



**Ohio Attorney General's Office
Bureau of Criminal Investigation
Investigative Report**



2025-1603
Officer Involved Critical Incident - 4482 Hampton Woods
Ct., Columbus, Ohio 43230 (L)

Investigative Activity: EMS Run Report & Hospital Records
Involves: Jerry Smith & Marybeth Bright
Activity Date: 05/27/2025
Authoring Agent: SA Chad Holcomb, #61

Narrative:

On Tuesday, May 27, 2025, Ohio Bureau of Criminal Investigation (BCI) Special Agent (SA) Chad Holcomb (SA Holcomb) received Marybeth Bright (Bright) & Jerry Smith's (Smith) EMS run reports from the Columbus Division of Fire. SA Holcomb reviewed the EMS run reports and noted the following:

Jerry Smith

TEMS Medic Benjamin Funk (Funk) wrote in the narrative that Smith was shot and fell to the ground. EMS found the Smith, "... [REDACTED]

[REDACTED]
[REDACTED]
[REDACTED]

After this assessment, all EMS personnel agreed that these injuries were clearly incompatible with life. Code 1 time of 2355L, 5/19/2025".

Mary Beth Bright

CFD Medic Ryan Hickey (Hickey) wrote in the narrative, [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

[REDACTED] Bright was then transferred to Mount Carmel East for further treatment.

While Bright was at Mt. Carmel East Hospital she met with Wendy Tripp, RN, who is a forensic nurse. [REDACTED]

[REDACTED]
[REDACTED]
[REDACTED]

This document is the property of the Ohio Bureau of Criminal Investigation and is confidential in nature. Neither the document nor its contents are to be disseminated outside your agency except as provided by law - a statute, an administrative rule, or any rule of procedure.



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[REDACTED]

The medical records obtained are attached to this report as well as the photos taken by the forensic nurse. The photos have been uploaded to Matrix in a zipped folder. Please refer to the attachments for further details.

References:

No references.

Attachments:

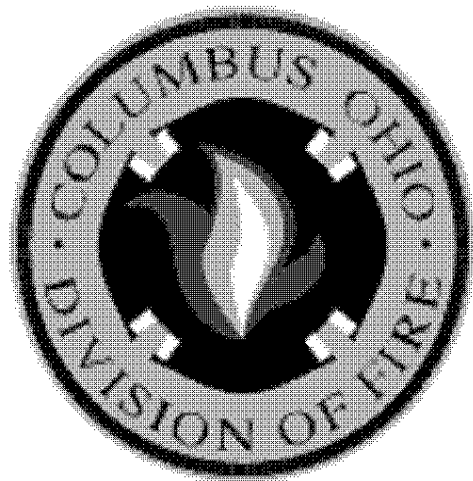
Attachment #01: Jerry Smith and Mary Beth Bright CFD Run Report

Attachment #02: Mary Beth Bright Strangulation Report

Attachment #03: Bright Strangulation Photos

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2025/05/21 08:43:48 1 /12



Columbus Division of Fire
3639 Parsons Avenue
Columbus, Ohio 43207

EMSRecordRequest@columbus.gov
Phone: (614) 645-7384
FAX: (614) 645-6332

FAX COVER SHEET

Date: 2025-05-21

To: OAG

Attention: Chadwick Holcomb

Fax Number: 91-866-534-6281

Comments: Jerry Smith & Mary Beth Bright

Optum Healthcare processes all billing charges. Their mailing address is 4720 Salisbury Road Suite 121 Jacksonville, Florida 32256. Their phone number is (855) 626-9660. Attorneys are encouraged to submit billing requests to ChartSwap.com.

Thank you for your cooperation.

Amy Cooper

Records Request
Phone: (614) 645-7384
Fax: (614) 645-6332

Attention: The Columbus Division of Fire is compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The attached fax is to be received and/or reviewed by only the party identified in the header on this face sheet. By accepting this fax you accept responsibility for the securing of confidential information that is HIPAA protected contained within. If you are **not** the intended recipient or do not accept responsibility for the securing of this information, you are instructed to contact the Columbus Division of Fire at (614) 645-7384 immediately.



Name: SMITH, JERRY

Incident #: [REDACTED]

Date: 05/19/2025

Patient 1 of 1

Assessments			
Assessment Time: 05/19/2025 23:54:00			
Category	Comments	Subcategory	
Extremities		Left Arm	[REDACTED]
		Right Arm	[REDACTED]
		Left Leg	[REDACTED]
		Right Leg	[REDACTED]
Neurological		Neurological	[REDACTED]
Neonatal			

Narrative

[REDACTED]

5/20/2025 12:43:05 PM COOPER, AMY
Updated the patient's SSN via the coroner's request.

Specialty Patient - 2021 Trauma Triage Guidelines	
Injury Patterns	[REDACTED]
Mental Status & Vital Signs	[REDACTED]
Mechanism of Injury	[REDACTED]
EMS Judgment	[REDACTED]
Trauma Triage Score	[REDACTED]

Incident Details		Destination Details		Incident Times	
Location Type	Home/Residence	Disposition		PSAP Call	
Location		Unit Disposition	Patient Contact Made	Dispatch Notified	05/19/2025 22:09:53
Address	4482 Hampton Woods Ct	Patient Evaluation and/or Care Disposition	Patient Evaluated, No Care Required	Call Received	05/19/2025 22:09:53
Address 2		Crew Disposition	Back in Service, No Care or Support Services Required	Dispatched	05/19/2025 22:10:03
Mile Marker		Transport Disposition	No Transport	En Route	05/19/2025 22:12:58
City	Columbus	Transport Mode		Staged	
County	Franklin	Reason for Refusal or Release		Resp on Scene	
State	OH	Transport Mode Descriptors		On Scene	05/19/2025 22:31:18
Zip	43230	Transport Due To		At Patient	05/19/2025 23:53:00
Country	US	Transported To		Care Transferred	
Medic Unit	M890	Requested By		Depart Scene	
Medic Vehicle		Transferred To		At Destination	
Run Type	Emergency Response (Primary Response Area)	Transferred Unit		Pt. Transferred	
Response Mode	Emergent	Destination		Call Closed	05/20/2025 01:29:50
Response Mode Descriptors		Department		In District	
Shift	3 Unit	Address		At Landing Area	
Zone		Address 2			
Level of Service		City			
EMD Complaint	Standby	County			
EMD Card Number	SWAT STANDBY	State			
Dispatch Priority		Zip			



Name: SMITH, JERRY

Incident #: [REDACTED]

Date: 05/19/2025

Patient 1 of 1

Incident Details		Destination Details		Incident Times
		Country	US	
		Zone		
		Condition at Destination		
		State Wristband #		
		Destination Record #		
		Trauma Registry ID		
		STEMI Registry ID		
		Stroke Registry ID		
Alternative Disposition Offered				

Crew Members				
Personnel	Role	Certification Level	PPE	Exposures
SALVADORE, KYLIE M.	Other	2009 Paramedic - (Ohio) - 87183		
FUNK, BENJAMIN E.	Lead	2009 Paramedic - (Ohio) - 132403		
HAGAN, JOHN P.	Driver	2009 Paramedic - (Ohio) - 101694		

Mileage		Delays		Additional Agencies
Scene	Destination	Category	Delays	
Loaded Miles				
Start				
End				
Total Miles				

Billing Authorization

Authorization

Section I - Patient / Parent of Minor Authorization Signature

Signature

Signed On	
Notice of Privacy Practices Provided	
Printed Patient / Parent Name	
Billing Authorization	
HIPAA Acknowledgement	

Section II - Authorized Representative Signature

Complete this section only if the patient is physically or mentally unable to sign.
Authorized representatives include only the following:(Check one)

Patient's Legal Guardian
Patient's Medical Power of Attorney
Relative or other person who receives benefits on behalf of the patient
Relative or other person who arranges treatment or handles the patient's affairs
Representative of an agency or institution that provided care, services or assistance to patient

I am signing on behalf of the patient to authorize the submission of a claim for payment to Medicare, Medicaid, or any other payer for any services provided to the patient by the transporting ambulance service now or in the past or in the future. By signing below, I acknowledge that I am one of the authorized signers listed below. **My signature is not an acceptance of financial responsibility for the services rendered.**

Signature

Signed On	
Notice of Privacy Practices Provided	
Printed Name	
Reason unable to sign	

Section III - EMS Personnel and Facility Signatures

Complete this section if the patient was mentally or physically incapable of signing, and no Authorized Representative (section II) was available or willing to sign on behalf of the patient at the time of service.

EMS Personnel Signature

A signature below authorizes the submission of a claim to Medicare, Medicaid, or any other payer for any services provided to the patient by the transporting ambulance service. My signature below indicates that, at the time of service, the patient was physically or mentally incapable of signing, and that none of the authorized representatives listed in Section II of this form were available or willing to sign on the patient's behalf. **My signature is not an acceptance of financial responsibility for the services rendered.**

Signed On	
Printed Name	
Reason unable to sign	

Facility Representative Signature

The patient named on this form was received by this facility on the date and at the time indicated and this facility furnished care, services or assistance to the patient. **My signature is not an acceptance of financial responsibility for the services rendered..**

Signed On	
Notice of Privacy Practices Provided	
Printed Name	
Title of Representative	

Facility Signatures

Signed On	
Receiving	

Signed On	
Paperwork Received	

Signed On	
Airway Confirmation	

Provider Signatures



Lead Provider	FUNK, BENJAMIN E.	Certification Level	2009 Paramedic - (Ohio) - 132403
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Provider		Certification Level	
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Provider		Certification Level	
----------	--	---------------------	--

Provider		Certification Level	
----------	--	---------------------	--



Name: BRIGHT, MARY BETH

Incident #: [REDACTED]

Date: 05/19/2025

Patient 2 of 2

Patient Information				Clinical Impression	
Last	BRIGHT	Address	4482 Hampton Woods Ct	Primary Impression	[REDACTED]
First	MARY BETH	Address 2		Secondary Impression	
Middle		City	Columbus	Protocols Used	
Gender	Female	State	OH	Local Protocol Provided Care Level	
DOB	02/08/1982	Zip	43230	Anatomic Position	
Age	43 Yrs, 3 Months, 11 Days	Country	US	Onset Time	
Weight		Tel		Last Known Well	
Height		Physician		Chief Complaint	
Pedi Color		Phys. Tel		Duration	
SSN	[REDACTED]	Ethnicity	Not Hispanic or Latino	Secondary Complaint	
Race	White			Duration	
Advance Directives				Patient's Level of Distress	
Resident Status				Signs & Symptoms	
Patient Resides in Service Area				Injury	
Temporary Residence Type				Additional Injury	
				Mechanism of Injury	
				Medical/Trauma	
				Barriers of Care	
				Alcohol/Drugs	
				Pregnancy	
				Initial Patient Acuity	
				Final Patient Acuity	
				Patient Activity	

Medications/Allergies/History/Immunizations	
Medications	[REDACTED]
Allergies	[REDACTED]
History	[REDACTED]
Immunizations	[REDACTED]
Last Oral Intake	[REDACTED]

Vital Signs	
[REDACTED]	[REDACTED]

Flow Chart			
Time	Treatment	Description	Provider
00:14	[REDACTED]	[REDACTED]	HICKEY, RYAN

Assessments			
Assessment Time: 05/20/2025 00:15:54			
Category	Comments	Subcategory	
Mental Status		Mental Status	[REDACTED]
Skin		Skin	[REDACTED]
HEENT		Head	[REDACTED]
		Face	[REDACTED]
		Eyes	[REDACTED]
		Neck	[REDACTED]



Name: BRIGHT, MARY BETH

Incident #: F25082616

Date: 05/19/2025

Patient 2 of 2

Assessments			
Assessment Time: 05/20/2025 00:15:54			
Category	Comments	Subcategory	
Chest			
Abdomen			
Back			
Pelvis/GU/GI			
Extremities			
Neurological			
Neonatal			

Narrative

C-Injured from assault

H-911 was called for pt being injured from an assault

[REDACTED]

[REDACTED]

[REDACTED] T driven to St. Annes ER without incident. Pt moved from cot to ER bed. PT care transferred to ER staff

Specialty Patient - 2021 Trauma Triage Guidelines			
Injury Patterns		Trauma Activation	
Mental Status & Vital Signs		Time	
Mechanism of Injury		Date	
EMS Judgment		Trauma level	
Trauma Triage Score		Reason Not Activated	

Incident Details		Destination Details		Incident Times	
Location Type	Home/Residence	Disposition		PSAP Call	
Location		Unit Disposition	Patient Contact Made	Dispatch Notified	05/19/2025 22:09:53
Address	SUNBURY RD / BAHAMAS DR	Patient Evaluation and/or Care Disposition	Patient Evaluated and Care Provided	Call Received	05/19/2025 22:09:53
Address 2		Crew Disposition	Initiated and Continued Primary Care	Dispatched	05/19/2025 22:19:47
Mile Marker		Transport Disposition	Transport by This EMS Unit (This Crew Only)	En Route	05/19/2025 22:21:25
City	Columbus	Transport Mode	Non-Emergent	Staged	
County	Franklin	Reason for Refusal or Release		Resp on Scene	
State	OH	Transport Mode Descriptors	No Lights or Sirens	On Scene	05/19/2025 22:25:59
Zip	43230	Transport Due To	Closest Facility	At Patient	05/20/2025 00:06:00
Country	US	Transported To	MT CARMEL EAST HOSPITAL	Care Transferred	

Columbus Division of Fire
Patient Care Record

Name: BRIGHT, MARY BETH

Incident #: [REDACTED]

Date: 05/19/2025

Patient 2 of 2

Incident Details		Destination Details		Incident Times	
Medic Unit	M29	Requested By	Patient	Depart Scene	05/20/2025 00:07:39
Medic Vehicle		Transferred To		At Destination	05/20/2025 00:26:00
Run Type	Emergency Response (Primary Response Area)	Transferred Unit		Pt. Transferred	
Response Mode	Emergent	Destination	Hospital	Call Closed	05/20/2025 00:36:00
Response Mode Descriptors		Department	Emergency Room	In District	
Shift	3 Unit	Address	6001 E Broad St	At Landing Area	
Zone	Battalion 2	Address 2			
Level of Service		City	Columbus		
EMD Complaint	Standby	County	Franklin		
EMD Card Number	SWAT STANDBY	State	OH		
Dispatch Priority		Zip	43213		
		Country	US		
		Zone			
		Condition at Destination			
		State Wristband #			
		Destination Record #			
		Trauma Registry ID			
		STEMI Registry ID			
		Stroke Registry ID			
Alternative Disposition Offered					

Crew Members				
Personnel	Role	Certification Level	PPE	Exposures
HICKEY, RYAN	Lead	2009 Paramedic - (Ohio) - 162883		
Snider, Troy	Driver	2009 Emergency Medical Technician (Ohio) - 197156		

Mileage		Delays		Additional Agencies	
Scene	Category	Delays			
Destination					
Loaded Miles					
Start					
End					
Total Miles					

Patient Transport Details			
How was Patient Moved To Stretcher		How was Patient Moved To Ambulance	Stretcher
How was Patient Moved From Ambulance	Stretcher	Patient Position During Transport	Semi-Fowlers
Condition of Patient at Destination			

Billing Authorization

Authorization	Billing Authorization
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Section I - Patient / Parent of Minor Authorization Signature

I request that payment of authorized Medicare, Medicaid, or any other insurance benefits be made on my behalf to City of Columbus, Ohio Fire Division ("CFD") for any services provided to me by CFD now, in the past, or in the future. I agree to immediately remit to CFD any payments that I receive directly from insurance or any source whatsoever for any services provided to me by CFD and I assign all rights to such payments to CFD. I authorize CFD to appeal payment denials or other adverse decisions on my behalf without further authorization. I authorize and direct any holder of medical information or documentation about me to release such information to CFD and its billing agents, and/or the Centers for Medicare and Medicaid Services and its carriers and agents, and/or any other payers or insurers as may be necessary to determine these or other benefits payable for any services provided to me by CFD, now, in the past, or in the future. A copy of this form is as valid as an original. Privacy Practices Acknowledgment: by signing below, I acknowledge that I have received CFD's Notice of Privacy Practices.

Signature

Mary Beth Bright

Signed On	05/20/2025 00:30:12
Notice of Privacy Practices Provided	Yes
Printed Patient / Parent Name	
Billing Authorization	Agree
HIPAA Acknowledgement	Agree

Section II - Authorized Representative Signature

Complete this section only if the patient is physically or mentally unable to sign.
Authorized representatives include only the following:(Check one)

- Patient's Legal Guardian
- Patient's Medical Power of Attorney
- Relative or other person who receives benefits on behalf of the patient
- Relative or other person who arranges treatment or handles the patient's affairs
- Representative of an agency or institution that provided care, services or assistance to patient

I am signing on behalf of the patient to authorize the submission of a claim for payment to Medicare, Medicaid, or any other payer for any services provided to the patient by the transporting ambulance service now or in the past or in the future. By signing below, I acknowledge that I am one of the authorized signers listed below. **My signature is not an acceptance of financial responsibility for the services rendered.**

Signature

[Empty signature box]

Signed On	
Notice of Privacy Practices Provided	
Printed Name	
Reason unable to sign	



Name: BRIGHT, MARY BETH

Incident #: [REDACTED]

Date: 05/19/2025

Patient 2 of 2

Section III - EMS Personnel and Facility Signatures

Complete this section if the patient was mentally or physically incapable of signing, and no Authorized Representative (section II) was available or willing to sign on behalf of the patient at the time of service.

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[Empty signature box]

Signed On	
Printed Name	
Reason unable to sign	

Facility Representative Signature

The patient named on this form was received by this facility on the date and at the time indicated and this facility furnished care, services or assistance to the patient. **My signature is not an acceptance of financial responsibility for the services rendered..**

[Empty signature box]

Signed On	
Notice of Privacy Practices Provided	
Printed Name	
Title of Representative	

Facility Signatures

[Handwritten signature]

Signed On	05/20/2025 00:32:00
Receiving	Vanessa RN

[Empty signature box]

Signed On	
Paperwork Received	

[Empty signature box]

Signed On	
Airway Confirmation	

Provider Signatures



Lead Provider HICKEY, RYAN **Certification Level** 2009 Paramedic - (Ohio) - 162883

Provider **Certification Level**

Provider **Certification Level**

Provider **Certification Level**

