

**TESTIMONY OF CHARLES J. WILLOUGHBY
INSPECTOR GENERAL
BEFORE THE D.C. COUNCIL
COMMITTEE ON THE JUDICIARY
EMERGENCY MEDICAL SERVICES**

JUNE 19, 2006

GOOD MORNING COUNCILMEMBER MENDELSON AND MEMBERS OF THE COMMITTEE. I WELCOME THIS OPPORTUNITY TO SHARE WITH YOU THE RESULTS OF OUR REVIEW OF THE RESPONSE TO THE JANUARY 6, 2006, INCIDENT INVOLVING MR. DAVID E. ROSENBAUM. HERE AT THE TABLE WITH ME TODAY ARE SUSAN KENNEDY, DIRECTOR OF THE MEDICAID FRAUD CONTROL UNIT, AND ALVIN WRIGHT, JR ASSISTANT INSPECTOR GENERAL FOR INSPECTIONS AND EVALUATIONS. MS. KENNEDY AND MR. WRIGHT LED THE OIG TEAM'S REVIEW OF THE MATTER. OUR TESTIMONY TODAY WILL PROVIDE BACKGROUND ON WHY AND HOW IT WAS CONDUCTED, AND WILL HIGHLIGHT THE TEAM'S MOST CRITICAL FINDINGS.

BACKGROUND

IN JANUARY OF THIS YEAR, MR ROSENBAUM WAS ASSAULTED AND ROBBED WHILE TAKING AN AFTER-DINNER WALK IN HIS NORTHWEST NEIGHBORHOOD. IN RESPONSE TO NUMEROUS QUESTIONS AND COMPLAINTS ABOUT THE EMERGENCY MEDICAL SERVICES PROVIDED TO MR. ROSENBAUM, AND THE DELAYED INVESTIGATION OF THE INCIDENT

THE CITY ADMINISTRATOR, ROBERT BOBB, REQUESTED THAT THE OFFICE OF THE INSPECTOR GENERAL (OIG) EXAMINE THE ACTIONS OF EMPLOYEES OF DISTRICT GOVERNMENT AGENCIES AND HOWARD UNIVERSITY HOSPITAL (HOWARD) IN PROVIDING CARE TO MR. ROSENBAUM. MR. BOBB INDICATED THAT HE WANTED OIG'S REVIEW "TO ENSURE THE MAINTENANCE OF PUBLIC CONFIDENCE IN THE EMERGENCY SERVICES PROVIDED BY THE DISTRICT GOVERNMENT." PURSUANT TO THAT REQUEST, THE OFFICE OF THE INSPECTOR GENERAL INITIATED A REVIEW OF THE RESPONSE IN THE ROSENBAUM MATTER AS IT RELATED TO THE PROVISION OF EMERGENCY SERVICES CITYWIDE. THE REPORT ISSUED LAST WEEK IS THE PRODUCT OF THAT REVIEW.

IN ORDER TO CONDUCT THIS REVIEW, I APPOINTED A TEAM OF INVESTIGATORS AND INSPECTORS WHO HAVE MANY YEARS OF TRAINING AND EXPERIENCE IN LAW ENFORCEMENT, FIREFIGHTING, EMT CARE, MEDICAL CARE, AND PROGRAM AND PERSONNEL MANAGEMENT. THE TEAM REVIEWED NUMEROUS DOCUMENTS PROVIDED BY THE FIRE AND EMERGENCY MEDICAL SERVICES DEPARTMENT (FEMS), METROPOLITAN POLICE DEPARTMENT(MPD), AND HOWARD, INCLUDING PROTOCOLS, POLICIES, PROCEDURES, SPECIAL AND GENERAL ORDERS, AND OTHER WRITTEN MANAGEMENT GUIDANCE. THE TEAM INTERVIEWED EVERY EMPLOYEE INVOLVED IN THE INCIDENT AND RELEVANT OFFICIALS, AND COORDINATED ITS ACTIVITIES WITH THOSE OF THE U.S. ATTORNEY'S OFFICE DURING THE GRAND JURY INVESTIGATION. THE TEAM VISITED

FEMS HEADQUARTERS AND ITS TRAINING DIVISION, THE OFFICE OF UNIFIED COMMUNICATIONS, THE OFFICE OF THE CHIEF MEDICAL EXAMINER, AND HOWARD UNIVERSITY HOSPITAL. MY TESTIMONY TODAY WILL FOCUS PRIMARILY ON FEMS AND MPD.

SCOPE OF THE REVIEW

OUR REVIEW FOCUSED ON THE EMERGENCY CARE DELIVERED ON JANUARY 6, 2006, AND THE SPECIFIC ACTIONS OF INDIVIDUAL FEMS, MPD, AND HOWARD EMERGENCY DEPARTMENT PERSONNEL. DURING THIS TARGETED REVIEW, CONCERNS REGARDING SYSTEMIC ISSUES SURFACED BECAUSE OF THE CHAIN OF FAILURES, AS WELL AS WELL AS BECAUSE THE FEMS PERSONNEL WHO RESPONDED TO THE GRAMERCY STREET 911 CALL WERE EXPERIENCED EMPLOYEES FROM VARIOUS DISCIPLINES AND FIREHOUSES. CONSEQUENTLY, WE CONSIDER THEM SOMEWHAT REPRESENTATIVE OF THE LARGER FEMS WORKFORCE. CUMULATIVE ERRORS AND FAILURES TO COMPLY WITH PROTOCOLS, AND COMPLACENT ATTITUDES ARE THEREFORE SIGNIFICANT, AND MAY INDICATE THAT THESE SAME DEFICIENCIES ARE MORE WIDESPREAD WITHIN FEMS.

KEY FINDINGS

THE PERCEPTION OF ALCOHOL INTOXICATION PRECIPITATED A CHAIN OF FAILURES. THE OIG TEAM CONCLUDED THAT ONCE MR. ROSENBAUM WAS PERCEIVED AS BEING INTOXICATED, THERE WAS AN UNACCEPTABLE CHAIN OF FAILURE BY FEMS, MPD, AND HOWARD EMERGENCY DEPARTMENT EMPLOYEES IN PROVIDING APPROPRIATE

EMERGENCY MEDICAL AND OTHER SERVICES THAT WERE REQUIRED BY PROTOCOLS, POLICIES, AND PROCEDURES. A NUMBER OF EMPLOYEES INVOLVED EXPRESSED A LACK OF CONCERN AND A NEGATIVE ATTITUDE TOWARD PATIENTS BELIEVED TO BE INTOXICATED, AND THAT ATTITUDE RESULTED IN SIGNIFICANT AND UNNECESSARY DELAYS IN IDENTIFYING AND TREATING MR. ROSENBAUM'S INJURIES. IT ALSO HINDERED RECOGNITION THAT A CRIME HAD BEEN COMMITTED. THE TEAM FOUND THAT TO THE FEMS, MPD, AND HOWARD PERSONNEL INVOLVED, MR. ROSENBAUM WAS "JUST ANOTHER DRUNK."

EMTS MADE ERRORS IN REACHING MR. ROSENBAUM AND TRANSPORTING HIM TO THE HOSPITAL. AMBULANCE 18 GOT LOST EN ROUTE TO THE GRAMERCY STREET EMERGENCY, AND WHEN LEAVING THE SCENE TO TRANSPORT MR. ROSENBAUM TO THE HOSPITAL. IN ADDITION, THEY FAILED TO COMPLY WITH FEMS POLICY TO TRANSPORT PATIENTS TO THE NEAREST HOSPITAL, IN THIS CASE, SIBLEY. THIS ERRONEOUS DECISION DELAYED MEDICAL TREATMENT IN AN EMERGENCY DEPARTMENT.

EMTS FAILED TO PROPERLY ASSESS MR. ROSENBAUM'S SYMPTOMS. EMTS FAILED TO FOLLOW PROTOCOLS FOR PERFORMING AN INITIAL ASSESSMENT, FAILED TO FOLLOW UP ON CRITICAL FINDINGS SUCH AS BLEEDING, ABNORMAL PUPIL RESPONSE, AND PERSISTENT VOMITING. ONCE THE FIRST RESPONDERS DETECTED AN ODOR OF ALCOHOL, THEY DISCOUNTED ALL OTHER POTENTIAL CAUSES AS REASONS FOR MR.

ROSENBAUM'S CONDITION.

FAULTY ORAL AND WRITTEN COMMUNICATION PERSISTED AMONG FEMS PERSONNEL PROVIDING CARE. FEMS PERSONNEL FAILED TO ADEQUATELY AND PROPERLY COMMUNICATE INFORMATION REGARDING MR. ROSENBAUM TO EACH OTHER AND TO HOWARD UNIVERSITY EMERGENCY DEPARTMENT PERSONNEL WHO ASSUMED RESPONSIBILITY FOR HIS CARE. MINIMAL INFORMATION WAS SHARED BETWEEN THE FIRST RESPONDERS AND THE AMBULANCE PERSONNEL, OR BETWEEN THE AMBULANCE CREW AND THE EMERGENCY DEPARTMENT NURSES. THIS LACK OF COMMUNICATION AFFECTED THE QUALITY AND TYPE OF CARE THAT MR. ROSENBAUM RECEIVED. FURTHERMORE, THERE WAS NO WRITTEN RECORD OF ENGINE 20'S ASSESSMENTS OR TREATMENT, AND AMBULANCE 18'S DOCUMENTATION WAS INCOMPLETE.

SIGNIFICANT PERFORMANCE MANAGEMENT ISSUES UNCOVERED. ONE SYSTEMIC ISSUE RECOGNIZED BY THE TEAM CONCERNED THE LACK OF PERFORMANCE EVALUATIONS FOR FIREFIGHTERS AND FIREFIGHTER/EMTS. AT THE TIME OF THIS REVIEW, THERE WAS NO SYSTEM IN PLACE FOR ROUTINELY EVALUATING THEIR PERFORMANCES. ALTHOUGH THERE IS A SYSTEM FOR EVALUATING NON-FIREFIGHTER EMTS, IT IS NOT CONSISTENTLY FOLLOWED AND, THE TEAM WAS TOLD, MANY EMTS HAVE NOT BEEN EVALUATED IN MANY YEARS. IN ADDITION, THE TEAM FOUND INSTANCES OF DELAYED OR DEFERRED DISCIPLINARY ACTION FOLLOWING SIGNIFICANT, PATIENT-CARE RELATED

INFRACTIONS. FINALLY, IN SOME INSTANCES, REQUIRED CERTIFICATIONS HAD EXPIRED (IN ONE CASE MORE THAN TWO YEARS AGO), BUT EMPLOYEES CONTINUED TO WORK WITHOUT SUCH CERTIFICATIONS.

MPD OFFICERS FAILED TO COMPLY WITH GENERAL ORDERS. MPD OFFICERS WHO RESPONDED TO THE SCENE DID NOT COMPLY WITH GENERAL ORDERS THAT REQUIRE PRELIMINARY INVESTIGATIVE ACTIVITIES SUCH AS SECURING THE SCENE, DETERMINING WHETHER A CRIME HAS BEEN COMMITTED, AND DETERMINING THE VICTIM'S IDENTITY. IN ADDITION, THEY FAILED TO COMPLETE THE REQUIRED REPORTS FOR "ANY INCIDENT OR CRIME THAT RESULTS IN A MEMBER BEING DISPATCHED OR ASSIGNED TO CALLS FOR SERVICE."

RECOMMENDATIONS

AS A RESULT OF THE TEAM'S FINDINGS, WE MADE WHAT WE BELIEVE ARE COMMON SENSE RECOMMENDATIONS THAT FOCUS ON MANAGEMENT OVERSIGHT AND QUALITY ASSURANCE MEASURES, AND INCLUDE:

- ENSURING THAT ALL PERSONNEL HAVE CURRENT CERTIFICATIONS AND TRAINING.
- ASSIGNING QUALITY ASSURANCE RESPONSIBILITIES TO EMPLOYEES WITH THE MOST ADVANCED TRAINING ON EACH DISPATCHED CALL TO ENSURE THE PERFORMANCE OF REQUIRED DUTIES.
- IMPLEMENTING A REPORTING FORM FOR FIRST RESPONDERS.

- DEVELOPING AND IMPLEMENTING A STANDARDIZED PERFORMANCE EVALUATION SYSTEM FOR FIREFIGHTERS, AND ADHERING TO THE STATED POLICY OF QUARTERLY EVALUATIONS OF EMTS; AND
- PROMPTLY REASSIGNING, RETRAINING, OR REMOVING POOR PERFORMERS.

CONCLUSION

THE OIG'S REVIEW INDICATES A NEED FOR INCREASED OVERSIGHT BY FEMS AND MPD MANAGERS IN THE AREAS OF TRAINING, CERTIFICATIONS, PERFORMANCE MANAGEMENT, ORAL AND WRITTEN COMMUNICATION, AND EMPLOYEE KNOWLEDGE OF PROTOCOLS, POLICIES, AND PATIENT CARE STANDARDS.

MULTIPLE FAILURES TO COMPLY WITH POLICIES, PROCEDURES, AND PROTOCOLS DURING A SINGLE EVENING BY MULTIPLE EMPLOYEES FROM VARIOUS DISTRICT AGENCIES SUGGEST AN IMPAIRED WORK ETHIC. THIS MUST BE ADDRESSED BEFORE IT BECOMES PERVASIVE AND TO ENSURE THE HIGH-QUALITY DELIVERY OF EMERGENCY SERVICES CITYWIDE. AS STATED IN OUR REPORT, APATHY, INDIFFERENCE, AND COMPLACENCY WERE APPARENT DURING OUR REVIEW. THESE ATTITUDES UNDERMINED THE EFFECTIVE, EFFICIENT, AND HIGH-QUALITY DELIVERY OF EMERGENCY SERVICES. SUCH QUALITY IS EXPECTED FROM THOSE ENTRUSTED WITH PROVIDING CARE TO THOSE WHO ARE ILL AND INJURED, AND THOSE WHO ARE CHARGED WITH

PROTECTING RESIDENTS OF AND VISITORS TO THE DISTRICT OF
COLUMBIA.

THAT CONCLUDES MY TESTIMONY, AND WE WILL BE HAPPY TO
RESPOND TO ANY QUESTIONS YOU MAY HAVE. THANK YOU.