a. That subject has a visible injury requiring medical attention; or

b. Subject complains of sustaining an injury or complains of illness.

c. If in fact a need for medical treatment exists by either the person whom the resistance countermeasures were used on or the officer, the platoon supervisor will be notified.

d. The platoon supervisor will investigate and document the injuries, photograph the existence or non-existence of said injuries if deemed necessary, investigate the circumstances surrounding the injury and forward any documentation to the chief of police for his review.

e. In the event that the use of resistance countermeasures results in a person's death, the supervisor will:

i. Notify the chief of police and chief of detectives;

ii. Initiate an investigation as directed;

iii. The supervisor will respond to the scene and protect the scene pending an investigation;

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Order #: A-085

Date: 02/15/2001

Category: GENERAL ORDERS

Title: USE OF FORCE

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iv. The supervisor shall insure any injured parties receive prompt medical treatment;

v. The shift commander shall complete a report including statements from all witnesses and all parties involved and submit it to the chief of police;

vi. The shift commander shall insure the involved officers do not discuss the incident with anyone not directly involved with the incident or the investigation thereof;

vii. It will be the responsibility of the supervisor at the scene to insure proper notifications are made.

viii. The incident shall be reviewed to determine if countermeasures were used lawfully and in accordance with department rules, regulations, and directives. The review shall also address the need for further training and the adequacy of the firearm and ammunition used.

# EXHIBIT 5



## Use of Force

### 300.1 PURPOSE AND SCOPE

This policy provides guidelines on the reasonable use of force. While there is no way to specify the exact amount or type of reasonable force to be applied in any situation, every member of this department is expected to use these guidelines to make such decisions in a professional, impartial, and reasonable manner (Executive Law § 840).

In addition to those methods, techniques, and tools set forth below, the guidelines for the reasonable application of force contained in this policy shall apply to all policies addressing the potential use of force, including but not limited to the Control Devices and Conducted Energy Device policies.

#### 300.1.1 DEFINITIONS

Definitions related to this policy include:

**Deadly force** - Force reasonably anticipated and intended to create a substantial likelihood of causing death or serious physical injury. This includes force that, under the circumstances, is readily capable of causing death or serious physical injury (Executive Law § 840).

**Feasible** - Reasonably capable of being done or carried out under the circumstances to successfully achieve the arrest or lawful objective without increasing risk to the officer or another person.

**Force** - The application of physical techniques or tactics, chemical agents or weapons to another person. It is not a use of force when a person allows him/herself to be searched, escorted, handcuffed, or restrained.

**Passive resistance** – An individual who refuses to comply with police commands but does not interfere with an officer and poses no physical threat.

**Active/defensive resistance** - Physical actions which attempt to prevent officer's control but do not attempt to harm the officer. This can be in the form of "bracing or tensing" or "attempts to push or pull away". This would also include running/walking away from police who are attempting to control said person. Spitting at police.

**Aggressive resistance**- An assault or imminent assault, upon a police officer.

**Aggravated aggressive resistance** – An assault with a dangerous instrument constituting serious violence, that could in some cases, justify deadly force.

**Imminent** - Ready to take place; impending. Note that imminent does not mean immediate or instantaneous.

**Totality of the circumstances** - All facts and circumstances known to the officer at the time, taken as a whole, including the conduct of the officer and the subject leading up to the use of force.

# Lockport Police Department

## Policy Manual

### *Use of Force*

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#### **300.2 POLICY**

The use of force by law enforcement personnel is a matter of critical concern, both to the public and to the law enforcement community. Officers are involved on a daily basis in numerous and varied interactions and, when warranted, may use reasonable force in carrying out their duties.

Officers must have an understanding of, and true appreciation for, their authority and limitations. This is especially true with respect to overcoming resistance while engaged in the performance of law enforcement duties.

The Lockport Police Department recognizes and respects the value of all human life and dignity without prejudice to anyone. Vesting officers with the authority to use reasonable force and to protect the public welfare requires monitoring, evaluation, and a careful balancing of all interests.

##### **300.2.1 DUTY TO INTERCEDE AND REPORT**

Any officer present and observing another law enforcement officer or a member using force that is clearly beyond that which is objectively reasonable under the circumstances shall, when in a position to do so, intercede to prevent the use of unreasonable force.

Any officer who observes another law enforcement officer or a member use force that is potentially beyond that which is objectively reasonable under the circumstances should report these observations to a supervisor as soon as feasible.

##### **300.2.2 PERSPECTIVE**

When observing or reporting force used by a law enforcement officer, each officer should take into account the totality of the circumstances and the possibility that other law enforcement officers may have additional information regarding the threat posed by the subject.

#### **300.3 USE OF FORCE**

Officers shall use only that amount of force that reasonably appears necessary given the facts and circumstances perceived by the officer at the time of the event to accomplish a legitimate law enforcement purpose.

The reasonableness of force will be judged from the perspective of a reasonable officer on the scene at the time of the incident. Any evaluation of reasonableness must allow for the fact that officers are often forced to make split-second decisions about the amount of force that reasonably appears necessary in a particular situation, with limited information and in circumstances that are tense, uncertain and rapidly evolving.

Given that no policy can realistically predict every possible situation an officer might encounter, officers are entrusted to use well-reasoned discretion in determining the appropriate use of force in each incident.

It is also recognized that circumstances may arise in which officers reasonably believe that it would be impractical or ineffective to use any of the tools, weapons or methods provided by this department. Officers may find it more effective or reasonable to improvise their response to rapidly unfolding conditions that they are confronting. In such circumstances, the use of any improvised

# Lockport Police Department

## Policy Manual

### *Use of Force*

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device or method must nonetheless be reasonable and utilized only to the degree that reasonably appears necessary to accomplish a legitimate law enforcement purpose.

While the ultimate objective of every law enforcement encounter is to avoid or minimize injury, nothing in this policy requires an officer to retreat or be exposed to possible physical injury before applying reasonable force.

Additional considerations are as follows:

- (a) Ability to disengage or escalate is imperative.
- (b) A tactical disengagement at any level is always an option for the officer, but not mandatory.
- (c) Verbalization should be utilized at all levels, if practical. (ie: POLICE... DON'T MOVE!)

#### Use of Force Matrix

##### 300.3.1 ALTERNATIVE TACTICS - DE-ESCALATION

When circumstances reasonably permit, officers should use non-violent strategies and techniques to decrease the intensity of a situation, improve decision-making, improve communication, reduce the need for force, and increase voluntary compliance (e.g., summoning additional resources, formulating a plan, attempting verbal persuasion).

##### 300.3.2 USE OF FORCE TO EFFECT AN ARREST

A police officer or a peace officer may use reasonable physical force to effect an arrest, prevent escape of a person from custody, or in defense of self or others from imminent physical force (Penal Law § 35.30).

Force shall not be used by an officer to (Executive Law § 840):

- (a) Extract an item from the anus or vagina of a subject without a warrant, except where exigent circumstances are present.
- (b) Coerce a confession from a subject in custody.
- (c) Obtain blood, saliva, urine, or other bodily fluid or cells from an individual for scientific testing in lieu of a court order where required.

##### 300.3.3 FACTORS USED TO DETERMINE THE REASONABLENESS OF FORCE

When determining whether to apply force and evaluating whether an officer has used reasonable force, a number of factors should be taken into consideration, as time and circumstances permit. These factors include but are not limited to:

- (a) Immediacy and severity of the threat to officers or others.
- (b) The conduct of the individual being confronted, as reasonably perceived by the officer at the time.
- (c) Officer/subject factors (e.g., age, size, relative strength, skill level, injuries sustained, level of exhaustion or fatigue, the number of officers available vs. subjects).
- (d) The effects of suspected drug or alcohol use.

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- (e) The individual's mental state or capacity.
- (f) The individual's ability to understand and comply with officer commands.
- (g) Proximity of weapons or dangerous improvised devices.
- (h) The degree to which the individual has been effectively restrained and his/her ability to resist despite being restrained.
- (i) The availability of other reasonable and feasible options and their possible effectiveness.
- (j) Seriousness of the suspected offense or reason for contact with the individual.
- (k) Training and experience of the officer.
- (l) Potential for injury to officers, suspects, and others.
- (m) Whether the individual appears to be resisting, attempting to evade arrest by flight, or is attacking the officer.
- (n) The risk and reasonably foreseeable consequences of escape.
- (o) The apparent need for immediate control of the individual or a prompt resolution of the situation.
- (p) Whether the conduct of the individual being confronted no longer reasonably appears to pose an imminent threat to the officer or others.
- (q) Prior contacts with the individual or awareness of any propensity for violence.
- (r) Any other exigent circumstances.

#### 300.3.4 PAIN COMPLIANCE TECHNIQUES

Pain compliance techniques may be effective in controlling a passively resisting or actively resisting individual. Officers may only apply those pain compliance techniques for which they have successfully completed department-approved training. Officers utilizing any pain compliance technique should consider:

- (a) The degree to which the application of the technique may be controlled given the level of resistance.
- (b) Whether the individual can comply with the direction or orders of the officer.
- (c) Whether the individual has been given sufficient opportunity to comply.

The application of any pain compliance technique shall be discontinued once the officer determines that compliance has been achieved.

#### 300.3.5 CAROTID CONTROL HOLD

A carotid control hold is a technique designed to control an individual by temporarily restricting blood flow through the application of pressure to the side of the neck and, unlike a chokehold, does not restrict the airway. The proper application of the carotid control hold may be effective in restraining a violent or combative individual. However, due to the potential for injury, the use

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of the carotid control hold is limited to those circumstances where deadly force is authorized and is subject to the following:

- (a) At all times during the application of the carotid control hold, the response of the individual should be monitored. The carotid control hold should be discontinued when circumstances indicate that the application no longer reasonably appears necessary.
- (b) Any individual who has had the carotid control hold applied, regardless of whether he/she was rendered unconscious, shall be promptly examined by paramedics or other qualified medical personnel and should be monitored until such examination occurs.
- (c) The officer shall inform any person receiving custody, or any person placed in a position of providing care, that the individual has been subjected to the carotid control hold and whether the individual lost consciousness as a result.
- (d) Any officer attempting or applying the carotid control hold shall promptly notify a supervisor of the use or attempted use of such hold.
- (e) The use or attempted use of the carotid control hold shall be thoroughly documented by the officer in any related reports.

#### **300.3.6 STATE RESTRICTIONS ON THE USE OF OTHER RESTRAINTS**

Any application of pressure to the throat, windpipe, neck, or blocking the mouth or nose of a person in a manner that may hinder breathing or reduce intake of air is prohibited unless deadly physical force is authorized (Exec. Law § 840).

This application is subject to the same guidelines and requirements as a carotid control hold.

#### **300.3.7 USE OF FORCE TO SEIZE EVIDENCE**

In general, officers may use reasonable force to lawfully seize evidence and to prevent the destruction of evidence. However, officers are discouraged from using force solely to prevent a person from swallowing evidence or contraband. In the instance when force is used, officers should not intentionally use any technique that restricts blood flow to the head, restricts respiration, or which creates a reasonable likelihood that blood flow to the head or respiration would be restricted. Officers are encouraged to use techniques and methods taught by the Lockport Police Department for this specific purpose.

#### **300.4 DEADLY FORCE APPLICATIONS**

When reasonable, the officer should, prior to the use of deadly force, make efforts to identify him/herself as a police officer and to warn that deadly force may be used, unless the officer has objectively reasonable grounds to believe the person is aware of those facts.

Use of deadly force is justified in the following circumstances involving imminent threat or imminent risk:

- (a) An officer may use deadly force to protect him/herself or others from what he/she reasonably believes is an imminent threat of death or serious bodily injury.
- (b) An officer may use deadly force to stop a fleeing subject when the officer has probable cause to believe that the individual has committed, or intends to commit, a felony

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involving the infliction or threatened infliction of serious bodily injury or death, and the officer reasonably believes that there is an imminent risk of serious bodily injury or death to any other person if the individual is not immediately apprehended. Under such circumstances, a verbal warning should precede the use of deadly force, where feasible.

Imminent does not mean immediate or instantaneous. An imminent danger may exist even if the suspect is not at that very moment pointing a weapon at someone. For example, an imminent danger may exist if an officer reasonably believes that the individual has a weapon or is attempting to access one and intends to use it against the officer or another person. An imminent danger may also exist if the individual is capable of causing serious bodily injury or death without a weapon, and the officer believes the individual intends to do so.

#### **300.4.1 MOVING VEHICLES**

Shots fired at or from a moving vehicle involve additional considerations and risks, and are rarely effective.

When feasible, officers should take reasonable steps to move out of the path of an approaching vehicle instead of discharging their firearm at the vehicle or any of its occupants.

An officer should only discharge a firearm at a moving vehicle or its occupants when the officer reasonably believes there are no other reasonable means available to avert the imminent threat of the vehicle, or if deadly force other than the vehicle is directed at the officer or others.

Officers should not shoot at any part of a vehicle in an attempt to disable the vehicle.

#### **300.5 REPORTING THE USE OF FORCE**

Any use of force by a member of this department shall be documented promptly, completely, and accurately in an appropriate report, depending on the nature of the incident. The officer should articulate the factors perceived and why he/she believed the use of force was reasonable under the circumstances.

To collect data for purposes of training, resource allocation, analysis, and related purposes, the Department may require the completion of additional report forms, as specified in department policy, procedure, or law (Executive Law § 840).

See the Report Preparation Policy for additional circumstances that may require documentation.

#### **300.5.1 NOTIFICATIONS TO SUPERVISORS**

Supervisory notification shall be made as soon as practicable following the application of force to include, but not limited to, any of the following circumstances:

- (a) The application caused a visible injury.
- (b) The application would lead a reasonable officer to conclude that the individual may have experienced more than momentary discomfort.
- (c) The individual subjected to the force complained of injury or continuing pain.
- (d) The individual indicates intent to pursue litigation.

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- (e) Any application of the TASER (TM) or control device.
- (f) Any application of a restraint device other than handcuffs, shackles or belly chains.
- (g) The individual subjected to the force was rendered unconscious.
- (h) An individual was struck or kicked.
- (i) An individual alleges any of the above has occurred.
- (j) The individuals conduct was altered by the drawing of a firearm, or TASER, or any other display of force.

All use of force should be reported to the shift supervisor.

### **300.6 MEDICAL CONSIDERATIONS**

Once it is reasonably safe to do so, medical assistance shall be obtained for any person who exhibits signs of physical distress, has sustained visible injury, expresses a complaint of injury or continuing pain, or was rendered unconscious. Any individual exhibiting signs of physical distress after an encounter should be continuously monitored until he/she can be medically assessed. Individuals should not be placed on their stomachs for an extended period, as this could impair their ability to breathe.

Based upon the officer's initial assessment of the nature and extent of the individual's injuries, medical assistance may consist of examination by an emergency medical services provider or medical personnel at a hospital or jail. If any such individual refuses medical attention, such a refusal shall be fully documented in related reports and, whenever practicable, should be witnessed by another officer and/or medical personnel. If a recording is made of the contact or an interview with the individual, any refusal should be included in the recording, if possible.

The on-scene supervisor or, if the on-scene supervisor is not available, the primary handling officer shall ensure that any person providing medical care or receiving custody of a person following any use of force is informed that the person was subjected to force. This notification shall include a description of the force used and any other circumstances the officer reasonably believes would be potential safety or medical risks to the subject (e.g., prolonged struggle, extreme agitation, impaired respiration).

Individuals who exhibit extreme agitation, violent irrational behavior accompanied by profuse sweating, extraordinary strength beyond their physical characteristics, and imperviousness to pain (sometimes called "excited delirium"), or who require a protracted physical encounter with multiple officers to be brought under control, may be at an increased risk of sudden death. Calls involving these persons should be considered medical emergencies. Officers who reasonably suspect a medical emergency should request medical assistance as soon as practicable and have medical personnel stage away.

See the Medical Aid and Response Policy for additional guidelines.

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#### 300.6.1 ADDITIONAL STATE REQUIREMENTS

An officer should take steps to obtain medical attention for a person who reasonably appears to be mentally ill and is behaving in a manner that is likely to result in serious harm to the person or to others.

Officers should document requests for medical or mental health treatment as well as efforts to arrange for such treatment.

#### 300.7 SUPERVISOR RESPONSIBILITIES

A supervisor should respond to a reported application of force resulting in visible injury, if reasonably available. When a supervisor is able to respond to an incident in which there has been a reported application of force, the supervisor is expected to (Executive Law § 840):

- (a) Obtain the basic facts from the involved officers. Absent an allegation of misconduct or excessive force, this will be considered a routine contact in the normal course of duties.
- (b) Ensure that any injured parties are examined and treated.
- (c) When possible, separately obtain a recorded interview or Body Worn Camera evidence with the individual upon whom force was applied. If this interview is conducted without the individual having voluntarily waived his/her *Miranda* rights, the following shall apply:
  1. The content of the interview should not be summarized or included in any related criminal charges.
  2. The fact that a recorded interview was conducted should be documented in a property or other report.
  3. The recording of the interview should be distinctly marked for retention until all potential for civil litigation has expired.
- (d) Once any initial medical assessment has been completed or first aid has been rendered, ensure that photographs have been taken of any areas involving visible injury or complaint of pain, as well as overall photographs of uninjured areas.
  1. These photographs should be retained until all potential for civil litigation has expired.
- (e) Identify any witnesses not already included in related reports, including any officers present at the incident.
- (f) Review and approve all related reports.
  1. Supervisors should require that officers who engaged in the use of force submit the appropriate report.
- (g) Determine if there is any indication that the individual may pursue civil litigation.
  1. If there is an indication of potential civil litigation, the supervisor should complete and route a notification of a potential claim through the appropriate Captain.



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- (h) Evaluate the circumstances surrounding the incident and initiate an administrative investigation if there is a question of policy noncompliance or if for any reason further investigation may be appropriate.
  - 1. Disciplinary actions will be consistent with any applicable disciplinary guidelines and collective bargaining agreements.

In the event that a supervisor is unable to respond to the scene of an incident involving the reported application of force, the supervisor is still expected to complete as many of the above items as circumstances permit.

#### **300.7.1 SHIFT SUPERVISOR RESPONSIBILITIES**

The Shift Supervisor shall review each use of force by any personnel within his/her command to ensure compliance with this policy and to address any training issues.

The Shift Supervisor should ensure that the Compliance Officer is provided with enough information to meet the use of force reporting requirements for the DCJS (Executive Law § 837-t; 9 NYCRR 6058.3).

#### **300.7.2 COMPLIANCE OFFICER RESPONSIBILITIES**

The Compliance Officer shall ensure that reports are submitted to the DCJS when an officer (Executive Law § 837-t; 9 NYCRR 6058.3):

- (a) Brandishes, uses, or discharges a firearm at or in the direction of another person.
- (b) Uses a carotid control hold or similar restraint that applies pressure to the throat or windpipe of a person in a manner that is reasonably likely to hinder breathing or reduce intake of air.
- (c) Displays, uses, or deploys a chemical agent or control device, including but not limited to oleoresin capsicum (OC), pepper projectiles, tear gas, batons, or kinetic energy projectiles (see the Control Devices Policy).
- (d) Brandishes, uses, or deploys an impact weapon.
- (e) Brandishes, uses, or deploys an electronic control weapon, including an electronic stun gun (see the Conducted Energy Device Policy).
- (f) Engages in conduct which results in the death or serious bodily injury of another person.

#### **300.8 TRAINING**

Officers will receive periodic training on this policy and demonstrate their knowledge and understanding.

Subject to available resources, officers should receive periodic training on:

- (a) Guidelines regarding vulnerable populations, including but not limited to children, elderly, pregnant persons, and individuals with physical, mental, or intellectual disabilities.
- (b) De-escalation tactics, including alternatives to force.

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- (c) Applications of use of force and conflict strategies as required by the state Use of Force Model Policy (Executive Law § 840).

#### **300.9 POLICY AVAILABILITY**

This policy shall be readily available to the public upon request and shall be posted on the department website (Executive Law § 840).

#### **300.10 USE OF FORCE ANALYSIS**

At least annually, the Detective Captain should prepare an analysis report on use of force incidents. The report should be submitted to the Chief of Police. The report should not contain the names of officers, suspects, or case numbers, and should include:

- (a) The identification of any trends in the use of force by members.
- (b) Training needs recommendations.
- (c) Equipment needs recommendations.
- (d) Policy revision recommendations.

## Attachments

## Use of Force Matrix.pdf

## MATRIX

Offender Resistance Level	Offender Actions	Police Level of Force	Police Response/Actions
Psychological Intimidation	Staring down Standing close to officer or victim	Officer Presence  Verbal direction	Interview stance Defensive fighting stance  De-escalation tactics, Verbal advice/ persuasive talk
Non-verbal and Verbal Non-compliance	Words/ gestures indicating resistance. Standing in close proximity.	Verbal orders  Taser presented	Verbal warning Direct order Laser light deployed/ spark test used
Passive Resistance	Limp body posture. Unresponsive Ignoring commands.	BolaWrap  Pepper Spray (OC)  Soft empty-hand	Pressure points Joint-lock control hold Control escort technique <b>* TASER may be deployed (drive stun/fired) if officer believes soft empty-hand would put officer or public at risk.</b>
Active/ Defensive Resistance	Holding onto, bracing against. Pushing/pulling away. Spitting. Walking/running away.	Hard empty-hand  Less Lethal (TASER) Muzzled K-9 (violation/misd apprehension)	Closed hand focused strikes Elbow, feet, knee strikes Deploy TASER
Aggressive Resistance	Attacking officer, punching, kicking.	Less-lethal (TASER) Impact weapons K-9 (felony/ officer-civilian protection)	Baton strikes Hard empty-hand strikes Hair takedown Deploy TASER Draw/present firearm
Aggravated Aggressive Resistance *(potential for deadly assault)	Armed with dangerous instrument.	Less Lethal (TASER) Impact weapons <b>*Deadly Force</b>	TASER <b>*Firearms</b> <b>* Any improvised device or method which is reasonable and necessary to accomplish a legitimate law enforcement purpose</b>
Deadly force assault	Lethal assault with deadly weapon (gun, knife, vehicle, etc)	Deadly Force	Firearms Any improvised device or method which is reasonable and necessary to accomplish a legitimate law enforcement purpose

# EXHIBIT 6



**COUNTY OF ERIE  
OFFICE OF THE MEDICAL EXAMINER**

501 Kensington Avenue  
Buffalo, New York 14214  
(716) 961-7591  
Fax: (716) 961-7581

**REPORT OF AUTOPSY**

**Name of Decedent:** Hodge, Troy Alexander

**M.E. #:** 19-0710

**Exam Performed by:** Alexandra Hart, M.D.

**Date of Exam:** June 17, 2019

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**FINAL DIAGNOSES**

- I. POSTMORTEM TOXICOLOGY POSITIVE FOR COCAINE, BENZOYLECGONINE, ECGONINE METHYL ESTER, BUPRENORPHINE, AND NORBUPRENOPHINE (REFER TO SEPARATE TOXICOLOGY REPORT)
- II. BLUNT FORCE INJURIES OF THE HEAD AND NECK
  - a. LACERATION, ABRASIONS, AND ECCHYMOSES
  - b. CONJUNCTIVAL PETECHIAE
  - c. SUBSCALPULAR HEMORRHAGES
  - d. BILATERAL TEMPORALIS MUSCLE HEMORRHAGES
  - e. STERNOCLEIDOMASTOID AND STERNOHYOID MUSCLE HEMORRHAGES
  - f. NO EVIDENCE OF INTRACRANIAL INJURIES (REFER TO SEPARATE NEUROPATHOLOGY REPORT)
- III. BLUNT FORCE INJURIES OF THE TORSO
  - a. ABRASIONS AND ECCHYMOSES
  - b. SUBCUTANEOUS AND MUSCULAR HEMORRHAGES
  - c. HEMORRHAGES OF THORACIC WALL INCLUDING INTERCOSTAL MUSCLES AND SOFT TISSUES ADJACENT TO THORACIC AORTA
  - d. HEMORRHAGE OF LOWER LOBES OF BILATERAL LUNGS
- IV. BLUNT FORCE INJURIES OF THE EXTREMITIES
  - a. ABRASIONS AND ECCHYMOSES
  - b. SUBCUTANEOUS AND MUSCULAR HEMORRHAGES

V. EMPHYSEMATOUS CHANGES, UPPER LOBE OF THE RIGHT LUNG  
VI. RENAL CORTICAL TUMOR, MICROSCOPIC, INCIDENTAL

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CAUSE OF DEATH:

SUDDEN DEATH ASSOCIATED WITH ACUTE  
COCAINE INTOXICATION AND PROLONGED  
PHYSICAL ALTERCATION

MANNER OF DEATH:

HOMICIDE