

**GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF THE INSPECTOR GENERAL**

**CORRESPONDENCE
RELATED TO THE
INVESTIGATION OF
THE
ASSAULT ON
DAVID E. ROSENBAUM**



**CHARLES J. WILLOUGHBY
INSPECTOR GENERAL**

Subsequent to the publication of the Office of the Inspector General's *Special Report: Emergency Response to the Assault on David E. Rosenbaum*, the OIG obtained additional information regarding actions taken by Fire and Emergency Services personnel as they related to Mr. Rosenbaum's care. The August 17, 2006, letter describes the circumstances by which the OIG acquired the additional information and provides notice of the discovery to appropriate government officials. The August 17 letter and attachments have been redacted to prevent disclosure of personal identifiers and medical information. The OIG is providing the redacted version in lieu of the originals in accordance with exemptions provided in the District of Columbia Freedom of Information Act (D.C. §§ 2-531-539 (Supp. 2004)) to preserve the privacy interests of Mr. Rosenbaum and other individuals mentioned in the original documentation.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Office of the Inspector General

Inspector General



August 17, 2006

Robert C. Bobb
Deputy Mayor and City Administrator
John A. Wilson Building
1350 Pennsylvania Avenue, N.W.
Suite 310
Washington, D.C. 20004

Dear Mr. Bobb:

Since the publication of the Office of the Inspector General (OIG) *Special Report: Emergency Response to the Assault on David E. Rosenbaum*, additional information has come to my attention regarding actions by Fire and Emergency Medical Services (FEMS) personnel that was not previously reported to us. Although this information does not change the conclusions of our investigation or the recommendations in the report, I believe it is important that I share it with you, Deputy Mayor Reiskin, and FEMS Chief Thompson.

The OIG team members who investigated the Gramercy Street incident interviewed all FEMS and Howard University Hospital (Howard) Emergency Department personnel involved in the emergency response to the incident, including FEMS Acting Medical Director Doctor 2, who was interviewed on March 30, 2006 (Enclosure 1).

Doctor 2 stated that he was working in the Emergency Department on January 6, 2006, and had some contact with the "John Doe" prior to his being identified as Mr. Rosenbaum. Doctor 2 also stated that he ordered Ambulance 18 out of service in his capacity as FEMS Acting Medical Director because the crew did not complete the 151 "Run Sheet," which provides details about a patient's condition to the Emergency Department staff.

In mid-July, approximately one month after our Special Report was issued, my staff was informed that Doctor 2, prior to the FEMS "Fire Board" hearings in January, provided information to FEMS officials concerning the events of January 6, 2006, that differed significantly from what he told our OIG investigators as documented in our report. For example, Doctor 2 told our team that he still had a patient in his care in

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Howard's Emergency Department when he was called to assist with Mr. Rosenbaum. During his interview with FEMS officials, however, he stated that he was "off the clock," and in another area of the hospital completing paperwork.

Of greater concern to us, however, is the fact that Doctor 2 reportedly told an FEMS official that he contacted senior EMS supervisors on the night of January 6, and ordered one of them, Lt. 1, to report to Howard in order to examine the "John Doe" (Mr. Rosenbaum). Because no one we interviewed had informed our team that Doctor 2 had contacted a FEMS supervisor that night, my staff recently requested from FEMS any reports written by Lt. 1 on this matter. We received two memoranda - one written by Lt. 1 on January 28, and one written by Captain 1 on January 29. (Enclosures 2 and 3).

According to Captain 1's memorandum, Doctor 2 called him and stated that there was a problem with a patient brought in by Ambulance 18. On Doctor 2's order, Captain 1 sent Lt. 1 to Howard to speak with Doctor 2, and then went there himself. Both the Lt. 1 and Captain 1 memoranda reflect Doctor 2's concerns that the Ambulance 18 crew did not perform a proper patient assessment, and that they gave the Howard Emergency Department staff the wrong information about Mr. Rosenbaum's condition. Lt. 1 stated in his memorandum that Doctor 2 was "visibly upset." Lt. 1 stated that he observed blood in the "right rear area" of Mr. Rosenbaum's head, "blood in his right ear, and both pupils were dilated and non-reactive." None of the FEMS or Howard employees told our investigators that they saw blood on Mr. Rosenbaum's head or in his ear. In fact, Doctor 2 stated to our investigators that he saw only a "quarter-sized bump" on the back of Mr. Rosenbaum's head.

Doctor 2 did not tell OIG investigators about his call to Captain 1, the visit to the hospital by Captain 1 and Lt. 1, his concerns about how the Ambulance 18 Emergency Medical Technicians (EMTs) had assessed Mr. Rosenbaum, and his belief that the Ambulance 18 EMTs had not properly briefed the Howard Emergency Department staff on Mr. Rosenbaum's condition. This is important information that would have led us to interview the two EMS supervisors, evaluate their actions, and include the results in our overall assessment of FEMS' emergency response.-

I am concerned that Doctor 2 may not have been fully responsive to our investigators and may have made misleading statements during an official investigation. In addition, the Lt. 1 and Captain 1 memoranda contain significant information about Mr. Rosenbaum's condition that would have been relevant to our evaluation of the information provided to

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us by other FEMS providers. Finally, the Lt. 1 and Captain 1 memoranda raise questions about whom they notified in the chain of command regarding their visit to Howard and when, and what actions, if any, were taken by those notified. If this information was not provided in a timely manner to the FEMS chain of command, their evaluation of the emergency response to the assault of Mr. Rosenbaum, like ours, was adversely affected.

Please contact me on (202) 727-2540 if you have questions or concerns. Thank you.

Sincerely,



Charles J. Willoughby
Inspector General

Enclosures

cc: Deputy Mayor Edward Reiskin
Chief Adrian Thompson, FEMS



**Office Of The Inspector General
Inspections and Evaluations Division**

MEMORANDUM OF INTERVIEW

INTERVIEWEE 1 of 1: Doctor 2

Agency: Howard University Hospital
Date: March , 2006
Start Time: 4:00 PM End Time: 6:00 PM
Location of
Interview: 717 14th Street, N.W. Washington, D.C. 20005 11th Fl.
Telephone: ██████████

Purpose:

To interview subject and gain information regarding his knowledge of events surrounding “John Doe,” later identified as Mr. David E. Rosenbaum, who was brought into the Emergency Room on January 6, 2006 at or about 10:15 PM.

Summary:

Interviewees’ information presents what he observed after he assisted another attending Emergency Room doctor with a critical trauma patient.

Per Doctor 2’s recollection, Friday, January 6, 2006, 11:00 PM to 1:00 AM

Doctor 2 is an emergency room (ER) attendant for Howard University Hospital (HUH). He was hired at HUH in ██████████ but did not start work until ██████████ to ██████████. In 2003, Doctor 2 went to one shift a month for HUH and went to work at Washington Hospital Center (WHC) from ██████████ to ██████████. In 2005, he stopped working for WHC and went back to HUH.

Doctor 2 went to George Washington University for his undergraduate and medical degrees. He did his intern/residency in emergency medicine at a medical college in Pennsylvania and worked for Hurricane Hospital in Philadelphia, PA for 3 years.

This MOI is a summary of the interview, not a verbatim account of the information provided. The information below is based on the writer’s notes and recollection of the interview.



Continuation of MEMORANDUM OF INTERVIEW

Doctor 2 works a rotating shift of 10 PM to 10 PM and has any where from 3-5 shifts a month. He is a part-time worker at HUH. Doctor 2 also works at Providence Hospital part-time as an ER doctor. Along with working at both hospitals, Doctor 2 is employed as the Acting Medical Director for DC Fire and EMS. He has an office at 1923 Vermont Avenue, NW Washington, DC 20001.

Doctor 2 explained that the ER was divided into two teams, a blue team and a red team. On the night of January 6, 2006, he was working with the red team. Doctor 2 explained that as an ER attending, the team concept of nursing was great. The team would make rounds but a single nurse would still be responsible for a patient. The team leader would assign a nurse to a patient. He stated personalities got in the way of the idea working smoothly. According to Doctor 2 HUH implemented a computer tracking system in December 2005 but unknown exactly when and that the team concept of nursing stopped about the same time.

Doctor 2 stated the night of January 6 was busy but not any busier than any other night. Doctor 2 remembers Doctor 1, the attending for the red team, saying she needed help. Doctor 2 said normally a resident would assist an attending but HUH no longer has ER residents because of academic issues. Doctor 2 said after Doctor 1 stated she needed help, he pulled his patient out of the Resuscitation room, after ensuring the patient was stable, and helped place Doctor 1's patient in the room. Doctor 2 then assisted in rolling the patient to one side in order to place a long spine board underneath him. That is when Doctor 2 noticed "John Doe" did not have much bruising. He only saw a quarter size bump on the back of "John Doe's" head and only because of the floodlights that are located in the trauma room. Doctor 2 described the room as being the equivalent to an operating room in terms of the size, equipment and lighting. According to Doctor 2, "John Doe" was fully dressed when he saw him and that it was not until the trauma team came and cut off his clothing that "John Doe" was undressed. Doctor 2 said he had no idea that "John Doe" was brought in by EMS and thought he was a walk-in. It was not until after assisting Doctor 1 that Doctor 2 learned the patient was brought in via ambulance. Doctor 2 looked at the ambulance run sheet 151 and noticed it did not answer all the questions. He called the on duty supervisor and said he needed special reports right away. He had A-18 placed out of service in order to get the special reports. Doctor 2 stated this was standard procedure and that it was how everything was handled in the fire department. Doctor 2 said he does not get involved in the fire department's operational quality and assurance (QA).

Doctor 2 was asked by Chief Thompson to step down from the investigation of the Gramercy Street incident and Doctor 3 from the Department of Health (DOH) performed the review. Doctor 2's involvement was limited to asking for the special reports from all involved and placing the ambulance out of service.

This MOI is a summary of the interview, not a verbatim account of the information provided. The information below is based on the writer's notes and recollection of the interview.



Continuation of MEMORANDUM OF INTERVIEW

Doctor 2 explained the program of the Emergency Medical Technician-Advance (EMT-A). The adult protocols for the EMT-A were designed in 2002. The program was funded initially by the closure of D.C. General Hospital. Two weeks of classroom training amounting to 80 hours is required. Afterwards the student does a rotation in the hospital and shadows a nurse. The student is then placed on a preceptor-training unit for 8-14 weeks. The EMT-A is trained to give Narcan for a heroin overdose, use a nebulizer, check someone's blood sugar using a Glucagons, start IV's and to administer epinephrine. According to Doctor 2, Emergency Medical Technician-Basics (EMT-B)s are not given this type of training. Once an EMT-B completes their 140 hours of training equivalent to 1 month, they are sent right out. Although Wadhwa stated DCFEMS teaches the course in 5 weeks not 4 weeks and are given 200 hours of instruction instead of the 140-160 hours. A Paramedic-Intermediate (Paramedic-I) receives 800-1000 hours of training while a Paramedic receives 1200-1600 hours of training. Doctor 2 stated DC does not distinguish a Paramedic-I from a Paramedic. Doctor 2 stated that there is a shortage of Paramedics in the District. A dual role FF/Paramedic makes a little more money. He did not state if a dual role FF/EMT gets more money.

Per Doctor 2, the standard of care used to train a FF/EMT comes from the Brady Emergency Care Book and the Mosby's Paramedic Textbook. Doctor 2 said these were the hallmark of care textbooks. Besides the books, the FF/EMT is also taught based on the national standards curricula set forth by the National Highway Traffic Safety Administration (NHTSA) Department of Transportation Emergency Medical Services Division. The Department of Health Emergency Health & Medical Services Administration (EHMSA) then tests the FF/EMT. According to Doctor 2, FF/EMTs are not able to recognize signs and symptoms of medical conditions and how to treat them.

This MOI is a summary of the interview, not a verbatim account of the information provided. The information below is based on the writer's notes and recollection of the interview.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
 FIRE AND EMERGENCY MEDICAL SERVICES DEPARTMENT
 WASHINGTON, D.C. 20001



MEMORANDUM

TO: Adrian H. Thompson
 Fire and EMS Chief

FROM: Lieutenant, EMS- , Plt-

DATE: January 28, 2006

SUBJECT: Gramercy St. NW incident involving Ambulance 18 on January 6, 2006

On January 7, 2006 at approximately 0015 hours I received a call from Capt. , EMS- , to report to Howard University Hospital. He stated that Dr. was requesting an EMS Supervisor due to an incident involving Ambulance 18. He further stated that he was en-route there as well. I arrived at Howard University Hospital at approximately 0030 hours and met with Dr.

Dr. was visibly upset and informed me that Ambulance 18 had, earlier in the evening of January 6th, brought a patient into the emergency department that had a more serious medical condition than the crew had indicated. Dr. stated that the crewmembers of Ambulance 18 had told the triage nurse that the patient was intoxicated. He then showed me the yellow copy of the 151 that Ambulance 18 had left with the triage nurse. Dr. pointed to the narrative on the 151 which stated "ETOH", the GCS score of in two places, and the transport code of 3. Dr. then asked me to accompany him to the code room where he had me take a look at the patient brought to Howard by Ambulance 18. Dr. pointed to an injury at the back of the patient's head and had me look at the patient's pupils.

My observations were of an unconscious white male approximately 60 years of age lying supine on the hospital stretcher. There was blood in the right rear area of his head, blood in his right ear, and both pupils were dilated and non reactive.

Dr. then stated to me that he felt that the crewmembers of Ambulance 18 did not do a proper patient assessment and wanted both members removed from duty immediately. Dr. asked me if I concurred with his decision to which I responded in the affirmative. A short time later Captain arrived at Howard and met with Dr. Captain then notified the appropriate Company Officer and Battalion Fire Chief, and had both members of Ambulance 18 removed from duty.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
 FIRE AND EMERGENCY MEDICAL SERVICES DEPARTMENT
 WASHINGTON, D.C. 20001



MEMORANDUM

TO: Adrian Thompson
 Fire and EMS Chief

FROM: EMS Captain

DATE: January 29, 2006

SUBJECT: Incident #2380 with Ambulance 18 at Hospital 05 ER

On January 6, 2006 I received a call from Dr. [redacted], M.D., DCFEMS Medical Director stating that there was a problem with a patient that Ambulance 18 brought into Howard University Hospital ER. That the ER staff was given wrong information on the patient's condition, they were given an ETOH patient assessment report and the patient was a serious code one head trauma. Dr. [redacted] presented the yellow hospital copy of the run sheet, there was no documentation on of an injury other than the patient was ETOH and combative. I also noticed GSC scores of [redacted] and transport priority of three.

He ordered that I have the crew of ambulance 18 placed out of service, have them submit special reports why the patient was not given proper treatment, and why the hospital was not notified. He wanted an EMS Supervisor to report to the hospital ER as soon as possible. I had EMS Lt. [redacted] go to the ER to speak with Dr. [redacted] M.D. on the incident.

I arrived at the hospital and spoke with Lt. [redacted] and Dr. [redacted] M.D. who both had taken a look at the patient in the ER. Dr. [redacted] stated that the patient had been brought into the ER in this condition and the ER staff was told that the patient was ETOH and combative and vomiting. Lt. [redacted] confirmed that the patient's present condition was bad and that he was unconscious, had blood in his right ear, had blood to the back of his head, and both pupils were dilated and non reactive.

I had communications place ambulance 18 placed out of service to return to quarters. Called Engine 18 and notified the house officer Lt. [redacted] of the incident and that ambulance 18 would be back soon and they were not to assume duty on the unit until their special reports are reviewed by Dr. [redacted]. I also notified 2nd BFC [redacted] of the incident and the order that was given from Dr. [redacted].