

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Office of the Inspector General

Inspector General



**Executive Summary Concerning the Results
of an Office of the Inspector General Investigation
Into Misconduct Violations by an Employee of the
District of Columbia Fire and Emergency Medical Services**

2008-0566 (S)

INVESTIGATIVE SYNOPSIS

The District of Columbia Office of the Inspector General (OIG) initiated an investigation in September 2008 after receiving allegations that an Assistant Chief, Fire and Emergency Medical Services (FEMS), did not allow FEMS Emergency Medical Technicians (EMTs) to respond to a gunshot wound victim. Although the investigation revealed no evidence to substantiate the allegations against the Assistant Chief, the investigation revealed that one of the EMTs who made the allegations, (EMT 1), violated three sections of the DPM and one section of the Rules and Regulations, Fire Department, District of Columbia.

The investigation, which was conducted by investigators from the OIG Investigations Division and the OIG Medicaid Fraud Control Unit, revealed that EMT 1 submitted to the OIG a sworn, false written statement to initiate an investigation and made false verbal statements to OIG investigators when interviewed during the investigation. EMT 1's written statement was submitted to the OIG on September 24, 2008, by a FEMS Paramedic and Union Steward (Union Steward). The Union Steward told OIG investigators that he was submitting these allegations against the Assistant Chief on behalf of three FEMS EMTs, EMT 1, EMT 2, and the mother of the gunshot wound victim who died (the mother of Patient 1, EMT 6).

In her written statement, EMT 1 wrote that on August 14, 2008, she attempted to examine a patient she later learned to be the son of EMT 6, and was interrupted by the Assistant Chief. EMT 1 also wrote:

Other personnel also attempted to aid [Patient 1], attempting assessments, and CPR [Cardiopulmonary Resuscitation]. However, [the Assistant Chief] discontinued any further care, actually declaring the young man to be presumed dead on arrival. In trauma related cases, the PDOA [Presumed Dead on Arrival] protocol requires that injuries to the patient are incompatible with life. Without a discernable gun shot wound to the patient's head, it is difficult to accept that this judgment to discontinue care to this particular patient was in accordance with the DC patient care protocol. . . . My professional concern of course is that [Patient 1]

was denied any other assistance, which was both delayed, and ultimately, due to [the Assistant Chief's] actions, the patient was not even transported to a local trauma facility for further assessment and care.

Further, I ask. Is it appropriate, in the eyes of others that an officer of this agency should be allowed to use his non-medical authority within the department to overthrow the possibility of better care for our patients by more experienced care-givers? I ask then; is it appropriate that EMS care-givers are forced to work under such authority?

Id.

In an interview with OIG investigators on October 14, 2008, EMT 1, assigned to a Medic Unit, stated that on August 14, 2008, she and EMT 2 were present on the scene. EMT 3 also was assigned to the Medic Unit. EMT 1 again stated that she went to the victim she identified as [Patient 1] to provide medical assistance, but was instructed by the Assistant Chief to assist with the other, older victim [Patient 2], who also was suffering from gunshot wounds. EMT 1 acknowledged that she questioned the Assistant Chief's instructions while attempting to provide medical assistance to Patient 1, before again being instructed to provide assistance to the other victim. According to EMT 1, she placed two of four Electrocardiogram (EKG) leads¹ on Patient 1's body prior to attending to the other victim, but failed to submit the required written Patient Care Report² because she was instructed to leave Patient 1. EMT 1 also stated that she did not see any blood on Patient 1 while attempting to provide medical assistance.

During a subsequent interview with OIG investigators on December 30, 2008, EMT 1 again stated that she did not see any blood on Patient 1, but later in the interview stated that she saw a couple of drops of blood on Patient 1's upper brow area. EMT 1 again told OIG investigators that she applied two EKG leads to Patient 1's body, specifically, to his lower left leg. According to EMT 1, she tended to the lower half of Patient 1's body, while EMT 2 assessed Patient 1. EMT 1 again acknowledged that she was responsible for submitting a Patient Care Report, but failed to do so. At this interview, however, she said she was not sure why she did not submit the required Patient Care Report.

In a written statement dated September 18, 2008, and submitted to the OIG on September 24, 2008, EMT 2 wrote that he was the Ambulance Crewman Aide on the Medic Unit on August 14, 2008, and was dispatched on this incident. EMT 2 wrote that after a

¹ A Deputy Fire Chief (DFC) explained that the EKG leads and EKG pads are used in conjunction with the EKG procedure. The EKG pad is placed on the body to detect electrical activity in the heart and is connected to leads or wires which lead to the EKG machine. The EKG machine depicts an analysis of the electrical activity in the heart.

² As stated in the FEMS Patient Care policies, a Patient Care Report is a medical record and the primary source of information for continuous quality improvement review. Pre-hospital care personnel shall be responsible for providing clear, concise, complete and accurate documentation. When a patient is transported, the Patient Care Report will be delivered with the patient to the receiving hospital.

Metropolitan Police Department (MPD) Officer directed him to a patient behind a wall, he began an assessment of the patient. EMT 2 wrote that he:

was approached by [the Assistant Chief]. He asked me what I had. I told him that so far I had found only blood on my glove which might have come from the back of the patient's head. He directed me away from continuing care, and told me to assist the other care-givers with the older patient.

In an interview with OIG investigators on November 6, 2008, EMT 2 stated that he and EMT 1 were together throughout this incident and that neither of them placed any EKG leads on Patient 1's body. EMT 2 also stated that he had observed an excessive amount of blood in Patient 1's mouth and nose, and on the back of Patient 1's head.

In an interview with OIG investigators, EMT 3 stated that once the Medic Unit arrived at the scene, he removed the backboard from the ambulance and went to the closest patient, which EMT 3 described as an older male (Patient 2). According to EMT 3, he and other emergency personnel provided medical assistance to Patient 2, which included CPR and bandaging. Then Patient 2 was transported to the hospital by the Medic Unit. EMT 3 explained that all of the medical assistance he, EMT 1, and EMT 2 provided was documented on the Patient Care Report. A review of the Patient Care Reports for this incident reveals that the only Patient Care Report signed by EMTs 1, 2, and 3 is the one for Patient 2. The Patient Care Report for Patient 1 is signed by EMTs 4 and 5.

EMT 3 told OIG investigators that he did not recall any interaction between EMT 1 and the Assistant Chief or any interaction between EMT 1 and the younger male patient (Patient 1). EMT 3 added that he did not witness EMTs 1 or 2 place any EKG leads on the body of Patient 1. EMT 3 further stated that he never provided any medical assistance to Patient 1.

During his interview with OIG investigators, the Assistant Chief stated that on August 14, 2008, he was the first FEMS official to respond to the scene of the shooting. MPD personnel also were on the scene. While conducting safety checks of the scene, the Assistant Chief noticed two males lying on their backs with gunshot wounds, approximately 30 feet apart. An MPD officer was conducting CPR on the older patient, and the Assistant Chief conducted a medical assessment of Patient 1. The Assistant Chief told OIG investigators that he observed evidence of multiple gunshot wounds, excessive blood around the face and airway, and concluded that Patient 1 had no pulse, no signs of breath, and was presumed dead on arrival.

A review of the FEMS Computer Aided Dispatch (CAD) chronology revealed that the first Engine arrived at the scene at 10:14:38 a.m. The Ambulance arrived at 10:15:11 a.m., the Medic Unit arrived at 10:15:46 a.m., and the second Engine arrived at 10:17:34 a.m.

The Assistant Chief stated that when the other FEMS units arrived at the scene, he directed the first Engine, the Ambulance, and the Medic Unit to the older patient because that patient had signs of life. He directed the second Engine to Patient 1. The Assistant Chief said that he noticed EMT 1 attempting to conduct a medical assessment of Patient 1 and repeated his instructions to EMT 1 for the Medic Unit to assist the older patient. EMT 4 of the second Engine conducted a medical assessment and EKG analysis of Patient 1. The EKG revealed no electrical activity in the heart and no signs of respiration. Patient 1 was deemed presumed dead on arrival. Subsequently, the Assistant Chief noticed that EMT 1 again attempted to attend to Patient 1, after he had directed her to attend to the older patient.

On August 14, 2008, the Assistant Chief reported to the DFC and the Medical Director that EMT 1 was not dedicated to the patient to whom she was assigned and he had to instruct her twice to assist Patient 2. The Assistant Chief, EMT 1, the DFC, and EMT 1's immediate supervisor, met later in the day on August 14, 2008, regarding EMT 1's conduct. During the meeting, the Assistant Chief identified some of EMT 1's errors on the scene, provided feedback, and informed her that insubordination would not be tolerated and that she was never to deviate from instructions given by a supervisor.

During his interview with OIG investigators, the DFC stated that he was aware of the incident between the Assistant Chief and EMT 1. The DFC further stated that the Assistant Chief had reported the incident to him on the day it occurred. According to the DFC, the Assistant Chief explained to the DFC that while on the scene, he instructed EMT 1 to tend to a specific patient. EMT 1, however, failed to comply with the Assistant Chief's orders at least twice. The Assistant Chief further explained that he had concerns about EMT 1's ability to provide proper patient care. The DFC stated that on the afternoon of the incident, he met with the Assistant Chief and EMT 1 regarding the incident. The DFC described the meeting as a debriefing and expectations were explained to EMT 1. The DFC reported that no disciplinary action was taken against EMT 1.

OIG investigators also interviewed EMT 4, who stated that his unit, the second Engine, was the last emergency response unit to arrive on the scene. When the second Engine arrived, EMT 4 noticed that the Assistant Chief, the Ambulance, the first Engine, and the Medic Unit were on the scene already and medical assistance was being provided to the older patient by several of the emergency response units. EMT 4 was unaware that there was a second victim until he and EMT 5, were instructed by the Assistant Chief to conduct an EKG analysis on Patient 1.

EMT 4 conducted a medical assessment and determined that Patient 1 had two gunshot wounds to the chest. EMT 4 also observed blood on Patient 1's neck, chest, and face, and an excessive amount of blood behind Patient 1's head. EMT 4 told OIG investigators that EMT 1 was standing near Patient 1, that there were no EKG leads on Patient 1's body prior to his medical assessment, and that he conducted an EKG analysis which verified that there was no electrical activity in the heart. EMT 4 also told OIG investigators that in his opinion, the Assistant Chief instructed the second Engine to conduct the EKG analysis on Patient 1 to reinforce the Assistant Chief's initial

determination that Patient 1 was deceased. EMT 4 explained that other FEMS supervisors similarly have given instructions for EKG analyses to be performed on patients presumed deceased to be certain the patient is deceased.

During his interview with OIG investigators, EMT 5 stated that the second Engine arrived at the scene and went to the patient who was later identified as Patient 2. EMT 5 explained that as they approached Patient 2, the Assistant Chief directed him and EMT 4 to conduct an EKG analysis on Patient 1. EMT 5 advised that they went to Patient 1 and he assisted EMT 4 with the EKG analysis. EMT 5 stated that he did not see any EKG leads on Patient 1's body prior to assisting EMT 4 with conducting the EKG analysis.

According to the Autopsy Report dated August 15, 2008, Patient 1's cause of death was "gunshot wounds of torso and left thigh." The Autopsy Report also notes that there was evidence of medical intervention including an EKG pad on the abdomen.

OIG investigators also reviewed photographs of Patient 1 taken by Office of the Chief Medical Examiner (OCME) personnel at the scene. The photographs document a large amount of what appears to be blood on the ground in the vicinity of Patient 1's head and on his face, in the area of his nose and mouth.

ANALYSIS AND CONCLUSIONS

EMT 1's written and verbal statements to OIG investigators regarding the Assistant Chief's conduct at the scene are contradicted by the statements of other FEMS personnel, including EMTs 2 and 3, who were in the Medic Unit with her and remained with her throughout their time on the scene, as well as by the physical evidence. EMT 1 insisted that she placed EKG leads on Patient 1's lower left leg. This statement is contradicted by EMTs 4 and 5's statements, and the Autopsy Report, which indicates that an EKG pad was located on Patient 1's abdomen. EMTs 4 and 5 also submitted the required Patient Care Report, rather than EMT 1, who acknowledged that if she had placed EKG leads on Patient 1 as she stated, she would have been required to submit a Patient Care Report, which she failed to do.

EMT 1 also told OIG investigators in her first interview that she did not observe any blood on Patient 1. In her second interview, EMT 1 stated that she saw a couple of drops of blood on Patient 1's upper brow area. Both statements are contradicted by: (1) the Assistant Chief, who observed an excessive amount of blood around Patient 1's face and airway; (2) EMT 4, who observed blood on Patient 1's neck, chest, and face, and excessive blood behind his head; (3) EMT 2, who observed an excessive amount of blood in Patient 1's mouth and nose, and on the back of his head; (4) the Autopsy Report, which states there was blood around Patient 1's mouth and nares (nostrils) and had "Blood" written on the autopsy diagram of Patient 1's body with an arrow drawn from the word to a circle drawn around the mouth; and (5) OIG investigators' review of OCME photographs of Patient 1 at the scene, which show a large amount of what appears to be blood on the ground near Patient 1's head, on his face, and in the area of his nose and mouth.

Further, EMT 1 concluded that the Assistant Chief erroneously declared Patient 1 presumed dead on arrival and prevented anyone on the scene from attempting to aid him or conduct a medical assessment. Not only did the Assistant Chief arrive on the scene before EMT 1's Medic Unit, the CAD chronology documents that two other emergency response units also arrived on the scene prior to the Medic Unit's arrival. Therefore, it would be impossible for EMT 1 to determine whether Patient 1 received medical attention or a medical assessment before she arrived on the scene and it was irresponsible for EMT 1 to conclude that Patient 1 had been ignored.

Given that: (1) EMT 1's sworn, written statement and verbal statements provided to the OIG were *inconsistent* with those provided by other individuals who were at the scene on August 14, 2008, and whose statements were consistent with each other and OCME documentation; and (2) EMT 1's verbal statements were *inconsistent* with each other, EMT 1's lack of candor is clear. It also is clear that EMT 1 intentionally engaged in a pattern of deception by filing a complaint against the Assistant Chief with the submission of a sworn, written statement containing material misrepresentations to the OIG, and subsequently providing conflicting verbal statements throughout the OIG investigation.

On March 5, 2009, the facts concerning EMT 1's false statements to the OIG were presented to the United States Attorney's Office for the District of Columbia, which declined prosecution.

EMT 1's submission of a meritless written complaint, supported by conflicting oral statements throughout the investigation, constitutes a knowing material misrepresentation on a document given to a government agency; impeded efficient conduct of the OIG's investigation; and affects adversely the confidence of the public in the integrity of the government, all in violation of the DPM. Further, EMT 1's conduct clearly violates FEMS Department Rules and Regulations, which prohibit FEMS employees from engaging in deception.

Accordingly, this investigation has **SUBSTANTIATED** that EMT 1 committed the following violations:

1. DPM § 1603.3 (d) Any knowing or negligent material misrepresentation on other document given to a government agency;
2. DPM § 1803.1 (a)(3) Impeding government efficiency or economy;
3. DPM § 1803.1 (a)(6) Affecting adversely the confidence of the public in the integrity of government; and
4. FEMS Department Rules and Regulations Article VI, § 8 Members shall refrain from immoral conduct, deception; violation or evasion of law or official rule, regulation, or order; and from false statements.

RECOMMENDATIONS

Based on the results of this investigation, the Office of the Inspector General recommends that:

- FEMS officials address the conduct of EMT 1 with appropriate administrative action.

June 14, 2010