



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



2026-1239

Officer Involved Critical Incident - 31000 Block U.S. Route 250, Uhrichsville, Ohio 44683, Harrison County

Investigative Activity: Review of Hopedale Fire Department Run Logs
Involves: Michael Decker (S)
Activity Date: 04/09/2026
Activity Location: BCI - Boardman
Authoring Agent: SA Joseph Lamping #184

Narrative:

On Thursday, April 9, 2026, Ohio Bureau of Criminal Investigation (BCI) Special Agent (SA) Joe Lamping (Lamping) contacted Hopedale Fire Department (HFD) Chief Michael Marchetta in reference to obtaining EMS reports related to Michael Decker (Decker). The EMS report was emailed to SA Lamping and then attached to this report where it can be reviewed in its entirety.

SA Lamping reviewed the report and documented information he deemed most pertinent. The run report was associated with incident [REDACTED], and was initiated at 21:00 hours on Monday, March 30, 2026. The report listed two Paramedics: Molinaro #549 and McCoy #576.

The patient was listed as Michael Decker, and his date of birth was listed as June 3, 1972. The following snippet was taken from the report and encompassed the initial assessment of Decker:

<u>Impression</u>	<u>Injury</u>	<u>Injury Type</u>	<u>Injury Cause</u>	<u>Chief Complaint</u>
Obvious Death	Yes	Penetrating	Injury sustained during encounter with law	DOA

One of the paramedics completed the following narrative:

SRT ACTIVATION BY HARRISON COUNTY. THEY ADVISED TO REPORT TO SCENE ON U.S. 22 OSP HAD COMMAND. AFTER MOVING LOCATIONS ONCE SUSPECT WAS LOCATED OSP REQUESTED CREWS TO MOVE CLOSER TO THE SCENE. IT WAS ADVISED OVER THE RADIO OFFICERS SHOT THE SUSPECT AND FIRST AID WAS BEING PROVIDED. AFTER THE SCENE WAS DEEMED SAFE OSP CALLED FOR CREWS TO ADVANCE TO THE SCENE OF THE SHOOTING. UPON ARRIVAL TO SCENE CREWS FOUND A MALE LAYING UNRESPONSIVE WITH A GSW TO THE CHEST AND RIGHT SIDE OF HIS HEAD. OSP SRT HAD PLACED A CHEST SEAL TO THE WOUND ON THE PATIENTS CHEST. 4 [REDACTED] PATIENT WAS PRONOUNCED DECEASED 21:09 HOURS ON 03/30/2026. CORNER WAS REQUESTED TO THE SCENE. ONCE CORNER ASSISTANT RELEASED THE BODY, BODY WAS TRANSPORTED TO HARRISON COMMUNITY HOSPITAL MORGUE. CREW WAS CLEARED FROM SCENE BY BCI AND CORNER INVESTIGATOR. 8:55:47 3/31/2026

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250, Uhrichsville, Ohio 44683, Harrison County

The below snippet was taken from the trauma assessment section of the report:

Trauma Assessment		
<u>Injury Present</u>	<u>Cause of Injury</u>	<u>Trauma Acuity</u>
[REDACTED]		
<u>Injury Type</u>	<u>Trauma Triage</u>	
[REDACTED]		

References:

None

Attachments:

1. 2026-04-09 - Hopedale EMS Run Reports

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Incident Unit 510	Date 3/30/2026 Monday	Called 21:00	Notified 21:00	Hopedale Fire Dept 34-201 MINE RD HOPEDALE OH 43976	Respond 21:00	Arrived 21:00	To ER 22:45 Apt.	At ER 23:00 Miles
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Hospital N/A Not Applicable

Res. No	53.9 y/o Male White	MICHEAL DECKER UNKNOWN STEUBENVILLE OH 43953	Dob 06/03/72 Apt/Lot	SS # 000-00-0000 Phone
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<u>Hx</u>	No History	<u>Med</u>	No Meds	<u>Allg</u>	NKA
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<u>Impression</u>	<u>Injury</u>	<u>Injury Type</u>	<u>Injury Cause</u>	<u>Chief Complaint</u>		
[REDACTED]						
<u>Onset</u>	<u>Face</u>	<u>Arms</u>	<u>Grips</u>	<u>Speech</u>	<u>Last Normal</u>	<u>Primary Dr.</u>

<u>Time</u>	<u>Pulse</u>	<u>Quality</u>	<u>BP</u>	<u>Resp</u>	<u>Quality</u>	<u>L Lung</u>	<u>R Lung</u>	<u>L Pupil</u>	<u>R Pupil</u>	<u>Pain</u>
21:09	[REDACTED]									
	<u>Rhythm</u>	<u>BGL</u>	<u>SpO2</u>	<u>EtCo2</u>	<u>Msp's</u>	<u>Skin Color</u>	<u>Skin Moisture</u>	<u>Cap</u>	<u>AVPU</u>	<u>Gcs</u>
	Asystole									[REDACTED]

Alcohol / Drug Indication: No Indicators of Alcohol/Drug Use

<u>Time</u>	<u>Interventions</u>	<u>Attempts</u>	<u>Succ.</u>	<u>Size</u>	<u>Location</u>	<u>Rate</u>	<u>Result</u>	<u>Member</u>
21:09	Assessment Adult	1	Yes					549
21:38	4 Lead	1	Yes					549

<u>Time</u>	<u>Medications</u>	<u>Dose</u>	<u>Unit</u>	<u>Route</u>	<u>Member</u>
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					RA	 549 Molinaro Paramedic 576 McCoy Paramedic
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Unit 510	Date 3/30/2026 Monday	Called 21:00	Notified 21:00	Hopedale Fire Dept 34-201 MINE RD HOPEDALE OH 43976	Respond 21:00	Arrived 21:00	To ER 22:45 Apt.	At ER 23:00 Miles
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Hospital N/A

Not Applicable

Narrative

SRT ACTIVATION BY HARRISON COUNTY. THEY ADVISED TO REPORT TO SCENE ON U.S. 22 OSP HAD COMMAND. AFTER MOVING LOCATIONS ONCE SUSPECT WAS LOCATED OSP REQUESTED CREWS TO MOVE CLOSER TO THE SCENE. IT WAS ADVISED OVER THE RADIO OFFICERS SHOT THE SUSPECT AND FIRST AID WAS BEING PROVIDED. AFTER THE SCENE WAS DEEMED SAFE OSP CALLED FOR CREWS TO ADVANCE TO THE SCENE OF THE SHOOTING. UPON ARRIVAL TO SCENE CREWS FOUND A MALE LAYING UNRESPONSIVE WITH A GSW TO THE CHEST AND RIGHT SIDE OF HIS HEAD. OSP SRT HAD PLACED A CHEST SEAL TO THE WOUND ON THE PATIENTS CHEST. [REDACTED] PATIENT WAS PRONOUNCED DECEASED 21:09 HOURS ON 03/30/2026. CORNER WAS REQUESTED TO THE SCENE. ONCE CORNER ASSISTANT RELEASED THE BODY, BODY WAS TRANSPORTED TO HARRISON COMMUNITY HOSPITAL MORGUE. CREW WAS CLEARED FROM SCENE BY BCI AND CORNER INVESTIGATOR. 8:55:47 3/31/2026

			<u>Additional Vitals</u>	<u>Directives</u>	None					
<u>Time</u>	<u>Pulse</u>	<u>Quality</u>	<u>BP</u>	<u>Resp</u>	<u>Quality</u>	<u>L Lung</u>	<u>R Lung</u>	<u>L Pupil</u>	<u>R Pupil</u>	<u>Pain</u>

<u>Additional Procedures</u>									
<u>Time</u>	<u>Interventions</u>	<u>Attempts</u>	<u>Succ.</u>	<u>Size</u>	<u>Location</u>	<u>Rate</u>	<u>Result</u>	<u>Member</u>	

<u>Additional Medications</u>						<u>Additional Crew</u>
<u>Time</u>	<u>Medications</u>	<u>Dose</u>	<u>Unit</u>	<u>Route</u>	<u>Member</u>	

Incident ██████████	Date 3/30/2026	Called 21:00	Notified 21:00	Hopedale Fire Dept 34-201 MINE RD HOPEDALE OH 43976	Respond 21:00	Arrived 21:00	To ER 22:45 Apt.	At ER 23:00 Miles
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Hospital N/A

Not Applicable

Privacy Practices Acknowledgment: by signing below the signer acknowledges that Hopedale Fire Dept 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 Hopedale Fire Dept 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 Hopedale Fire Dept 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 Hopedale Fire Dept 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 Hopedale Fire Dept. I authorize Hopedale Fire Dept 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 Hopedale Fire Dept 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 Hopedale Fire Dept. 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 _____ 3/30/2026

X _____ 3/30/2026

Patient Signature

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 _____ 3/30/2026

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:

X _____ 3/30/2026

Signature of Crew Member

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:
N/A

X _____ 3/30/2026

Signature of Receiving Facility Representative

Name and Title of Receiving Facility Representative

Incident [REDACTED]	Date 3/30/2026	Called 21:00	Notified 21:00	Hopedale Fire Dept 34-201 MINE RD HOPEDALE OH 43976	Respond 21:00	Arrived 21:00	To ER 22:45 Apt.	At ER 23:00 Miles
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Hospital N/A

Not Applicable

12 Lead EKG

Incident [REDACTED]	Date 3/30/2026	Called 21:00	Notified 21:00	Hopedale Fire Dept	Respond 21:00	Arrived 21:00	To ER 22:45	At ER 23:00
Unit 510	Monday	34-201 MINE RD HOPEDALE OH 43976					Apt.	Miles

Hospital N/A

Not Applicable

Additional Vitals

<u>Time</u>	<u>Pulse</u>	<u>Quality</u>	<u>BP</u>	<u>Resp</u>	<u>Quality</u>	<u>L Lung</u>	<u>R Lung</u>	<u>L Pupil</u>	<u>R Pupil</u>	<u>Pain</u>
Additional Procedures										

<u>Time</u>	<u>Interventions</u>	<u>Attempts</u>	<u>Succ.</u>	<u>Size</u>	<u>Location</u>	<u>Rate</u>	<u>Result</u>	<u>Member</u>
Additional Crew								

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Incident [REDACTED]	Date 3/30/2026	Called 21:00	Notified 21:00	Hopedale Fire Dept 34-201 MINE RD HOPEDALE OH 43976	Respond 21:00	Arrived 21:00	To ER 22:45 Apt.	At ER 23:00 Miles
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Hospital N/A

Not Applicable

Additional Hx, Meds, Allergies

<u>History</u>	<u>Meds</u>	<u>Allergies</u>

Additional Medications Given

<u>Time</u>	<u>Medications</u>	<u>Dose</u>	<u>Unit</u>	<u>Route</u>	<u>Member</u>

Incident	Date	Called	Notified	Hopedale Fire Dept	Respond	Arrived	To ER	At ER
██████████	3/30/2026	21:00	21:00	34-201 MINE RD HOPEDALE OH 43976	21:00	21:00	22:45 Apt.	23:00 Miles
Unit	Monday							
510								

Hospital N/A

Not Applicable

Extended Narrative

Incident [REDACTED]	Date 3/30/2026	Called 21:00	Notified 21:00	Hopedale Fire Dept	Respond 21:00	Arrived 21:00	To ER 22:45 Apt.	At ER 23:00 Miles
Unit 510	Monday	MINE RD HOPEDALE OH 43976			34-201			

Hospital N/A

Not Applicable

Patient Assessment

<u>Anatomic Loc.</u>	<u>Loc. Detail</u>	<u>Findings</u>	<u>Severity</u>	<u>Treatment</u>

Trauma Assessment

<u>Injury Present</u>	<u>Cause of Injury</u>	<u>Trauma Acuity</u>
[REDACTED]		
<u>Injury Type</u>	<u>Trauma Triage</u>	
[REDACTED]		
<u>Protective Devices</u>	<u>Airbag Deployment</u>	<u>Alcohol Indicators</u>
		Not Applicable

Incident [REDACTED]	Date 3/30/2026	Called 21:00	Notified 21:00	Hopedale Fire Dept 34-201 MINE RD HOPEDALE OH 43976	Respond 21:00	Arrived 21:00	To ER 22:45 Apt.	At ER 23:00 Miles
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Hospital N/A

Not Applicable

Photos

Photo # 1

Photo # 2

Photo # 3

Photo # 4

Photo # 5

Photo # 6

Incident [REDACTED]	Date 3/30/2026	Called 21:00	Notified 21:00	Hopedale Fire Dept 34-201 MINE RD HOPEDALE OH 43976	Respond 21:00	Arrived 21:00	To ER 22:45 Apt.	At ER 23:00 Miles
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Hospital N/A

Not Applicable

Physician Certification Statement for Non-Emergency Ambulance Services

SECTION I - GENERAL INFORMATION

Patient's Name: MICHEAL DECKER Date of Birth: 06031972 Medicare # _____
 Transport Date: _____ (PCS is void 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 ambulat: 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

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

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

3/30/2026

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

Incident	Date	Called	Notified	Hopedale Fire Dept	Respond	Arrived	To ER	At ER
██████████	3/30/2026	21:00	21:00	34-201 MINE RD HOPEDALE OH 43976	21:00	21:00	22:45	23:00
Unit							Apt.	Miles
510	Monday							

Hospital N/A Not Applicable

Hopedale Fire Dept Patient Refusal Form

Patient Name: Micheal Decker

Date: 3/30/2026

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

This form is being provided to me because I have:

- Refused Assessment**
 Refused Treatment
 Refused Transport
 Diverted Destination

I understand that the EMS personnel are not physicians and are not qualified or authorized to make a diagnosis and that their care is not a substitute for that of a physician. I recognize that I may have a serious injury or illness which could get worse without medical attention even though I (or the patient on whose behalf I legally sign this document) may feel fine at the present time.

I understand that I may change my mind and call 9-1-1 if treatment or assistance is needed later. I also understand that treatment is available at an emergency department 24 hours a day or from my physician. If I have insisted on being transported to a destination other than that recommended by the EMS personnel, I understand and have been informed that there may be a significant delay in receiving care at the emergency room, that the emergency room may lack the staff, equipment, beds or resources to care for me promptly, and/or that I might not be able to be admitted to that hospital.

I acknowledge that this advice has been explained to me by the Hopedale Fire Dept and that I have read this form completely and understand its provisions. I agree, on my own behalf (and on behalf of the patient for whom I legally sign this document), to release, indemnify and hold harmless the Hopedale Fire Dept and its officers, members, employees or other agents, and the medical command physician and medical command facility, from any and all claims, actions, causes of action, damages or legal liabilities of any kind arising out of my decision, or from any act or omission of the Hopedale Fire Dept or its crew, or the medical command physician or medical command facility.

Privacy Practices Acknowledgment: by signing below the signer acknowledges that Hopedale Fire Dept 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.

OTHER SPECIFIC INSTRUCTIONS TO PATIENT:

X

X

_____ 3/30/2026

_____ 3/30/2026

Patient Signature

Witness Signature

- Parent Legal

Printed Name

IF PATIENT REFUSES TO SIGN: I attest that the patient has refused care and/or transportation by the emergency medical services providers. The patient was informed of the risk of this refusal and refused to sign this form when asked by the EMS providers.

X

_____ 3/30/2026

Witness Signature

Printed Name