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

2024-3862
Officer Involved Critical Incident - 234 Mansfield Avenue, Shelby, Ohio 44875, Richland County

Investigative Activity:	EMS Run Report for Tyler Jacobs
Involves:	Tyler Jacobs (S)
Activity Date:	12/17/2024
Activity Location:	4055 Highlander Parkway, Richfield, Ohio, 44286
Authoring Agent:	SA John Tingley

Narrative:

On Tuesday, December 17, 2024, Ohio Bureau of Criminal Investigation (BCI) Special Agent (SA) John Tingley (Tingley) reviewed the Emergency Medical Services (EMS) records from the Shelby Fire Department (SFD) and the Mansfield Fire Department (MFD) for Tyler Jacobs (Jacobs) related to the officer involved critical incident which occurred on December 7, 2024, at 234 Mansfield Avenue, Shelby, Richland County, Ohio.

SA Tingley reviewed the documentation from SFD and noted the following:

On December 7, 2024, Shelby Fire Department (SFD) unit R-39 responded to 234 Mansfield Avenue, Shelby, Ohio, for Jacobs related to an officer involved critical incident. Upon the arrival of the EMS unit, Jacobs was found to have [redacted] with SPD Officers rendering aid. Jacobs' clothing was cut off and a medic [redacted]

SA Tingley then reviewed the documentation from MFD and noted the following:

[redacted]

Upon arrival at Ohio Health Mansfield Emergency Room, Jacobs was [redacted] and treatment was transferred to Ohio Health Mansfield Hospital staff.

The content of this Investigative Report is not intended to be a substitute for professional medical advice, diagnosis, treatment or analysis. Reliance on any information provided by SA Tingley or any supporting employee of the Ohio Attorney General's Office is solely at your own risk.

Please refer to the attached records from both the SFD and the MFD for a full account of the injuries observed and the medical treatment provided.

References:

None

Attachments:

1. 2024-3862 EMS RUN REPORT TYLER JACOBS

Incident	Date	Called	Notified		Respond	Arrived	To ER	At ER
[redacted]	12/7/2024	23:24	23:24	Shelby FD 70-017	23:24	23:27	23:52	00:05
Unit R-33	Saturday			234 MANSFIELD AVE SHELBY OH 44875			Apt.	Miles 10.2

Hospital Ohio Health Mansfield

[redacted]

Res.				Dob	SS #
Yes	31.4 y/o Female White	TYLER JACOBS 67 INDEPENDENCE DR SHELBY OH 44875		07/25/93 Apt/Lot	[redacted] Phone

Hx

Med

Allg

Impression	Injury	Injury Type	Injury Cause	Chief Complaint
[redacted]				

Alcohol / Drug Indication: [redacted]

Time	Interventions	Attempts	Succ.	Size	Location	Rate	Result	Member
[redacted]								

Time	Medications	Dose	Unit	Route	Member

RA 103115 Shade
Paramedic
172184 Ostrander
EMR

Dispatch Report: [redacted]

Incident	Date	Called	Notified	Shelby FD	Respond	Arrived	To ER	At ER
[redacted]	12/7/2024	23:24	23:24	70-017	23:24	23:27	23:52	00:05
Unit	Saturday			234 MANSFIELD AVE SHELBY OH 44875			Apt.	Miles
R-33								10.2

Hospital Ohio Health Mansfield [redacted]

Narrative

[redacted]

Additional Vitals

Directives None

Time	Pulse	Quality	BP	Resp	Quality	L Lung	R Lung	L Pupil	R Pupil	Pain

Additional Procedures

Time	Interventions	Attempts	Succ.	Size	Location	Rate	Result	Member

Additional Medications

Additional Crew

Time	Medications	Dose	Unit	Route	Member

Incident	Date	Called	Notified	Shelby FD	Respond	Arrived	To ER	At ER
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Hospital Ohio Health Mansfield [redacted]

Extended Narrative

[redacted]

Incident	Date	Called	Notified	Shelby FD	Respond	Arrived	To ER	At ER
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Hospital Ohio Health Mansfield

[redacted]

Patient Assessment

Anatomic Loc.	Loc. Detail	Findings	Severity	Treatment

Trauma Assessment

Injury Present	Cause of Injury	Trauma Acuity
[redacted]		

Protective Devices	Airbag Deployment	Alcohol Indicators
		[redacted]

Tyler Jacobs
7/25/93

[redacted]

Incident	Date	Called	Notified	Shelby FD	Respond	Arrived	To ER	At ER
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Hospital Ohio Health Mansfield

[redacted]

Photos

Photo # 1

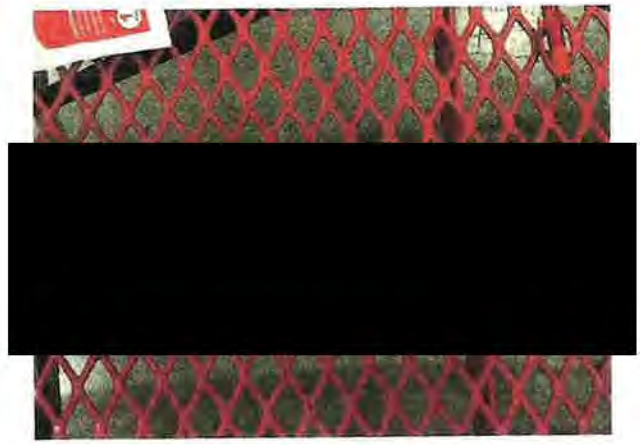

Photo # 2

Photo # 3

Photo # 4

Photo # 5

Photo # 6

Incident	Date	Called	Notified	Shelby FD	Respond	Arrived	To ER	At ER
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Hospital Ohio Health Mansfield [redacted]

Physician Certification Statement for Non Emergency Ambulance Services

SECTION I -GENERAL INFORMATION

Patient's Name: TYLER JACOBS Date of Birth: 07251993 Medicare #

Transport Date: (PCS is vaid for round trips on this date and for all repetitive trips in the 60-day range as noted below.)

Origin Destination:

Is the pt's stay covered under Medicare Part A (PPS/DRG?) ○ Yes ○ No

Closest appropriate facility? ○ Yes ○ No If no why is transport to more distant facility required?

If hosp-hosp transfer, describe services needed at 2nd facility not available at 1st facility:

If hospice pt, is this transport related to pt's terminal illness? ○ Yes ○ No Describe:

SECTION II - MEDICAL NECESSITY QUESTIONNAIRE

Ambulance Transportation is medically necessary only if other means of transport are contraindicated or would be potentially harmful to the patient. To meet this requirement, the patient must be either "bed confined" or suffer from a condition such that transport by means other than ambulance is contraindicated by the patient's condition. **The following questions must be answered by the medical professional signing below for this form to be valid:**

1) Describe the MEDICAL CONDITION (physical and/or mental) of this patient AT THE TIME OF AMBULANCE TRANSPORT that requires the patient to be transported in an ambulance and why transport by other means is contraindicated by the patient's condition.

2) Is this patient "bed confined" as defined below? ○ Yes ○ No

To be "bed confined" the patient must satisfy all three of the following conditions: (1) *unable* to get up from bed without Assistance: AMD (2) *unable* to amvulat: AND (3) *unable* to sit in a chair or wheelchair

3) Can this patient safely be transported by car or wheelchair van (ie: seated during transport, without a medical attendant or monitoring?

4) **In addition** to completing questions 1-3 above, please check any of the following conditions that apply*: ○ Yes ○ No

**Note: supporting documentation for any boxes checked must be maintained in the patient's medical records*

- ☐ Contractures
- ☐ Non-healed fractures
- ☐ Patient is confused
- ☐ Patient is comatose
- ☐ Moderate/sever pain on movement
- ☐ Danger to self/others
- ☐ IV meds/fluids required
- ☐ Patient is combative
- ☐ Need or possible need for restraints
- ☐ DVT requires elevation of a lower extremity
- ☐ Medical attendant required
- ☐ Requires oxygen-unable to self-administer
- ☐ Special handling/isolation/infection control precautions required
- ☐ Unable to tolerate seated position for time needed to transport
- ☐ Hemodynamic monitoring required en-route
- ☐ Unable to sit in a chair or wheelchair due to decubitus ulcers or other wounds requiring special handling during transport
- ☐ Cardiac monitoring required en-route
- ☐ Morbid obesity requires additional personnel/equipment
- ☐ Orthope
- ☐ Other

SECTION III - SIGNATURE OF PHYSICIAN OR HEALTHCARE PROFESSIONAL

I certify that the above information is true and correct based on my evaluation of this patient, and represent that the patient requires transport by ambulance and that other forms of transport are contraindicated. I understand that this information will be used by the Centers for Medicare and Medicaid Services (CMS) to support the determination of medical necessity for ambulance services, and I represent that I have personal knowledge of the patient's condition at the time of transport.

☐ **If this box is checked**, I also certify that the patient is physically or mentally incapable of signing the ambulance service's claim and that the institution with which I am affiliated has furnished care, services or assistance to the patient. My signature below is made on behalf of the patient pursuant to 42 CFR *424.36(b)(4). In accordance with 42 CFR *424.37, ***the specific reason(s) that the patient is physically or mentally incapable of signing the claim form is as follows***:

X _____

Signature of Physician* or Healthcare Professional

12/7/2024

Date Signed
(For scheduled repetitive transport, this form is not valid for transport performed more than 60 days after this date).

Printed Name and Credentials of Physician or Healthcare Professional (MD, DO, RN, etc.)

**Form must be signed only by patient's attending physician for scheduled, respective transports. For non-repetitive, unscheduled ambulance transports, if unable to obtain the signature of the attending physician, any of the following may sign (please check appropriate box below):*

○ Physician ○ Nurse ○ Clinical Nurse Specialist ○ Discharge Planner ○ Registered Nurse

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Unit							Apt.	Miles
R-33	Saturday		234 MANSFIELD AVE SHELBY OH 44875					10.2

Hospital Ohio Health Mansfield

[redacted]

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Hospital Ohio Health Mansfield

[redacted]

[redacted]

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Hospital Ohio Health Mansfield [redacted]

Additional Vitals

Time	Pulse	Quality	BP	Resp	Quality	L Lung	R Lung	L Pupil	R Pupil	Pain

Additional Procedures

Time	Interventions	Attempts	Succ.	Size	Location	Rate	Result	Member

Additional Crew

Incident	Date	Called	Notified	Shelby FD	Respond	Arrived	To ER	At ER
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Hospital Ohio Health Mansfield [redacted]

Additional Hx, Meds, Allergies

History	Meds	Allergies

Additional Medications Given

Time	Medications	Dose	Unit	Route	Member

Incident	Date	Called	Notified	Shelby FD	Respond	Arrived	To ER	At ER
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Hospital Ohio Health Mansfield [redacted]

Privacy Practices Acknowledgment: by signing below the signer acknowledges that Shelby FD provided a copy of it's Notice of Privacy Practices to the patient or other party with instructions to provide the Notice to the patient.

*** A copy of this form is as valid as an original ***

SECTION I - PATIENT SIGNATURE

The patient must sign here unless the patient is physically or mentally incapable of signing.
NOTE: If the patient is a minor, the parent or legal guardian should sign in this section.

I authorize the submission of a claim for payment to Medicare, Medicaid, or any other payor for any services provided to me by Shelby FD now, in the past, or in the future, until such time as I revoke this authorization in writing. I understand that I am financially responsible for the services and supplies provided to me by Shelby FD regardless of my insurance coverage, and in some cases, may be responsible for an amount in addition to that which was paid by my insurance. I agree to immediately remit to Shelby FD any payments that I receive directly from insurance or any source whatsoever for the services provided to me and I assign all rights to such payments to Shelby FD. I authorize Shelby FD to appeal payment denials or other adverse decisions on my behalf without further authorization. I authorize and direct any holder of medical information or other relevant documentation about me to release such to Shelby FD and billing agents, the Centers for Medicare and Medicaid Services, and / or any other payor or insurers, and their respective agents or contractors, as may be necessary to determine these or other benefits payable for any services provided to me by Shelby FD, now, in the past, or in the future.

☐ **For Known or Suspected COVID-19 Patient Only**

CHECK HERE if patient gave consent for ambulance crew to sign

X _____ 12/7/2024
Patient Signature

X _____ 12/7/2024
Ambulance Crew Member Signature
(Crew member should sign own name and not pt's name)

SECTION II - AUTHORIZED REPRESENTATIVE SIGNATURE

Complete this section only if the patient is physically or mentally incapable of signing.
On the line below, explain the circumstances that make it impractical for the patient to sign:

X _____ 12/7/2024
Representative Signature

_____
Name and Address of Representative

SECTION III - AMBULANCE CREW AND RECEIVING FACILITY SIGNATURES

Complete this section only if: (1) the patient was physically or mentally incapable of signing and
(2) no authorized representative (Section II) was available or willing to sign on behalf of he patient at the time of service.

A. Ambulance Crew Member Statement (must be completed by crew member at time of transport).

My signature below indicates that, at the time of service, the patient named above 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.
On the line below, explain the circumstances that make it impractical for the patient to sign:

[redacted]

X _____ 12/7/2024
Signature of Crew Member

SHADE
PARAMEDIC

B. Receiving Facility Representative Signature

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

Receiving Facility:
Ohio Health Mansfield

X _____ 12/7/2024
Signature of Receiving Facility Representative

Brianna Felder Rn RN
Name and Title of Receiving Facility Representative