Statement of Charles J. Willoughby, Inspector General
At the First Convening of the
Task Force on Emergency Medical Services
April 17, 2007

Good afternoon Chairman Rubin, Mayor Fenty, and other members of the Task Force on Emergency Medical Services (Task Force). Thank you for the opportunity to address this first Task Force meeting on improving the delivery of emergency medical services to District citizens and visitors.

Review of the Rosenbaum Case

Background

With me today are Susan Kennedy and Alvin Wright, Jr. who led the Office of the Inspector General (OIG) team that investigated the emergency response to the assault on Mr. David E. Rosenbaum in January 2006. Following the assault upon Mr. Rosenbaum and his subsequent death, numerous questions were raised and complaints made by both citizens and District government officials about the emergency medical services provided to him by the D.C. Fire and Emergency Medical Services Department (FEMS). Subsequently, then-City Administrator Robert C. Bobb asked the OIG to conduct a review of the response by FEMS and other District entities. Mr. Bobb indicated that he and former Mayor Anthony A. Williams wanted the review "to ensure the maintenance of public confidence in the emergency services provided by the District government." In addition, the Rosenbaum family requested that the Office of the Inspector General answer questions they posed about the emergency response "so that errors [they]

experienced are not repeated in the future ….” The OIG team that I assigned to this task had training and experience in law enforcement, firefighting, medical care, and pre-hospital care. The scope of the team’s review included the entire emergency response provided to Mr. Rosenbaum on January 6, 2006, and the review conducted by the Office of the Chief Medical Examiner. The care and treatment of Mr. Rosenbaum at Howard University Hospital subsequent to the discovery of his head injury, and the Metropolitan Police Department (MPD) assault and robbery investigation that was opened on January 7, 2006, were not part of the OIG review.

Conclusions and Recommendations Regarding FEMS

With regard to FEMS, the OIG team concluded that FEMS personnel failed to respond to Mr. Rosenbaum in accordance with established protocols. Individuals who played critical roles in providing these services did not adhere to applicable policies, procedures, and other guidance from their employers. These failures included incomplete patient assessments, poor communication between emergency responders, and inadequate evaluation and documentation of the incident. The results were significant and unnecessary delays in identifying and treating Mr. Rosenbaum’s injuries, and delayed recognition that a crime had been committed.

The team found that FEMS personnel made errors both in getting to the scene and in transporting Mr. Rosenbaum to a hospital in a timely manner. Ambulance 18 did not take a direct route from Providence Hospital to the Gramercy Street incident. In addition, for personal reasons, the Emergency Medical Technician (EMT) driver of Ambulance 18 did not take the patient to the

nearest hospital. As a result of that decision, it took twice as long for the ambulance to reach Howard University Hospital as it would have taken to get to Sibley Memorial Hospital. Once FEMS personnel at the Gramercy Street scene detected the odor of alcohol, they failed to properly analyze and treat Mr. Rosenbaum's symptoms according to accepted pre-hospital care standards. Failure to follow protocols, policies, and procedures affected care of the patient and the efficiency with which the EMTs completed the call. In addition, FEMS employees' failure to adequately and properly communicate information regarding the patient affected subsequent caregivers' abilities to carry out their responsibilities.

The Office of the Inspector General's review recommended increased oversight and enhanced internal controls by FEMS in the areas of training and certifications, performance management, quality assurance, oral and written communication and reporting, and employee knowledge of protocols, General Orders, and patient care standards. The team also recommended global positioning devices in all ambulances. We noted that multiple failures during a single evening by employees to comply with applicable policies, procedures, and protocols suggested an impaired work ethic that must be addressed before it becomes pervasive. Apathy, indifference, and complacency—apparent even during some of our interviews with caregivers—undermined the effective, efficient, and high quality delivery of emergency services expected from those entrusted with providing care to those who are ill and injured.

We believe that in the aftermath of the Rosenbaum events, a program of strong quality assurance measures will assist FEMS in reducing the risk of a recurrence of the many failures that occurred in the emergency responses to Mr.

Rosenbaum. These would include on-the-scene evaluations and after-action reports by senior personnel, comprehensive and timely performance evaluations, and meaningful administrative action in cases of employee misconduct or incompetence.

Initial OIG Inspection of FEMS in 2002

As most of you know, the OIG issued a Report of Inspection on FEMS in October 2002, and currently is conducting a re-inspection of that agency. Our inspection process is aimed at evaluating and analyzing agency management and operations of District agencies to help managers make improvements, correct deficiencies, and make better decisions. We focus on both the systemic and specific issues that are key to successful completion of an agency's mission. We conduct our re-inspections after a year or more has passed and after agencies have had time to act on the recommendations to which they have agreed.

Our 2002 inspection of FEMS looked at response times, abuse of the 911 Call System, deficiencies in the processing of emergency calls, problems with paramedic certifications, the lack of policies and procedures, staffing deficiencies, inadequate quality assurance programs, and other issues. The Inspection Team made 30 recommendations, all of which were agreed to by then-Interim Fire Chief Adrian Thompson.

What follows are highlights of notable systemic problems found in FEMS during the 2002 inspection that may be of interest to this Task Force:

Inadequate Number of Paramedics for Ambulance Units

(1) A number of Advanced Life Support (ALS) ambulance units were frequently out of service because they lacked paramedics.

a) The Field Operations Division often did not have enough paramedics on duty to keep all of its ALS units in operation during each shift. During one 3-month period reviewed by the inspection team, 21% of ALS units were not in service for 62 days. Supervisors accused some paramedics of abusing sick leave, and stated that others were just "burned out."

b) At the time, FEMS had 211 employees trained as paramedics, but 23% worked as field supervisors, evaluators, or Training Academy instructors.

Some Paramedics Worked With Expired Certifications

(2) The team also found that a number of paramedics whose certifications had expired continued to provide services to patients.

a) Members of the FEMS Continuous Quality Improvement (CQI) unit told the inspection team that they routinely requested extensions for paramedics' certifications from the Department of Health's Office of Emergency Health and Medical Services (OEHMS). The inspection team found that OEHMS routinely granted the requested extensions on expired paramedic certifications, despite an absence of written authorizations, regulations, or policies.

b) Extensions were said to be necessary because CQI personnel were unable to conduct the number of field evaluations required by OEHMS for recertification in a timely manner. Not all CQI evaluators were assigned full time to be field evaluators, which significantly limited their availability.

Complaints about Paramedic and EMT Training

(3) In 2002, paramedics and EMTs criticized the quality of the training provided by the FEMS Training Academy.

a) Interviewees cited a lack of professionalism among Training Academy instructors: they arrived late, were not prepared, and allowed students to leave class early.

b) FEMS management agreed that instructor accountability had been an issue of concern, and agreed to establish qualifications and create a hiring policy for EMS training instructors.

No Quality Assurance Program for EMT Performance

(4) The 2002 inspection found no process in place to monitor how well basic Emergency Medical Technicians (EMTs) were performing their jobs while in the field.

a) The team found that the FEMS Quality Control Unit did not evaluate the field performance of basic level EMTs.

b) Basic EMTs were not being evaluated in the field primarily because evaluations were not required as part of the OEHMS recertification process.

c) The OIG recommended that the FEMS medical director develop a field evaluation process for basic EMTs similar to the evaluation process applied to paramedics. FEMS agreed with this recommendation and stated that a draft program was being developed, including the addition of employees to its Quality Control Unit to evaluate EMTs.

Current OIG Re-inspection of FEMS

I will conclude with this very brief overview of several topics currently being addressed by our FEMS re-inspection team:

a) Verification of compliance with the 2002 inspection recommendations and more recent recommendations from the Rosenbaum review, including an evaluation of quality assurance programs in place at FEMS and the personnel who administer them.

b) The status of emergency response times and whether standards are being met.

c) Employee concerns about the mandatory transition from EMS status to the dual-role of EMS/Firefighter. Initial interviews indicate some anxiety among EMS employees.

d) FEMS performance in obtaining appropriate reimbursements from insurance companies and other sources, such as Medicaid, following FEMS ambulance transport of patients on emergency medical calls.

e) The status of major technology initiatives such as automation upgrades.

It would not be appropriate at this time for me to discuss any specific findings we have thus far on these re-inspection topics since the team has not completed its work and has not given FEMS the opportunity to comment.

This concludes my prepared remarks, and I welcome your questions or comments. Thank you.