

[Modified from original format for printing purposes fonts modified, indexing, subheads, and maps deleted from web page format. Indecipherable errors occurring in format conversion indicated by ??and deleted. Footnotes preserved as text.]

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

**SUMMARY OF SPECIAL REPORT: Emergency  
Response to the Assault on David E. Rosenbaum**

**CHARLES J. WILLOUGHBY  
INSPECTOR GENERAL**

**OIG No. 06-I-003-UC-FB-FA-FX**

June 2006

This Summary describes the D.C. Office of the Inspector General's review of the emergency response efforts provided by District agencies and hospital personnel in light of applicable policies and procedures. The OIG is providing this Summary in lieu of the full report in accordance with the exemptions provided in the District of Columbia Freedom of Information Act (D.C. Code <sup>0000</sup> 2-531-539 (Supp. 2004)) to preserve the privacy interests of Mr. Rosenbaum and other individuals mentioned in the full report.

GOVERNMENT OF THE DISTRICT OF COLUMBIA  
Office of the Inspector General  
717 14th Street, N.W.,  
Washington, D.C. 20005 (202) 727-2540

June 15, 2006

The Honorable Anthony A. Williams Mayor  
Office of the Mayor for the District of Columbia  
1350 Pennsylvania Ave. N.W., Suite 600  
Washington, D.C. 20004

Dear Mayor Williams:

In response to Mr. Bobb's request that the Office of the Inspector General (OIG) review the response to the January 6, 2006, incident involving David E. Rosenbaum, please find enclosed our final report. My Office reviewed the actions of the Office of Unified Communications (OUC), the Fire and Emergency Medical Services Department (FEMS), the Metropolitan Police Department (MPD), Howard University Hospital, and the Office of the Chief Medical Examiner (OCME), regarding their response to the incident. In order to conduct this review, I appointed a team of investigators and inspectors who have training and experience in law enforcement, firefighting, medical care, and prehospital care. The team reviewed policies, procedures, protocols, General and Special Orders, personnel files, patient care standards, hospital and ambulance medical records, certification and training records, and reports issued by FEMS, MPD, the Office of the Chief Medical Examiner, and the Department of Health. The team also interviewed all District government and Howard University Hospital personnel involved in Mr. Rosenbaum's emergency care and the autopsy.

The OIG team concluded that, with the exception of OUC and OCME, there was an unacceptable chain of failure in the provision of emergency medical and other services to Mr. Rosenbaum as required by FEMS, MPD, and Howard University Hospital protocols. Individuals who played critical roles in providing these services failed to adhere to

applicable policies, procedures, and other guidance from their respective employers. These multiple individual failures during the Rosenbaum emergency suggest alarming levels of complacency and indifference which, if systemic, could undermine the effective, efficient, and high quality delivery of emergency services to District residents and visitors. Our review indicates a need for increased oversight and enhanced internal controls by FEMS, MPD, and Howard University Hospital managers in the areas of training and certifications, performance management, and oral and written communications, as well as employee knowledge of protocols, General Orders, and patient care standards. The OIG recommends, among other things, that FEMS and MPD implement quality assurance programs that would assign quality assurance responsibilities to the best-trained or most senior employees dispatched to every medical and non-medical emergency.

In order to give your office and the affected District agency heads the clearest and most useful picture of the actions we reviewed, this full version of the report contains the names of the individuals involved, medical information, and sensitive personnel information that should be handled securely. In addition, we are enclosing a redacted version of the report without names and other sensitive information, which will be available to the public on the OIG website. The significant concerns resulting from this review will necessitate follow-up to our recommendations by the affected District agency managers. So that I can be assured that our findings and recommendations have been given the attention warranted, I request that corrective actions that you require and receive from the agencies be provided to me as soon as possible.

If you have questions about this report or if we can be of further assistance, please feel free to contact me on (202) 727-9501.

Sincerely,

Charles J. Willoughby  
Inspector General  
CJW/lid

## **Executive Summary**

### **Background and Perspective**

**Man Down.** On January 6, 2006, at approximately 9:20 p.m., a resident of Gramercy Street, N.W. went to his car to retrieve an item and found an unknown man lying on the sidewalk in front of his home. The resident's wife called 911, and the Office of Unified Communications dispatched emergency responders to the scene for a man down. The fire (first responders), police, and ambulance (second responders) personnel who were at the scene did not detect serious injuries, illness, or evidence that the then-unknown man had been physically attacked. He had no identification in his pockets, but was wearing a wedding band and a watch. Stereo headphones were found near him on the grass.

Because he was vomiting, and because one or more responders thought they smelled alcohol, the man was presumed to be intoxicated. Consequently, the man was classified as a low priority patient and transported to the Howard University Hospital (Howard) Emergency Department where, after lying in a hallway for more than an hour, medical personnel discovered that he had a critical head injury.

At approximately 11:31 p.m., Rosenbaum's wife reported to the Metropolitan Police Department (MPD) that her husband, David E. Rosenbaum, had gone for an after-dinner walk at approximately 9 p.m., but had not returned. The police broadcast a descriptive lookout, and a police officer who had responded to the Gramercy Street man down call realized that the description of the missing person matched that of the man who had been found lying on the sidewalk. It was later determined that the man down was David Rosenbaum.

Mr. Rosenbaum's head injury was discovered at Howard in the early morning hours of January 7 and reported to MPD. MPD officers then returned to the Gramercy Street scene to look for evidence that might indicate the cause of the head injury. Later, on January 7, the Rosenbaum family was alerted by credit card companies to unusual activity on Mr. Rosenbaum's credit cards. MPD subsequently linked Mr. Rosenbaum's injuries, his missing wallet, and the unusual credit card activity, and initiated an assault and robbery investigation. Despite surgery and other medical

interventions to save him, Mr. Rosenbaum died on January 8, 2006. The autopsy report issued on January 13, 2006, by the Office of the Chief Medical Examiner concluded that Mr. Rosenbaum was a victim of homicide due to injuries sustained to his head and body.

### **Scope and Methodology**

Following Mr. Rosenbaum's death, numerous questions were raised and complaints made by both citizens and District government officials about the emergency medical services provided to him by D.C. Fire and Emergency Medical Services Department (FEMS) and Howard personnel. Questions were also raised regarding the delayed recognition by MPD officers that a crime had been committed.

In a letter to the Inspector General dated January 19, 2006, City Administrator Robert C. Bobb requested that the Office of the Inspector General conduct a review of the response to David E. Rosenbaum's assault and subsequent death.

1. Mr. Bobb indicated that he and Mayor Anthony A. Williams wanted the review to ensure the maintenance of public confidence in the emergency services provided by the District government. In his letter to the Inspector General, Mr. Bobb asked that the Office of the Inspector General's review specifically include answers to the following questions:

- || Did the Office of Unified Communications properly handle, dispatch, and monitor the incident?
- || Did FEMS employees follow all rules, policies, protocols, and procedures?
- || Did first responders properly assess the patient?
- || Were FEMS written reports and oral communication adequate?
- || Did MPD responders properly assess the situation at the scene, and were steps taken by MPD responders prior to opening an investigation adequate?
- || Did the second responders arrive with all due and proper haste?
- || Did the second responders properly assess the patient?
- || Did the second responders select an appropriate hospital?
- || Are there any identifiable improvements to FEMS rules, policies, protocols, and procedures?
- || Did Howard properly triage and assess the patient upon his arrival at the hospital?
- || Did the Office of the Chief Medical Examiner promptly and completely discharge its review and report of the death?

In addition to Mr. Bobb's questions, the Office also received inquiries from Council members Phil Mendelson and Kathy Patterson regarding issues of concern with respect to this matter. Finally, the Rosenbaum family requested that the Office of the Inspector General answer questions they posed "so that errors [they] experienced are not repeated in the future."

We believe that this report is responsive to many of the questions that have been raised.

The scope of the Inspector General'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. 2. To conduct the review, the Inspector General appointed a team of inspectors and investigators to examine the circumstances surrounding the January 6, 2006 incident. The team members have training and experience in law enforcement, firefighting, medical, and pre hospital care. 3. The team reviewed policies, procedures, protocols, General and Special Orders, personnel files, patient care standards, hospital and ambulance medical records, certification and training records, and reports issued by FEMS, MPD, the Office of the Chief Medical Examiner, and the Department of Health. The team also interviewed all District government and Howard personnel involved in Mr. Rosenbaum's emergency care and autopsy. Upon conducting its review, the OIG team noted multiple discrepancies in statements made by interviewees. (See Appendix 1)

## Findings and Recommendations

### Office of Unified Communications

¶ The Office of Unified Communications properly handled, dispatched, and monitored the Gramercy Street call. The call taker and dispatchers who handled the 911 call carried out their duties appropriately.

**Recommendation :** None

### Fire and Emergency Medical Services Department

¶ Engine 20 personnel did not follow all applicable rules, policies, protocols, and procedures. The firefighter in charge of the Engine 20 crew on January 6 did not have a current CPR certification as required. In addition, the firefighter/Emergency Medical Technician (EMT) with the highest level of pre-hospital training did not take charge of patient care during the Gramercy Street call.

¶ Firefighter/EMTs did not properly assess the patient. None of the firefighter/EMTs performed a complete assessment of the patient, and not one of the patient's vital signs was recorded at the scene. Once the firefighter/EMTs perceived an odor of alcohol coming from the patient, they did not focus on other possibilities as the cause of his altered mental status such as stroke, drug interaction or overdose, seizure, diabetes, head trauma, or other injury.

¶ Oral communication and standard reports were not adequate. Firefighter/EMTs did not pass on key information to the ambulance crew such as observing blood on the patient and detecting the patient's constricted pupils. Engine 20 personnel did not prepare a written report on the Gramercy Street incident because the FEMS form for such purpose is being revised.

#### Recommendations:

¶ That FEMS ensure all personnel have current required training and certifications prior to going on duty.

¶ That FEMS immediately implement a reporting form for firefighter/EMTs who respond to medical calls so that first responder actions and patient medical information can be documented.

¶ That FEMS develop and implement a standardized performance evaluation system for all firefighters. The Office of the Inspector General team determined that FEMS employees are not evaluated on a regular basis, in the manner that other District government employees are evaluated. Consequently, FEMS lacks standards to guide firefighters' performance and for use in evaluating their performance.

¶ That FEMS assign quality assurance responsibilities to the employee with the most advanced training on each emergency medical call. The designated employee should: (a) have in-depth knowledge of the most current protocols, General Orders, Special Orders, and other management and medical guidance; (b) monitor compliance with FEMS protocols by all personnel at the scene; and (c) provide on-the-spot guidance as required.

### Metropolitan Police Department Responders

MPD officers did not properly assess the situation upon arrival. The three responding MPD officers did not secure the scene, did not conduct an adequate preliminary investigation in accordance with MPD General Orders, and did not take adequate steps to determine if a crime had been committed. They also did not complete a report on the incident pursuant to the relevant MPD General Order.

#### Recommendations

¶ That MPD immediately review and reissue the pertinent General Orders relating to officer responsibilities at emergency incidents. In addition, MPD should consider implementing or revising as necessary a quality assurance program that includes supervisory review of required reports, and a tracking system to ensure that reports are written and retrievable for every call.

¶ That MPD assign quality assurance responsibilities to the senior officer responding to each call.

### **Fire and Emergency Medical Services Department**

EMTs did not follow applicable rules, policies, and protocols. The highest-trained EMT, an EMT-Advanced, was not in charge of the patient as required by protocol. The EMT-Advanced did not assess the patient, or help her partner assess him. Neither EMT adequately questioned the first responding firefighter/EMTs about the patient's vital signs, or other care and treatment. The patient's low Glasgow Coma Scale results were disregarded, and not brought to the attention of Howard Emergency Department personnel.

The ambulance did not arrive on the scene expeditiously. The ambulance driver got lost after being dispatched from Providence Hospital, and then did not take a direct route to Gramercy Street. This error added 6 minutes to the trip. (See Appendix 2)

¶ EMTs did not thoroughly assess the patient. The EMT who assessed the patient failed to conduct all of the required assessments, and did not fully document his assessment and treatment on the FEMS 151 Run Sheet. (See Appendix 3)

¶ Transport of the patient to the hospital did not follow FEMS protocol. EMTs are required to transport patients to the closest appropriate open facility. Although Ambulance 18 was closest to Sibley Hospital, the EMT in charge, for personal reasons, decided to transport the patient to Howard. Howard is 1.85 miles further from Gramercy Street than the Emergency Department at Sibley Hospital. (See Appendix 4)

¶ EMTs did not properly document actions. The EMT who cared for the patient did not completely fill out the FEMS 151 Run Sheet. For example, the form shows no times when treatment, care, or testing was provided or performed. An entire page of the form relating to patient care was left blank.

### **Recommendations**

¶ That FEMS ensure all personnel have current required certifications prior to going on duty.

¶ That FEMS take steps to comply with its own policy on evaluating EMTs on a quarterly basis.

¶ That FEMS promptly reassign, retrain, or remove poor performers.

¶ That FEMS assign quality assurance responsibilities to the most highly trained pre-hospital provider for each incident. This individual should: (a) have in-depth knowledge of the most current FEMS protocols and other management guidance; (b) monitor compliance with protocols and other guidance by all personnel at the scene; and (c) include the results of on-scene compliance monitoring in all reports required by management.

¶ That FEMS consider installing global positioning devices in all ambulances to assist EMTs in expeditiously reaching their destinations on emergency calls.

### **Howard University Hospital**

¶ Nurses did not properly triage<sup>5</sup> and assess Mr. Rosenbaum. The triage nurse did not perform basic assessments and did not communicate an abnormal temperature reading. The patient was incorrectly diagnosed as intoxicated, but employees did not follow triage policy on treating an intoxicated patient. Howard's Patient Care Standards including

monitoring airway and breathing, assessing for trauma, conducting routine lab tests, and monitoring vital signs every 15 minutes were not followed.

#### **Recommendations:**

¶ That Howard develop a system in the Emergency Department that will allow staff to readily identify patients' priority level while they are awaiting care.

¶ That Howard consider adopting a patient records system that would enable nursing and medical staff to review documents when they are at a patient's side. The current system prevents staff access to such information in a timely manner.

#### **Office of the Chief Medical Examiner**

The Office of the Chief Medical Examiner conducted the Rosenbaum autopsy expeditiously and promptly issued a report.

#### **Recommendation**

¶ That Office of the Chief Medical Examiner consider using digital camera technology to photograph all autopsies. The Office of the Inspector General was unable to review requested autopsy pictures because of photo processing delays and mislaid slides.

#### **Conclusion**

The OIG team concludes that personnel from the Office of Unified Communications properly monitored the 911 call from Gramercy Street and immediately dispatched adequate resources to respond to the emergency. However, FEMS, MPD, and Howard personnel failed to respond to David E. Rosenbaum in accordance with established protocols. Individuals who played critical roles in providing these services failed to adhere to applicable policies, procedures, and other guidance from their respective employers. These failures included incomplete patient assessments, poor communication between emergency responders, and inadequate evaluation and documentation of the incident. The result, significant and unnecessary delays in identifying and treating Mr. Rosenbaum's injuries, hindered recognition that a crime had been committed.

On January 6, 2006, David E. Rosenbaum consumed alcohol, both before and during dinner prior to leaving home for a walk. Neighbors discovered Mr. Rosenbaum lying on the sidewalk in front of their home and called 911. Upon assessment, emergency responders concluded that Mr. Rosenbaum's symptoms, which included poor motor control, inability to speak or respond to questions, pinpoint pupils, bleeding from the head, vomiting, and a dangerously low Glasgow Coma Scale, were the result of intoxication. Hospital laboratory and other tests, however, confirmed that Mr. Rosenbaum's symptoms were caused by a head injury. Emergency responders' approach to Mr. Rosenbaum's perceived intoxication resulted in minimal intervention by both medical and law enforcement personnel.

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 EMTs did not take the patient to the nearest hospital. As a result of that decision, it took twice as long for Ambulance 18 to reach Howard than it would have taken to get to Sibley 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. MPD officers initially dispatched in response to the Gramercy Street call failed to secure the scene, collect evidence, interview all potential witnesses, canvass the neighborhood, conduct other preliminary investigative activities, or

properly document the incident.

Both FEMS and MPD failures were later compounded by similar procedural failures on the part of Howard Emergency Department personnel, who also initially believed Mr. Rosenbaum's condition to be the result of intoxication. Upon Mr. Rosenbaum's arrival at Howard, Emergency Department personnel failed to properly assess his condition and failed to communicate critical medical information to each other, thereby delaying necessary medical intervention, all in violation of Howard's own patient care standards. Further, a number of Emergency Department staff members passed Mr. Rosenbaum in the hallway and neglected to provide clinical and therapeutic care.

The Office of the Inspector General's review indicates a need for increased oversight and enhanced internal controls by FEMS, MPD, and Howard managers in the areas of training and certifications, performance management, oral and written communication, and employee knowledge of protocols, General Orders, and patient care standards. Multiple failures during a single evening by District agency and Howard employees to comply with applicable policies, procedures, and protocols suggest an impaired work ethic that must be addressed before it becomes pervasive. Apathy, indifference, and complacency apparent even during some of our interviews with care givers 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.

Accordingly, while the scope of this review was limited, these multiple failures have generated concerns and perceptions about the systemic nature of problems related to the delivery of basic emergency medical services citywide. Such failures mandate immediate action by management to improve employee accountability. Specifically, we believe that several quality assurance measures may assist in reducing the risk of a recurrence of the many failures that occurred in the emergency responses to Mr. Rosenbaum: systematic compliance testing, comprehensive and timely performance evaluations, and meaningful administrative action in cases of employee misconduct or incompetence.

## **Operations and Protocols of District Agencies and Howard University**

### **Office of Unified Communications**

The 911 call from Gramercy Street was received in the Office of Unified Communications (Communications), which responds to emergency and non-emergency calls in the District. Communications centralizes the coordination and management of public safety communication systems and resources. It is a consolidation of emergency 911, non-emergency 311, and 727-1000 calls for the MPD, FEMS, and District government customer service operations. Communications employs an automated system, I-Tracker, that continuously tracks the location of all mobile emergency units and identifies the closest unit that can be dispatched to an emergency event. It is Communications policy to dispatch the closest appropriate unit to the scene of an emergency.

Documentation provided by Communications management shows that all universal call takers and dispatchers have the training required for their positions. This includes training in basic anatomy, systems of the body, management of different types of calls and callers, and emergency medical dispatch procedures. Communications management stated that the national standard for call takers and dispatchers does not require them to be Emergency Medical Technicians (EMTs). Based on the answers elicited from a 911 caller, predicated on a predetermined set of questions asked by the call taker, an automated system<sup>6</sup> categorizes and assigns a priority designation<sup>7</sup> to each call. Dispatchers then use computer software to identify and dispatch the closest available units. Radio operators give directions to locations and provide other assistance as needed. The Director of Communications stated that the system in place is one of the most widely used and accepted by the emergency medical community.

### **Fire and Emergency Medical Services Department**

According to the Fire and Emergency Medical Services Department (FEMS) website, FEMS "provides fire protection and medical attention to residents and visitors in the District of Columbia." Fire stations have engine companies and/or truck companies,<sup>8</sup> and may have one or more ambulances. Two paramedics<sup>9</sup> are generally assigned to Advanced Life Support (ALS) ambulances,<sup>10</sup> although they may be staffed by a paramedic and an

EMT.11 Two EMTs are assigned to Basic Life Support (BLS) ambulances. The District has 8 engine companies with EMTs, 3 heavy-duty rescue squads with EMTs, 19 Paramedic ALS ambulances, a Rapid Response, 24-hour ALS ambulance, and 17 BLS ambulances.

When a call comes into a firehouse, a lighted sign alerts the crew that they are being dispatched to an address, the reason for the dispatch, and what other emergency responders are being dispatched to the same call. BLS fire engines are stocked with oxygen, cervical collars, and a jump bag. The jump bag contains plastic airways, nonrebreather oxygen masks,12 nasal cannulas,13 bandages, an obstetrical kit, and vital signs testing equipment. There are no blankets, stretchers, back boards, or medications on BLS fire engines. Upon completion of any call, firefighters record minimal details such as date, time, location, and nature of the call in a log book that is maintained at the firehouse.

The FEMS Training Division in southwest Washington, D.C. is responsible for training firefighters. Since 1989, all firefighters have been required to obtain certification as EMTs. All recruits attend the training academy for an 18-week course, 6 weeks of which are devoted to EMT training. EMT candidates who are not firefighters are trained at private EMT training institutions. In addition to formal training, all EMT trainees must pass an EMT Basic Certification written and practical skills examination. This one-day examination is administered by the D.C. Department of Health, Office of Emergency Health Medical Services Administration. A score of 75% is required to obtain certification as an EMT. EMTs must obtain recertification every 2 years by attending a 40-hour refresher course and passing a practical and a written test. In addition, all firefighters and EMTs must have CPR certification, which is renewed after refresher training every 2 years.

The National Highway Transportation Safety Administration (NHTSA), under the federal Department of Transportation, sets standards and establishes guidelines and curricula for the nation's emergency medical services providers. According to NHTSA, there are three levels of EMT certification: EMT-Basic, EMT-Intermediate, and EMTParamedic. In 2000, pursuant to Special Order 2005-17, FEMS instituted a protocol course for "EMT-Advanced," a local program that is intended to "ensure the highest possibility of care." The EMT-Advanced program is not sanctioned by NHTSA. All EMTs were scheduled to attend the additional protocol course, which included 2 weeks of didactic, laboratory, and clinical training. Upon completion of all components of the training, an EMT-Advanced could provide additional pre-hospital services, such as administering certain medications and performing advanced airway management.

Non-firefighter EMTs were trained first, and two classes of firefighter/EMTs were trained in 2002. After 2002, however, funding for continued training was no longer available, and EMT-Advanced training ended. EMT-Advanced personnel are given a wallet card with the EMT-Advanced designation. The card does not expire and EMT-Advanced refresher training is not required.

FEMS protocols governing medical treatment are based on NHTSA guidelines, state protocols, U.S. Department of Transportation training curricula, EMT guidelines, and other reference materials.14 In addition, FEMS publishes General Orders which dictate operational procedures for all FEMS personnel. Special Orders update General Orders, while Memoranda and Bulletins inform personnel of special issues or changes of note. All FEMS personnel can access the General Orders, Special Orders, and Memoranda online, and hard copies are kept in binders at each firehouse. The current FEMS D.C. Adult Pre-Hospital State Medical Protocols were approved in May 2002, partially revised in 2004, and "apply to every EMS agency that operates in the District of Columbia."

FEMS General Patient Care Protocols: EMT-Basic Scope of Practice, at A-5.1 through A-5.2, outlines what certified EMTs are authorized to do: evaluate the ill and injured; render basic life support, rescue, and first aid; obtain diagnostic signs (e.g., temperature, blood pressure, pulse and respiration, level of consciousness, and pupil status); perform CPR; use airway breathing aids; use stretchers and body immobilization devices; provide initial pre-hospital emergency trauma care; perform basic field triage; perform blood glucose testing;15 initiate IV lines for saline;16 administer oxygen, glucose, and charcoal; administer selected medications;17 assist EMT-Intermediates and EMTParamedics; manage patients within their scope of practice; and transport patients. The protocol for Patient Care states that after assuring the EMTs and the patient's safety, and employing precautions to prevent contact with body fluids, the EMT performs an initial assessment on every patient to form a general impression of needs and priorities."



According to this patient care protocol, the initial assessment includes an evaluation of:

- . mental status<sup>18</sup>
- . airway
- . breathing
- . circulation
- . disability, which includes performance of neurological assessment and injuries. This includes removal of clothing as necessary and maintenance of spinal immobilization, if needed.

This section of the protocol includes a detailed chart that addresses the "Appropriate Focused History and Physical Examination" for the unresponsive and responsive patient, which includes the detailed examination and ongoing assessment that is to be performed. Upon completion of the assessment, the protocol requires that a clinical priority be assigned as follows: Priority 1 is Unstable; Priority 2 is Potentially Unstable; and Priority 3 is Stable. A "Note Well" <sup>19</sup> in the patient care protocol states: "The provider with the highest level of pre-hospital training and seniority will be in charge of patient care."

### **Metropolitan Police Department**

The Metropolitan Police Department (MPD) is the primary law enforcement agency for the District of Columbia. General Orders establish policies and procedures for MPD officers. MPD General Order SPT-401.01, entitled "Field Reporting System, dated March 4, 2004, states, in part, at page 3:

It shall be the responsibility of the first member on the scene, regardless of his/her assignment, to begin conducting the preliminary investigation after safety precautions have been taken and the investigation does not interfere with the criminal case or defeat the ends of justice.

The General Order Procedural Guidelines section provides on pages 3-4:

The preliminary investigation is the combination of those actions that should be carried out, as soon as possible, after the first responding member arrives on the scene. At a minimum, he/she shall:

- "Ensure that injured or sick persons receive medical attention.
- "Secure the crime scene to prevent the evidence from being lost or contaminated.
- "Determine whether a crime has been committed and, if so, the exact nature of the offense or incident.
- "Determine the identity of the suspect and make an apprehension when appropriate.
- . "Provide lookout information to the dispatcher and other units, such as descriptions, method and direction of travel, whether armed or unarmed, and any other identifiable information about any suspect(s) and/or the suspect's vehicle.
- "Identify, interview, and take statements from all victims, witnesses and suspects to determine in detail the exact circumstances of the offense or incident.
- "Arrange for the collection of evidence.
- "Take any other action that may aid in resolving the situation or solving the crime as directed by a supervisor.

The Procedural Guidelines section of this same General Order further states that the preliminary investigation begins when the first MPD Officer arrives on the scene of "a crime or incident." All information obtained is to be documented on appropriate forms and submitted for review and signature. The section entitled Regulations states that appropriate reports and paperwork are to be completed for "[a]ny incident or crime that results in a member being dispatched or assigned to calls for service."

### **Howard University Hospital**

Howard University Hospital (Howard) is a 482-bed university and teaching hospital. Its services include a Level I trauma center and emergency department that responds to more than 48,000 visits a year. An Assistant Clinical Manager oversees all activities of the Emergency Department, and a Charge Nurse supervises and directs the patient care activities. One triage nurse is assigned to the ambulance receiving area known as the back triage, and another triage nurse is assigned to the "front triage" or "walk in" area, where all patients seeking emergency care<sup>20</sup> are received. In addition, there also is a "fast track" section for patients who need treatment for acute, minor illnesses, such as earache, or minor lacerations not needing sutures. Fast track care is available from 10 a.m. until 12 midnight.

The Emergency Department is organized into two teams: Red and Blue. The Red Team works out of the rooms on hallways A and B, and the Blue Team works out of the rooms on hallways C and D. The teams function separately, with a team leader and assigned staff nurses. Each team should be staffed with three Registered Nurses and an Emergency Department tech. On January 6, 2006, there were three registered nurses on the Red Team, two on the Blue Team, and neither team had an assigned technician.

According to page 1 of the Howard Emergency Department triage policy, Triage is designed to provide timely assessment and management of all patients who arrive at the Emergency Department. When a patient enters the Emergency Department, a triage nurse evaluates the patient, performs an assessment, and indicates what level of care he or she needs. Levels of care are described in the triage policy. For example, Level I patients have conditions which are critical and life-threatening, and which require immediate therapeutic intervention. Level I conditions include cardiac arrest, unconsciousness, or emergency child birth.

According to Howard's policy, Level II patients have conditions which are critical and require immediate intervention after triage. These conditions include cardiac chest pain, sudden headache, and alcohol and drug intoxication. Level III patients are defined as having conditions which are not critical or life-threatening, but require immediate intervention after triage and registration.

Howard's triage policy provides that patients requiring Level III care, including those with abdominal pain and victims of child abuse and sexual assault, should be seen within 2 hours.

Level IV patients have conditions such as minor burns, dental injuries, and allergic reactions, for which intervention can be delayed.

The Howard Policy for Admission, dated January 2005, states that the triage nurse will utilize the algorithms<sup>21</sup> in determining the priority level of care appropriate to manage the patient. According to the algorithm for alcohol abuse, found in the Howard Emergency Department Triage Manual, a patient with any of the following is considered a Level II patient:

- abnormal vital signs
- altered mental state (including combative, loud, inappropriate behavior)
- non-ambulatory
- history of fall or syncope<sup>22</sup>
- history of acute seizure episode.

A patient with these symptoms goes to the main Emergency Department, where the staff is to urgently proceed. If none of the above signs are present, the patient is a Level IV.

#### **Office of the Chief Medical Examiner**

According to the Office of the Chief Medical Examiner home page on the D.C. government website, the Chief Medical Examiner: Investigates and certifies all deaths in the District of Columbia that occur as the result of violence (injury) as well as those that occur unexpectedly, without medical attention, in custody, or pose a threat to public health.

## **Chronology of Events**

### ***Discovery of Man Down and 911 Call for Assistance***

At approximately **9:20 p.m.** on January 6, 2006, a resident of Gramercy Street, N.W. (Neighbor 1) observed an unknown man lying on the sidewalk directly in front of his house. According to Neighbor 1, he approached the man, who was lying face up on the ground, and saw that he appeared to be ill or injured. He was unable to rise. When Neighbor 1 spoke to the man, he responded with groans. Neighbor 1 called to his wife, Neighbor 2, and told her to dial 911 for assistance. Neighbor 2 relayed the 911 call taker's questions about the man to her husband. She then relayed her husband's answers to the 911 call taker. After ending the call, Neighbor 2 went outside to see if she could help the man. According to Neighbor 2, the man was dressed nicely and not unkempt. Stereo headphones were lying next to him, and as he kept raising his left arm, she noticed that he was wearing a watch and a wedding band. Neighbor 2 stated that the man's eyes did not connect with hers when she spoke to him, and he did not appear to understand what was being said to him. He was using only the left side of his body, as he kept trying to sit up. However, he would fall back each time, striking his head on the ground. He appeared unable to use his right side, and was never able to sit up or stand up. Neighbor 2 also stated that her husband, who was wearing slippers, placed his foot under the man's head to keep it from hitting the ground. Neighbor 2 brought a blanket from the house and covered the man, and she and her husband knelt on either side of him while waiting for the ambulance. Neighbor 1 stated that he did not notice any bleeding, physical harm, or trauma to the patient's body from the time he found him until he was transported to the hospital. However, after the man was put into the ambulance, Neighbor 1 did notice a wet spot on the ground where the man had been lying. He stated that he could not tell what it was until the next morning, when he recognized it as blood.

### **Office of Unified Communications Response**

#### **Universal Call Taker**

According to Communications records and recordings, the 911 call from Neighbor 2 was answered by a call taker at **9:27 p.m.** The call taker interviewed Neighbor 2 by using software-generated questions to assess the nature of the problem. According to the call taker, after she keyed in the answers provided by Neighbor 2, the software made an assessment of the call and produced a description of Unknown Problem (man down). The software also determined that a dual response by FEMS and MPD was warranted. This information was transmitted electronically to both the FEMS and MPD dispatchers.

In July 2005, FEMS issued a policy change entitled Revised Dispatch Policy Change # 3. The purpose of the policy change was to improve ALS and BLS response times by dispatching ALS units on Charlie and Delta Level responses and BLS units on Alpha and Bravo Level responses. According to this policy, Bravo Level calls will be handled by a first responder and a Basic Life Support Unit. ALS units will no longer be dispatched on Alpha or Bravo Level calls. The policy further states that if the first responders (firefighter/EMTs) on the scene request an ALS unit, they must notify Communications with an update on the patient's condition, and the requested ALS unit will be dispatched. The Gramercy Street call was classified as requiring a Bravo level (BLS) response from FEMS.

#### **Fire and Emergency Medical Services Dispatch**

Using the information elicited by the call taker, the software identified, selected, and recommended as first responders, Engine 20, and BLS Ambulance 18. The Communications Event Chronology<sup>23</sup> indicated that Engine 20 was .54 miles, and Ambulance 18 was 5.61 miles from the Gramercy Street incident. At **9:30 p.m.**, the FEMS dispatcher radioed Engine 20, located at 1617 U Street N.W., and Ambulance 18, which was at Providence Hospital (Providence) on Varum Street, N.E., to respond to the Gramercy Street incident.

#### **Metropolitan Police Department Dispatch**

According to the Event Chronology, at **9:31 p.m.**, MPD unit 2022 was dispatched to respond to the Gramercy Street call. Communications software had designated the call a Priority 2, and required the dispatcher to relay this information to a police unit.

within 10 minutes. At **9:37 p.m.**, MPD unit 2021 with Officer 1 and Officer 2, contacted Communications and advised that they would take the Gramercy Street call, and that MPD unit 2022 should disregard that call. MPD unit 2022 driven by Officer 3 acknowledged this message, but advised that she would respond to the location and would remain in service.

### ***ISSUE AND FINDING***

#### **Did the Office of Unified Communications properly handle, dispatch and monitor the incident?**

Communications staff followed protocols. Based on the Office of the Inspector General's (OIG) review of Office of Unified Communications' protocols, procedures, tape recordings, and employee interviews, the OIG team determined that the call taker and dispatchers who handled the Gramercy Street 911 call carried out their duties appropriately. According to Neighbor 2, when she made the 911 call, the call taker was thorough, helpful, and courteous. Further, the team's review of the taped 911 call shows that the call taker worked according to the predetermined script, and sent the call information to the FEMS and MPD dispatchers within the allotted time of 60 seconds.

**RECOMMENDATION:** None.

#### **Fire and Emergency Medical Services Engine 20 Response**

##### **Engine 20 Arrives at Gramercy Street**

On January 6, 2006, at **9:30 p.m.**, Communications dispatched Battalion 4, Engine 20, headquartered at 1617 U Street, N.W., to the Gramercy Street 911 call. According to interviews and the Event Chronology, Engine 20, a BLS vehicle, arrived on the scene at **9:35 p.m.** Four firefighters responded to the Gramercy Street 911 call: FF, FF/EMT 1, FF/EMT 2, and FF/EMT 3. A review of FEMS personnel records showed that three of the four, FF/EMT 1, FF/EMT 2, and FF/EMT 3 had current EMT certifications.<sup>24</sup> FF/EMT 2 was an EMT-Advanced. FF, who was the officer in charge that evening, had never been trained or certified as an EMT.

##### ***Firefighter Interviews***

FF has been a firefighter at Engine Company 20 for 24 years. When he was hired, EMT training was not required. After such training became a requirement, FF still never received training. According to FF, he just fell through the cracks. FF informed his supervisor about his lack of training but was never put into a class. The last time FF tried to get into a class was 6 years ago. FF's CPR certification expired 2 years ago, and he does not have first aid training. On January 6, FF's immediate supervisor was sick, and he was designated as the acting officer in charge, supervising the activities of the crew assigned to Engine Company 20. FF was assigned to this supervisory position even though he was not trained, certified, or in any way qualified to oversee the firefighter/EMTs' care and treatment of ill or injured persons.

According to FF, Engine Company 20 personnel received a call for a man down on Gramercy Street, N.W. around 8:30 or 9 p.m.<sup>25</sup> They responded and found a man lying on the sidewalk. The firefighter/EMTs began attending to the patient. The patient immediately began to vomit, and the firefighter/EMTs had to clean him up with gauze pads retrieved from the jump bag. The vomit smelled like alcohol. It was like food, not a lot of vomit. It kind of dribbled down his jacket. When asked who put gauze to the back of the patient's head,<sup>26</sup> FF initially stated, [FF/EMT 2] or [FF/EMT 1]. Later in the interview, FF stated, "I don't remember anyone placing gauze on the patient's head. We used gauze to clean up the vomit."

FF radioed dispatch to ask for status of the responding ambulance and was told that Ambulance 18 was responding from Providence. He could tell by the radio traffic that it was pretty busy that night and that only a few ambulances were available. FF spoke with the couple who had called 911. Neighbor 1 said he was going out to his car when he saw the patient. FF/EMT 1 started a patient assessment to check for injuries, and Neighbors 1 and 2 placed a blanket on the patient. FF/EMT 1 was holding the patient in the sitting position with FF/EMT 1's legs supporting the patient's back. FF/EMT 3 took the first set of vital signs, and FF/EMT 2 the second. FF watched them do this because [he] wanted to make sure [his] guys were doing the right things. The firefighter/EMTs wore gloves, and he

saw them feel for trauma and blood. They found no signs of trauma or blood. The patient vomited at least two more times. FF stated that the patient never spoke, but was conscious and a little combative when we tried to place oxygen on him.

The lighting in the area where the firefighter/EMTs were working was dim. FF's recollection was that he turned the truck light on to provide more illumination. FF stated that a female police officer arrived and stayed in the car. Soon after, other MPD officers arrived. After Engine 20 firefighter/EMTs had taken the patient's vitals and stabilized him, all the ambulance had to do was pull the stretcher out and take the patient to the hospital.

When the ambulance arrived, FF talked with a female EMT, who asked, "What do we have?" One of the firefighters replied by telling her, "ETOH." 27 The male EMT never inquired about the patient. Either FF/EMT 2 or FF/EMT 3 gave the female EMT the patient's vital signs, which had been written on a firefighter/EMT's glove. FF did not see her write them down. The male EMT placed the patient into the back of the ambulance, and the female EMT sat in the driver's seat. FF asked where they were going and the female EMT stated, "Howard."

When asked about the firefighters' EMT training and the level of pre-hospital care they could provide, FF stated that no one was an EMT-Advanced. 28 He knew this because their name tags would show their status. Subsequent to the Gramercy Street call, FF wrote a report as directed by FEMS officials, and submitted it to his battalion chief. On January 18, an interview panel comprised of FEMS and Department of Health officials at Company 20 firehouse interviewed him about the Gramercy Street call.

FF/EMT 1 has been a firefighter/EMT since May 1992. He was re-certified as an EMT-Basic in the fall of 2004. FF/EMT 1 is based with Engine Company 9, but on January 6, he was detailed to Engine Company 20 to help staff a shift that was shorthanded. FF/EMT 1 stated that Engine 20's regular driver, FF, was the acting officer in charge that night. FF/EMT 1 recalled that when Engine 20 arrived at the Gramercy Street address, two or three, but not more than four, people were standing right over a man lying on the sidewalk. The man was on his back, moving and moaning. He described the man's movement as "squirming," and remembered that the patient must have vomited because he saw vomit on him. FF/EMT 1 stated that he did not smell alcohol at that time.

According to FF/EMT 1, he helped FF/EMT 2 and FF/EMT 3 take the patient's left arm out of his jacket so that someone could take his blood pressure. They sat the patient up and took turns holding him in a sitting position because he was vomiting. FF/EMT 1 recalled that the patient vomited at least twice while Engine 20 was there. FF/EMT 1 stated that he checked for a medical identification (ID) bracelet, but he did not find one. He stated that he usually performs this kind of check, especially when people can't talk. FF/EMT 1 remembered hearing one of his colleagues announce that he was going through the patient's pockets looking for identification, but could not remember who said it. FF/EMT 1 explained that firefighter/EMTs say this out loud to avoid the perception by observers that they are searching patients' pockets in order to steal their belongings.

FF/EMT 1 put an oxygen mask to the patient's face and cranked it up, meaning that he was giving the patient 15 liters of oxygen per minute in order to get him to come around. When asked if the patient was unconscious, FF/EMT 1 responded, "He was moaning, and he couldn't respond. I didn't know what was wrong. The patient repeatedly took the oxygen mask off, and FF/EMT 1 kept putting it back on. FF/EMT 1 stated that he did not know who took over the oxygen mask duty when he left the patient's side, but there were three firefighter/EMTs and, "We were all doing everything. We all switched up." He stated that he could not describe what the other firefighter/EMTs did for the patient because he was concentrating on giving the patient the oxygen, which was hard enough. FF/EMT 1 could not say whether other firefighter/EMTs gave the patient medications, performed an assessment, provided any other care, or determined the cause of the patient's illness.

When FF/EMT 1 was asked what firefighter/EMTs are required to do when they arrive at an emergency, he stated, "all we are supposed to do is take vital signs and stabilize until transport comes." When asked what stabilizing efforts might be made for a man down, FF/EMT 1 replied, "There's a long list of stuff we could do. I don't know." He then said that firefighter/EMTs could do everything except push drugs. FF/EMT 1 also stated that firefighter/EMTs could radio to Communications and inform the call center that a call is of a more or less serious nature than originally dispatched. FF/EMT 1 did not describe any medical urgency related to the patient's condition. In addition, since the man had no medical alert bracelet identifying him as a diabetic, the firefighter/EMTs did not

consider him to be a diabetic. FF/EMT 1 went to the truck and turned on the sidelights. The position of the truck and its lights did not make the illumination real bright, but it was better than without them. FF/EMT 1 returned to the patient and continued giving oxygen. At some point, two MPD officers arrived, but FF/EMT 1 did not know them, nor was he able to describe what they said or did. FF/EMT 1 remembered that the night was cold, and he heard other firefighters ask for a blanket, which a citizen provided. The firefighter/EMTs used the blanket to cover the patient. The patient was shaking his head and vomiting, which made the vomit go everywhere. FF/EMT 1 could smell alcohol, but he thinks it was the vomit.

After the ambulance arrived, the ambulance crew did not ask FF/EMT 1 any questions, and he did not talk to them. He overheard others talking to them, but was not paying attention to what was being said. FF/EMT 1 helped one of the ambulance EMTs put the patient on the ambulance cot and move the patient into the ambulance. Engine 20 returned to the firehouse, and FF/EMT 1 completed his shift at 7 a.m. on January 7. FF/EMT 1 did not make a written report on January 6 on the care provided to the patient but noted that generally, the firefighter/EMT who assesses the patient writes notes and vital signs on the glove or whatever and gives the glove to the ambulance personnel.

When FF/EMT 1 returned to work on January 10, there was an order that he write a special report regarding the Gramercy Street call. FF/EMT 1 wrote the report, and submitted it to his battalion chief. He stated that an interview panel at Company 20 firehouse interviewed him about the Gramercy Street call. FF/EMT 2 has been a firefighter/EMT with FEMS for almost 4 years and has been at Engine Company 20 for the last 10 years. Both his CPR and EMT certifications are current. FF/EMT 2 has received EMT-Advanced training.

FF/EMT 2 recalled that on January 6 the regular engine driver, FF, was the acting officer in charge. FF/EMT 2 was the engine driver for the night. When Engine Company 20 personnel arrived at the Gramercy Street address, they saw a person lying on the sidewalk. According to FF/EMT 2, the driver usually does not leave the truck. However, he could see that the patient was vomiting, and because he had the highest level of training, he left the truck to assist his colleagues.

One of the firefighter/EMTs performed a sternum rub<sup>29</sup> when they first arrived, and FF/EMT 2 gave the patient oxygen via a non-rebreather mask. However, the patient vomited again. FF/EMT 2 removed the oxygen mask so the patient could vomit freely. After FF/EMT 2 removed the oxygen mask, he smelled alcohol. FF/EMT 2 recalled that when FF/EMT 1 put the oxygen mask back on the patient's face, the patient kind of grimaced and pushed the oxygen mask away from his face. FF/EMT 2 described the patient as in and out of it, but the oxygen brought him around. The patient was compliant, but didn't like the oxygen. If I tapped him he would look around at me.

When MPD officers arrived on the scene, FF/EMT 2 asked them if he could check the patient for identification. FF/EMT 2 went through the patient's pockets, but did not find anything. FF/EMT 2 stated that he performed a patient assessment, took the patient's vital signs, and checked the patient's head. His assessment consisted of palpating<sup>30</sup> the patient's head, upper back, neck, lower back, and the front of his chest. He found a speck of blood on the patient's head above his right ear. There was no swelling, and there were no lacerations. FF/EMT 2 applied pressure to the patient's head with 4 x 4 gauze pads. This stopped the bleeding, which was minimal. FF/EMT 2 checked [the patient's] motor responses and they were fine. FF/EMT 2 wrote the patient's vital signs on a piece of paper, which he retrieved from the jump bag, and gave the paper to FF/EMT 3. When he was asked if he always writes the vital signs down, FF/EMT 2 replied, Yes, this is how it's done. Vital signs are recorded and the writing is provided to the ambulance crew. FF/EMT 3 also took vital signs as well as at least two additional blood pressure readings. FF/EMT 2 recorded FF/EMT 3's readings.

According to FF/EMT 2, FF/EMT 1 performed an assessment of the patient's lower body, which included everything below the patient's waist. The patient was sitting up with help from FF/EMT 1, who had the patient's back against his legs to hold him up. FF/EMT 2 stated that the patient would look at the firefighters but would not respond when asked a question. FF/EMT 2 stated that the patient wore a wedding band and a nice watch, and there was a one-piece radio headphone set in the grass nearby. According to FF/EMT 2, It was cold that night, so I got a blanket from the truck and a person that was standing there, a female neighbor, placed a nice blanket on the patient. I remember hearing someone say, Get the blanket; get the blanket," because the patient was vomiting [on it]. The firefighter/EMTs placed the patient on the neighbor's blanket to get him off the ground, and placed the firefighters'



blanket on top of him. When asked if he checked the patient's pupils, FF/EMT 2 replied, "Yes, with my Streamlight." <sup>31</sup> According to FF/EMT 2, the pupils were constricted, meaning small and not reacting to light. Because the interviewers recognized this as a symptom requiring further assessment, they asked if he was sure of the pupil response. FF/EMT 2 then changed his statement and said the patient's pupils did react, and they contracted, meaning they became smaller when exposed to light.

The ambulance arrived, and the female EMT asked the firefighters, "What we got?" FF/EMT 3 told her, "ETOH." FF/EMT 1 and FF/EMT 3 helped the Ambulance 18 crew load the stretcher with the patient onto the ambulance, and care of the patient was transferred to the EMTs. The patient was not placed on a back board and did not have a neck collar. Engine 20 returned to the firehouse after clearing trash from the scene. FF/EMT 2 wrote a report and submitted it to his battalion chief. FF/EMT 2 stated that an interview panel at Engine Company 20 firehouse interviewed him about the Gramercy Street incident.

FF/EMT 3 has been a FEMS firefighter for 15 years. He has worked at Engine Company 20 for 4 years. FF/EMT 3 remembered they received a call at the firehouse on January 6 to Gramercy Street for a man down. Engine 20 arrived on the scene and FF/EMT 3 went to the side of the truck to retrieve supplies. The other firefighters went to the patient. While he was retrieving supplies, a woman approached and told him she had found the man on the ground. The patient was vomiting by the time FF/EMT 3 got to him. FF/EMT 3 repositioned the patient's head so he would not choke. The vomit looked like a full meal and was red. FF/EMT 3 then assessed the patient's level of consciousness. He stated that the patient: "was looking at me sarcastically. He never said anything. I could smell the alcohol reeking from him, like it was coming out of his pores. I tried talking with him, but he didn't speak. I told him we were going to take his blood pressure, but he was not really complying."

FF/EMT 3 took one of the man's arms out of his coat in order to take his blood pressure. Because the patient did not tell them what was wrong, they performed a head-to-toe assessment. After checking the patient, FF/EMT 3 saw a speck of what he thought was blood on his white gloves. He checked the patient again but could not find where the speck came from. He stated he thought it was food from the vomit. Firefighter/EMTs tried to give the patient oxygen at 25 liters per minute, but the patient took the oxygen mask off. FF/EMT 3 stated that the patient kept rolling his eyes at me. FF/EMT 3 stated that the patient was not combative and was "okay" after I turned down the oxygen. He let the oxygen mask stay on a lot longer. The only thing notable about the patient's condition was that he did not respond verbally or follow commands.

FF/EMT 3 stated that when MPD units arrived, there were two black male officers and one black lady [officer] in her vehicle, "chillin'". FF/EMT 3 told one officer standing nearby that he was going to go through the man's pockets for ID but could not find any. FF/EMT 3 stated, "Just from growing up, I thought something was wrong. I found it odd that the patient did not have a wallet or ID on him. No one usually walks around with nothing. I told the guys, 'Somebody got him,' meaning he was robbed. His colleagues said, 'Yeah, something's wrong.' The MPD officer just shrugged. FF/EMT 3 stated that he took one set of vital signs, which he explained included pulse, respiration, and blood pressure. FF/EMT 2 took vital signs two more times. FF/EMT 3 stated that he took the lead, but mostly I had [FF/EMT 2] doing most of the stuff. Even though [FF/EMT 2] is a higher level by training, because he's an EMT Advanced, I always take the lead because I have more time on [the job]. The patient's vital signs were stable, and FF/EMT 2 wrote them on the back of his glove. FF/EMT 3 stated, "I never write down vitals. How hard is it to remember them? I give it to them [the ambulance crew] orally." FF/EMT 2 told him that the patient's pupils were "pinpoint," <sup>32</sup> meaning, according to FF/EMT 3, "small." According to FF/EMT 3, FF/EMT 2 did not give him anything in writing.

The ambulance arrived, and FF talked to the female EMT. A male EMT put the patient into the back of the ambulance. FF/EMT 3 gave an oral briefing to the male EMT on the patient's vital signs. FF/EMT 3 wrote a report and submitted it to his battalion chief. An interview panel at Engine Company 20 firehouse interviewed him about the Gramercy Street incident.

### **Residents' Observations**

Neighbors 1 and 2 told the OIG team that while the arrival time of the fire truck was good, they believed the

ambulance took too long to get there. When the firefighter/EMTs arrived, Neighbor 2 asked them if they would be able to help and kept trying to talk to them, but they did not pay any attention to her. Neighbor 2 thought the injured man had a stroke. She believes that she heard the firefighters rule out a stroke or heart attack. Neighbor 1 heard the firefighters say that 9 out of 10 times it's alcohol related.

Neighbors 1 and 2 did not smell alcohol on the patient's breath. Neighbor 2 saw the firefighter/EMTs give the patient oxygen, and that seemed to make him vomit. She saw him vomit twice. The firefighter/EMTs wiped the vomit from his mouth with what looked like a Kleenex. They kept trying to sit him up, and at the same time, they were tapping on his chest. According to Neighbor 2, the firefighter/EMTs did not appear to know what they were doing. She explained that they were not cohesive and were just standing around not doing anything specific other than giving the patient oxygen and waiting for the ambulance.

## ISSUES AND FINDINGS

### *Did FEMS employees follow all applicable rules, policies, protocols, and procedures?*

¶ **Firefighter had no CPR certification.** FEMS protocol requires that all fire personnel have current CPR certification. FF advised that his CPR certification has not been current for 2 years. Despite his expired CPR certification and the fact that he was not an EMT, FF was in charge of the crew. He also stated that he monitored their actions to ensure that they performed correctly.

¶ **EMT with highest level of pre-hospital training not in charge.** The firefighter/EMT with the highest level of pre-hospital training, FF/EMT 2, did not take charge of patient care during the Gramercy Street call as required by protocol. Oxygen delivery contrary to protocol. FF/EMT 3 administered oxygen to the patient at 25 liters per minute (LPM). This action exceeded both FEMS protocol<sup>33</sup> and accepted medical practice of 15 LPM.

### *Did first responders properly assess the patient?*

¶ **Perceived alcohol intoxication dictated firefighter/EMT actions.** Firefighter/EMTs could not obtain a health history or a cogent response from the patient. They stated that they smelled alcohol, and assumed that the patient's altered mental status was solely caused by intoxication. Firefighter/EMTs did not consider that in addition to having consumed alcohol, the patient could be experiencing other illnesses or conditions such as stroke, drug interaction or overdose, seizure, or diabetes. They also disregarded the possibility that head trauma or other injury could have contributed to his altered mental status.

¶ **Spinal cord injury potential disregarded.** FF/EMT 1 described sitting the patient up and removing his clothing prior to assessing him for head, spinal, or other injuries which would have made moving the patient from a prone position inadvisable. FF/EMT 3 described moving the patient's head prior to assessing his level of consciousness or the presence and extent of injury. In addition, firefighter/EMTs described their continuing efforts to keep the patient in an upright position, despite the patient's inability to sit up, which is an indication of possible head or spinal cord injury.

¶ **Diabetes discounted due to absence of medical ID bracelet.** Firefighter/EMTs made assumptions about the patient's medical condition because of the absence of a medical ID bracelet. FF/EMT 1 stated that the absence of a medical ID bracelet for diabetes eliminated their concern that diabetes was the cause of the Gramercy Street patient's current condition.

¶ **No patient priority assigned.** Firefighter/EMTs did not perform a neurological assessment of the patient, and did not assign the patient a priority as required by the FEMS Patient Care Protocol. This protocol is described in the Operations and Protocol section of this report.

¶ **Faulty patient assessment.** No single firefighter/EMT performed a complete patient assessment, which resulted in a patient assessment that was disjointed and incomplete. According to the firefighter/EMTs, they divided the patient's body in half. One assessed the lower body, while the other assessed the top half. Two took the patient's



blood pressure a total of four times, two took vital signs, two gave oxygen, and one checked the patient's pupils. None of the vital signs was recorded, and only one set was communicated verbally to the male EMT.

¶ **Suspicion of criminal attack not followed-up.** When firefighter/EMTs checked for the patient's ID, they noted that he did not have a wallet or any ID on his person. FF/EMT 3 relayed to the OIG team that he said out loud, in the presence of his colleagues and an MPD officer, that he thought the patient had been robbed. However, even though his FEMS colleagues agreed that something was wrong, neither FF/EMT 3 nor the other firefighter/EMTs conducted a thorough assessment of the patient for assault-related injuries or communicated this concern to the EMT who assumed care of the patient. FF/EMT 3 also did not connect his stated suspicion to the physical signs he observed. These indicators included vomiting, combativeness, bleeding, and non-responsiveness, all of which are symptoms indicative of a head injury.<sup>34</sup>

¶ **Inadequate assessment performed after blood found.** Firefighters/EMTs FF/EMT 2 and FF/EMT 3 described finding blood when they examined the patient. Neither reported using the available flashlight to inspect the patient's head and body for the source of the blood.

¶ **No follow-up to critical finding regarding pupils.** FF/EMT 2 told FF/EMT 3 that the patient's pupils were pinpoint, meaning that the pupils were constricted and unresponsive. FF/EMT 3 stated that he, FF/EMT 3, had seniority and always took the lead. Both firefighter/EMTs should have known that pinpoint pupils are abnormal and warrant follow-up. However, neither conducted any follow-up, nor did they connect the condition to other symptoms the patient displayed. In addition, neither FF/EMT 2 nor FF/EMT 3 conveyed this information to Ambulance 18 EMTs.

¶ **Scope of EMT practice misunderstood.** FF/EMT 1 gave an incomplete description of firefighter/EMTs' responsibilities as taking vitals and stabilizing the patient until transport arrives. In addition, FF/EMT 1 incorrectly described the scope of EMT practice as EMTs can do everything except push drugs. FEMS protocols clearly describe the EMT scope of practice, which is summarized in the Operations and Protocols section of this report.

*Were standard written reports and oral communication by FEMS employees adequate during and following the incident?*

¶ **Oral communication flawed.** Firefighter/EMTs at the scene conveyed minimal information to the Ambulance 18 EMTs upon their arrival. Although FF/EMT 2 and FF/EMT 3 noted seeing blood when they examined the patient, they did not relay this information to Ambulance 18 EMTs. FF/EMT 2 told FF/EMT 3 that the patient's pupils were constricted; however, neither FF/EMT 2 nor FF/EMT 3 relayed this information to the EMTs. FF/EMT 3 stated that he thought the patient had been robbed, but did not convey his suspicion to Ambulance 18 EMTs. According to the firefighter/EMT statements, vital signs were assessed multiple times; yet the male EMT stated that he only received one set of vital signs verbally from FF/EMT 3. FF/EMT 3 told the male EMT that the patient was just intoxicated.

¶ **FEMS requirement for written report not followed.** There was no written patient care report prepared on January 6 by any firefighter or firefighter/EMT who responded to the Gramercy Street incident. However, FEMS Special Order Number 49, Fire Fighting Division Units on Medical Locals, dated September 6, 1996, requires taking the patient's vital signs, including but not limited to pulse, respiration, pupil response, skin color, skin temperature, and blood pressure, and recording them on Form 902 EMS. The OIG team was told that Form 902 EMS has not been used for some time because it is undergoing revision. Some information about the Gramercy Street incident was logged in the Engine Company 20 firehouse journal.

The OIG team reviewed the firehouse log book for entries prior to and subsequent to January 6, 2006 in order to determine the type of information routinely documented. Medical-related calls were documented with minimal detail. However, the January 6 entry made for the Gramercy Street call appears to contain information that was added to the original entry. Similar information is not present in any entries on dates prior to January 6, or on subsequent dates reviewed by the OIG team. The additional information included a blood pressure and pulse reading, and the word verbal written in a different color ink from the original entry. The added entries also included the notation: MPD on scene. Finally, it appears that a sentence was changed with an overwritten word.

¶ **Contradictory interview statements about documenting patient information.** Although three firefighters made statements indicating that care information was documented, their statements were inconsistent and confusing. FF stated that either FF/EMT 2 or FF/EMT 3 wrote the vital signs on a glove and gave it to the Ambulance 18 female EMT. FF/EMT 2 stated that he wrote his own and FF/EMT 3's vital sign readings on a piece of paper retrieved from the fire truck jump bag, and that he gave the paper to FF/EMT 3. FF/EMT 3 stated that FF/EMT 2 wrote the vital signs on the back of his glove. FF/EMT 3 also stated that he gave an oral briefing to the Ambulance 18 male EMT, and that he got nothing in writing from FF/EMT 2. Ambulance 18 EMTs denied receiving any documentation on a glove or on paper.

## RECOMMENDATIONS

¶ **That FEMS ensure all personnel have current required training and certifications prior to going on duty.** The OIG team determined that FF, who was in charge of the Engine 20 EMTs responding to the Rosenbaum call, had not been trained as an EMT, and his CPR certification had not been current for 2 years.

¶ **That FEMS develop a form that is mandated for use by firefighter/EMTs who respond to any medical call.** First responders' actions and patient medical information must be documented as required by Special Order Number 49. The form implemented by FEMS should identify: 1) the EMT responders; 2) their actions regarding assessments and pre-hospital medical care; 3) patient information, including identification, past medical history, chief complaint, current condition; and 4) other pertinent information. This form would remain with the patient when care is transferred to other pre-hospital care givers and Emergency Department personnel.

¶ **That FEMS develop and implement a standardized performance evaluation system for all firefighters.** The OIG team determined that FEMS firefighters are not evaluated on a regular basis, in the manner that most other District government employees are evaluated. According to a senior FEMS official and confirmed by the District's Office of Personnel, firefighters have no performance measures and do not receive written performance evaluations. Grade and step salary increases occur irrespective of the quality of their work. Consequently, FEMS lacks standards to guide firefighters' performance and for use in evaluating their performance.

¶ **That FEMS assign quality assurance responsibilities to the employee with the most advanced training on each emergency medical call.**

This report documents numerous failures to follow FEMS protocols that provide guidance for all aspects of the duties performed during emergency incidents. The OIG team recommends that the senior responder on each emergency call:

- \* □ have in-depth knowledge of the most current protocols, General Orders, Special Orders, and other management and medical guidance that govern emergency response activities;
- \* □ monitor compliance with FEMS protocols by all personnel at the scene, and provide on-the-spot guidance to ensure that all key duties are performed; and
- \* □ include the results of on-scene compliance monitoring in reports as required by FEMS management.

### Metropolitan Police Department Officers Response]

#### **MPD Units Arrive at Gramercy Street**

According to the Event Unit Information, <sup>35</sup> the MPD dispatcher at Communications dispatched unit 2022 at 9:31 p.m. to the Gramercy Street scene. Another unit, 2021, which covers the same geographical area, was finishing a call nearby. Unit 2021 officers radioed Dispatch at 9:37 p.m. to advise that they would take the Gramercy Street call because Field Training Officer, Officer 1, wanted his trainee partner, Officer 2, to gain

experience. Officer 1 told Dispatch that unit 2022 should disregard the call. The disregard communication was radioed to the officer in unit 2022, Officer 3. Officer 3 acknowledged receipt of the dispatch to disregard the call. However, she told the dispatcher that she was going to the scene anyway, and arrived at 9:38 p.m., prior to Officer 1 and 2's arrival.

### ***MPD Officer Interviews 36***

Officer 3 has been a police officer at the Second District for 4 years. She works the third watch, which is 2:30 p.m. to 11:00 p.m. During the interview with the OIG team, Officer 3 referred to a written document to help her remember details about the Gramercy Street incident. On January 6, Officer 3 received a call for service at 9:30 p.m. for a man down on Gramercy Street. She stated that she did not remember why she went to a scene to which she had been dispatched and then told to disregard. She stated, It was my area.

According to Officer 3, Officers 1 and 2 arrived before she did.<sup>37</sup> She saw firefighters on the scene, and a man sitting upright. He was going in and out of consciousness, and fighting the firefighters off. One of the firefighter/EMTs told her the man had a seizure. They also told her that he appeared drunk. It looked as though the firefighter/EMTs put something small under his nose, and every time they did, he would come around. Officer 3 asked the firefighter/EMTs if the man had identification or could give his name and was told, No. Officer 3 stated that she interviewed the male neighbor whose wife had called 911. She did not try to question the man receiving treatment. Officer 3 also did not search the man's clothing for identification and did not conduct any search or other interview. The patient tried to stand up, but the firefighter/EMTs held him down. Officer 3 noted a patch on the man's head, and that he was vomiting. She did not see an oxygen mask but noted that the man wore a watch and a ring. Officer 3 remembered that it was dark, and she had her patrol car spotlight on. Officer 3 could not remember if the fire truck had lights on.

Officer 3 left approximately 1 minute after the ambulance arrived, but she did not notify Dispatch of her departure. When asked if she wrote a report on the Gramercy Street incident, Officer 3 responded that she does not write reports when she is not the primary responder.

Officer 1 has been a police officer for ?? years and has been at the Second District for 2 years. Officer 1 remembered the Gramercy Street incident as a call for a man down. When he and his partner in unit 2021 heard the call, they radioed Dispatch to say they would take it, and to cancel the dispatch of MPD unit 2022. Officer 1 was a field training officer to his partner Officer 2, and wanted Officer 2 to get experience, so he volunteered to take the call. When Officer 1 and Officer 2 arrived at the scene, FEMS Engine 20 was present. Officer 1 stated that Officer 3 was interviewing a man, presumably the complainant. Officer 1 looked around the scene but did not immediately talk to the firefighters from Engine 20.

Officer 1 observed a man sitting on the ground vomiting. According to Officer 1, the man was conscious, his eyes were open, and he was moaning. Firefighter/EMTs were clearing his mouth and throat. They were also giving him oxygen and were holding gauze to the back of his head. Firefighter/EMTs were talking to the man, but he did not respond to them. Officer 1 did not talk to the man. Officer 1 talked to the firefighter/EMTs, who said they were treating the patient for an injury to the back of his head, possibly caused by a fall or a seizure. Officer 1 was not close enough to smell alcohol and did not look for the man's ID. The man being treated looked like a regular person who belonged in the area. He was not out of place. The man was wearing jewelry and stereo headphones were on the ground nearby. Officer 1 did not collect the headphones as possible evidence.

Officer 1 stated that he and Officer 2 talked to the male complainant (Neighbor 1) and asked if he knew the man or knew how he got there. The complainant responded that he did not know the man or what happened to him. When the ambulance arrived, the man was placed on a stretcher and moved into the ambulance. Officer 1 did not talk to the ambulance EMTs. He remembered a white male EMT, but he did not remember anything about the other EMT. When asked if he wrote a report following the incident, Officer 1 stated, No, not for a drunk. He stated that reports concerning drunks are completed by FEMS.

Officer 2 has been a police officer for a year. He attended the MPD training academy from January-September 2005 and has been at the Second District since then. Officer 2 works the third watch. On January 6, he was in

training and was partnered with Officer 1, who was his Field Training Officer.

Officer 2 remembered the Gramercy Street incident. When he and his partner heard the call for a man down, they radioed Dispatch to say they would take it and to cancel the other unit. When they arrived at the scene, Officer 3 and the firefighters were there. Officer 2 saw a man sitting on the ground who was not talking. Firefighter/EMTs were holding something white, either a towel or a bandage, to the back of his head. Officer 2 saw a quarter-sized spot of blood on the bandage. He asked the firefighter/EMTs what was wrong, and one told him the man was possibly intoxicated. He fell and hit his head. Officer 2 does not know which of the firefighter/EMTs said this. He asked where the ambulance was coming from, and a firefighter/EMT told him the ambulance was coming from Providence Hospital. Officer 2 asked why it was coming from Providence, and was told that it was the closest one.

Officer 2 did not get a close look at the man, and saw no signs of an assault. He saw that the man had on a watch and a wedding ring but did not search for ID or talk to the man. Officer 2 asked a firefighter/EMT if the man had any ID and was told he did not. Officer 2 stated that he talked to the complainant, who said that he did not know the man lying in front of his residence and did not know how he got there. Officer 2 wrote identifying information on the complainant in his notebook.

Officer 2 stated that the ambulance arrived, staffed by a male and female EMT. Firefighter/EMTs and the male EMT put the patient into the rear of the ambulance. Officer 2 asked the male EMT where they were going with the patient, and he stated, sibley. The female EMT then said, No, we're going to Howard. He stated that he thought it was curious that they were going to Howard because they were closer to other hospitals. Officer 2 stated that he gave statements regarding the Gramercy Street call to his captain, the MPD Violent Crimes Branch, and to the United States Attorney's Office. He had a copy of the report that he wrote for the internal investigation conducted in the MPD Second District regarding the MPD response and provided a copy to the OIG team.

### ***Initiation of Assault and Robbery Investigation***

While working overtime following his regular shift, Officer 1 heard a radio call concerning a missing person and responded to the caller's home. After being shown a photograph of the missing person, David E. Rosenbaum, Officer 1 recognized the man in the photograph as the same individual in the man down call on Gramercy Street who was transported to Howard by Ambulance 18. Officer 1 relayed this information to MPD officials, who subsequently verified that Mr. Rosenbaum was a patient at Howard.

On Saturday, January 7, Mr. Rosenbaum's daughter notified MPD that several credit card companies had contacted her father's residence regarding suspicious activity on her father's accounts. This information, combined with MPD's knowledge that Mr. Rosenbaum was a patient at Howard, prompted notification to the MPD Violent Crimes Branch, which assumed investigative responsibility for the case, and opened an assault and robbery investigation.

## **ISSUE AND FINDINGS**

***Did MPD responders properly assess the situation upon arrival on the scene, and were the steps taken in advance of opening an investigation adequate?***

¶ **No search of the man down for identification.** MPD General Orders require that a preliminary investigation shall include identification of victims, witnesses and suspects. The three responding MPD officers stated that they did not search the man for identification. Instead, the officers relied on the firefighter/EMTs' search for identification, which was conducted in the course of carrying out emergency medical activities. Two firefighter/EMTs stated that they searched the patient for identification.

¶ **No preliminary investigation.** Officer 3, the first MPD officer to arrive at the Gramercy Street scene, did not conduct a preliminary investigation, secure the scene, or determine if a crime had been committed. Officer 3's failure to perform these steps violated MPD General Orders as described in the Operations and Protocols section of this

OIG report. No explanation was provided as to why this officer responded to a call that she had been told to disregard, why she did not consider herself to be the first responding officer, and why she did not conduct a preliminary investigation. The two officers who assumed the primary responsibility for the call, Officers 1 and 2, also failed to conduct a preliminary investigation, secure the scene, and determine if a crime had been committed.

¶ **No connection made between the man's condition and possible crime.** MPD officers stated that they found a semi-conscious individual who could not speak or give information about his identity, residence, or circumstances. The officers stated that they observed a bandage or gauze being held to the back of the man's head, and one officer said that he saw blood on the bandage. The man was wearing a watch and ring, stereo headphones were lying on the ground nearby, but he had no wallet or identification. Despite these facts, the officers did not connect the man's condition with the possibility that a crime had been committed.

¶ **No report on incident completed.** MPD officers did not complete a report pursuant to the General Order SPT-401.01 Field Reporting System, Section IV A, which states, [m]embers shall investigate and complete the appropriate reports<sup>38</sup> and paperwork as outlined in this General Order in the following situations [a]ny incident or crime that results in a member being dispatched or assigned to calls for service. The officers responsible for investigating the subsequent missing person report made by Mr. Rosenbaum's wife had no information about the man down on Gramercy Street incident that occurred just 2 hours earlier, not far from the Rosenbaum residence. It was merely by coincidence that Officer 1 was on overtime duty and recognized the subject of the missing person report as the man found on Gramercy Street.

#### ***RECOMMENDATIONS:***

¶ **That MPD immediately review and reissue the pertinent General Orders relating to officer responsibilities at emergency incidents.** In addition, MPD should consider implementing or revising as necessary a quality assurance program that includes supervisory review of required reports, and a tracking system to ensure that reports are written and retrievable for every call.

¶ **That MPD assign quality assurance responsibilities to the senior officer responding to each call.** This officer would: have in-depth knowledge of the most current General Orders, Special Orders, and other management guidance that governs emergency response activities; monitor compliance with MPD General Orders and other guidance by all personnel at the scene to ensure that all key actions are taken; and include the results of on-scene compliance monitoring in reports as required by MPD management.

#### ***Fire and Emergency Medical Services Ambulance 18 Response***

##### **Ambulance 18 Arrives at Gramercy Street**

According to Communications Event Unit Information, BLS Ambulance 18 with an EMT-Advanced and a firefighter/EMT-Basic was **dispatched at 9:30 p.m.** and arrived at Gramercy Street at **9:53 p.m.** Ambulances are designed to transport patients from the scene of an emergency to a medical facility. Minimum staffing consists of two certified Basic EMTs. Ambulances cannot exceed the speed limit and must stop for all red lights. The vehicle is equipped with a Direct Entry Keyboard (DEK) system, which enables the ambulance crew to communicate electronically with Communications regarding the vehicle's location and status. Its purpose is to provide real time response time calculations and to reduce radio traffic between emergency responders and Communications. Ambulance crews use the DEK system to indicate that they have received a message, have arrived on a scene, are available for service, are in transport, or have arrived at a hospital.

Ambulance medical equipment includes a cot (stretcher), backboard and cervical collars, splints, bandaging supplies, oxygen, and an automatic defibrillator. The two EMTs responding to the Gramercy Street call on January 6 were EMT 1 and EMT 2. As an EMT-Advanced with the highest level of pre-hospital training, EMT 1 was Ambulance Crew member in Charge (ACIC), and EMT 2 was Ambulance Crew member Assistant. According to a review of FEMS files, both EMT 1 and EMT 2 have current EMT certifications.

##### **Emergency Medical Technician Interviews**

EMT 139 has worked for FEMS since 2001. Prior to that, she was a dispatcher for MPD for a year. EMT 1 received EMT training at a private emergency medical technician training program. EMT 1 renewed her EMT certification in July 2005. According to EMT 1, she was qualified as an EMT-Advanced, but that certification expired 2 years ago. EMT 1 stated that she has not renewed it, or pursued the necessary retraining to regain certification as an EMT-Advanced. However, the OIG team reviewed a document written and signed by EMT 1 in August 2005 on which she indicated that her status was EMT-A[dvanced]. In addition, the OIG team reviewed documents written in November and December 2005 in which EMT 1 is referred to as an EMT-Advanced.

EMT 1 has worked at Engine Company 18, Ambulance 18, quartered at 414 8th Street, S.E., for the past 2 years. Three EMTs, including EMT 1, are assigned to that firehouse, and two of the three have partners. EMT 1 has no partner, so she works with a different firefighter/EMT on every shift depending on the firehouse work schedule. EMT 1 said she had worked with EMT 2 many times, and EMT 2 thinks she is an EMT Advanced. EMT 1 and EMT 2 alternate driving and patient care duties.

On January 6, EMT 1 reported to work at 7 p.m. As the ACIC, she was responsible for checking the equipment and stocking the ambulance. EMT 1 considered herself to be the ACIC because, according to her, it is a seniority kind of thing, based on time on the job. As ACIC, EMT 1 could determine the patient priority level and override her partner's decisions. EMT 1 remembered that on January 6, they were at Providence Hospital around 9:30 p.m. when the Gramercy Street call came in. EMT 1 was outside smoking and believes that she answered the call. EMT 1 indicated that she knew where to go as soon as [Communications] said "3800 block of Wisconsin." I have never been to Gramercy but I have been to that area. The OIG team played the dispatch call tape for EMT 1 on which a male voice could be heard answering Dispatch and asking for directions. After listening to the tape, EMT 1 stated, "I thought I answered the call, but I can't remember everything."

When asked if she protested going to Gramercy Street, EMT 1 denied protesting. The OIG team then played the tape, on which EMT 1 is heard questioning why Ambulance 18 was being sent to Gramercy Street. On the tape, the dispatcher tells EMT 1, "The lead [dispatcher] says you are to go to this call. If another unit closer becomes available, it will be sent there." The OIG team then asked EMT 1 if it is usual for an EMT to question Dispatch about being sent on a particular call, as EMT 1 had done on the tape. EMT 1 replied, "That's my right. I can question anything. They ain't always right."

EMT 1 described how she and EMT 2 left Providence Hospital.<sup>40</sup> EMT 1 stated that her partner was giving her directions, and they drove to Rhode Island Avenue, to Florida Avenue, and to Connecticut Avenue. She did not recall the exact route from Connecticut Avenue to Gramercy Street. When they arrived at the Gramercy Street scene, EMT 1 saw four to five firefighters, and a patient sitting or lying on the sidewalk in front of a house where there was a man on the porch. It was a cold, clear night. The patient on the sidewalk was a white male, conscious and breathing with vomit all over him. According to EMT 1, the man had a lot of vomit on his shirt and jacket. EMT 1 assumed he was a drunk because he had vomit all over him. The patient never said anything to her. She did not get close enough to smell alcohol because, in her words, "It wasn't my patient."

According to EMT 1, firefighter/EMTs usually give the ambulance crew members some information or a little story about the patient. However, this time they provided no story or information. EMT 1 asked Engine 20 personnel, "What we got?" They replied, "ETOH." EMT 1 responded that she replied, "We came all this way for an ETOH?" EMT 1 does not remember which of the firefighter/EMTs said what. According to EMT 1, none was wearing gloves, no one said anything other than "ETOH," and no medical information was given. A male MPD officer was present, but did not say anything. EMT 1 did not assess the patient. EMT 2 and a firefighter put the patient on a stretcher, and she helped them put the stretcher on Ambulance 18. EMT 1 asked EMT 2, "You okay?" EMT 2 replied, "I got it." Before driving away, EMT 1 waited for EMT 2 to finish his assessment of the patient. EMT 2 told her the patient was a [Level] 3.<sup>41</sup> EMT 1 radioed Communications that she had a [Level] 3 to 5 [Howard]. When asked if she questioned EMT 2 about the patient's priority level, EMT 1 replied that she did not argue with her partner regarding the patient's status. EMT 1 stated, "If he said it was a 3, it was a 3."

The OIG team asked why they did not take the patient to Sibley Hospital. EMT 1 stated, "We can go where we want to go. [Howard] was available, and he was deemed a low priority." When asked if she wanted to go to Howard, EMT

1 initially said No, then changed her answer to Yes and said she knew the way to Howard from Gramercy Street.

At Howard, EMT 1 and EMT 2 unloaded the patient, and EMT 2 took the patient's vital signs. EMT 1 went outside to smoke. When she returned, the nursing staff told her and EMT 2 to put the patient in a bed around the corner. The OIG team asked EMT 1 how long Ambulance 18 was at Howard. EMT 1 could not remember exactly but said, It was a while. EMT 1 said that she cleaned up the ambulance. There was not a lot of vomit, just some that appeared to have come from the sleeve of the patient's jacket. EMT 1 did not smell alcohol or vomit in the ambulance.

When asked what Ambulance 18 did after leaving Howard, EMT 1 initially stated that they went to back to the firehouse. EMT 1 then stated that she thought that she drove the ambulance to her house to get money for dinner and then went to the firehouse on 8th Street, S.E.

After returning to the firehouse, Ambulance 18 was taken out of service. In the early morning hours of January 7, EMT 1 was sent home on administrative leave. EMT 1 stated that she had never been sent home before, did not know why she was sent home, and could not remember who sent her home. She thinks a lieutenant made the decision. She asked the lieutenant why she was being sent home, and why her partner, EMT 2, was reassigned to a fire truck. EMT 1 called the firehouse 2 hours later, and was told about statements from the FEMS Medical Director that the Gramercy Street patient should have been a Level 1.

EMT 1 had to write a special report, which she submitted to a lieutenant, whose name she could not remember. On January 18, 2006, a FEMS interview panel interviewed EMT 1 about the Gramercy Street call. The team reviewed the FEMS interview panel's January 24, 2006, report regarding the Gramercy Street incident and found multiple discrepancies between EMT 1's statements to the interview panel and those made to the OIG team.

On Monday, January 10, EMT 1 was told to go to Engine Company 16 at 1018 13th Street, N.W. for retraining. At the time of her OIG interview, EMT 1 stated that she was in a training unit and, upon completion of retraining, would be assigned to an ambulance. EMT 1 stated that the retraining included 2 days of classroom training and occasional ambulance calls. According to EMT 1, she [was] not learning anything.

EMT 2 is a firefighter/EMT who has worked for FEMS for 5 years. He previously worked as an EMT in Colorado for 5 years. He is assigned to Battalion 2, Engine Company 18, located at 414 8th Street, S.E. EMT 2 is assigned to ambulance duty approximately once or twice per month. EMT 2 has worked with EMT 1 many times. He always works with her because, at this firehouse, she is the only civilian (non-firefighter) EMT who does not have a permanent partner. EMT 2 stated that all civilian EMTs are EMT-Advanced level. According to EMT 2, when an EMT-Advanced and an EMT-Basic are working together, the EMT-Advanced is in charge of patient care. Some teams split the driving and patient care duties, but if the patient in the back of the ambulance is bad off, the EMT Advanced needs to be with the patient.

EMT 2 described an EMT-Advanced as a Basic EMT with a broader scope of practice, such as starting IVs and administering drugs with a doctor's orders. According to EMT 2, both EMTs are responsible for checking the ambulance and stocking it prior to departure, although the previous crew should ensure that it is ready. Both he and EMT 1 checked the ambulance on January 6. EMT 2 checked the treatment area, and EMT 1 checked the cab. EMT 2 stated that there is a map of the District in the cab of the ambulance. EMT 1 announced at the beginning of the shift that she was going to drive. EMT 2 stated that EMT 1 likes to drive during the first half of the shift and provide patient care during the second half.

EMT 2 stated that the first call of the night ended at Providence Hospital, which was not that busy. After dropping the patient at Providence, EMT 1 told EMT 2 that she wanted to go to the ATM near their firehouse at 8th and Pennsylvania Avenue, S.E. to get money for dinner. EMT 2 and EMT 1 were outside of the hospital smoking when he heard radio traffic asking for the status of three or four different ambulance units. EMT 2 pushed the button on the DEK to notify Communications that Ambulance 18 was available for a call. He also radioed Communications via the ambulance radio that they were available. EMT 2 stated that EMT 1 became



agitated because he had put them back into service. She yelled at him, "Don't touch the radio!" meaning that he was not to answer the radio calls. [42& 43 not in original. 44 note location lost in conversion]

According to the Communications Event Unit Information for the Gramercy Street call, Communications dispatched Ambulance 18 to Gramercy Street, N.W. at 9:30 p.m., and put it en route at 9:31 p.m.<sup>44</sup> EMT 2 stated that EMT 1 did not want to go to upper northwest. They pulled out of the Providence Hospital area with EMT 1 driving. EMT 1 advised EMT 2 that she did not know where Gramercy Street was and told him to get directions. Meanwhile, EMT 1 was driving toward Rhode Island Avenue, which is in the opposite direction from their intended destination.<sup>45</sup> EMT 2 told EMT 1 to stop and pull over, but she refused. According to EMT 2, she was gonna do what she was gonna do.

Ambulance 18 advised Communications via the DEK that they were en route to Gramercy Street at 9:40 p.m. EMT 2 asked Dispatch for information about the location. He could not understand the dispatcher because of her accent, and asked for clarification. Dispatch advised that Gramercy was off Wisconsin, Harrison, and Garrison. EMT 2 told EMT 1 that he needed the map. EMT 1, who stated during her OIG interview that she had checked and stocked the front of the ambulance prior to departure, told EMT 2 that she did not know where the map was. EMT 2 found it behind his seat. By the time EMT 2 figured out where Gramercy Street was, using the directions from Dispatch and the map, Ambulance 18 was at the intersection of Rhode Island and Florida Avenues. EMT 2 stated that it took Ambulance 18 about 20 minutes to get to Gramercy Street from that location.

While Ambulance 18 was en route to Gramercy Street, EMT 1 told EMT 2 that she wanted to go to Howard because she had a toothache and wanted to go to her house for medicine. EMT 1 then wanted to get some money from a nearby ATM for dinner. EMT 1 complained to EMT 2, "This is b\*\*\*\*\*. We shouldn't be all the way up here."

According to the Event Unit Information, Ambulance 18 arrived at Gramercy Street at 9:53 p.m. EMT 2 saw Engine 20 personnel with a patient who was sitting up. One firefighter/EMT was standing behind him, holding him up. It was hard to distinguish the firefighter/EMTs from each other because none of them wore identifiable D.C. Fire Department uniforms. It was cold and they were all covered up. EMT 2 stated that EMT 1 approached one of the responders, who was about 20 feet away from the patient, and started talking to him. FF/EMT 3 approached EMT 2, who asked FF/EMT 3 what was going on. FF/EMT 3 told him that the patient was just intoxicated. EMT 2 asked if they needed a collar and board, and FF/EMT 3 repeated, "No, he's just intoxicated." FF/EMT 3 gave EMT 2 one set of vital signs for the patient. EMT 2 stated that he did not receive any written documentation from the firefighters.

The area was dark, even with the fire truck's light on. One MPD officer had a flashlight that he was shining in the area where the patient lay. The patient was a 60-70 year old white male who was covered with a blanket. EMT 2 took the blanket off and observed that the patient had vomit on his face and chest. According to EMT 2, the vomit did not smell like anything. Engine 20 firefighter/EMTs told EMT 2 that they had tried to give oxygen to the patient but he took the oxygen mask off. EMT 2 described the patient as incoherent, and growling incomprehensible words. EMT 2 recalled seeing many citizens standing around the scene, and the police holding them back.

EMT 2 did not assess the patient while he was lying on the sidewalk because he wanted to get him out of the cold and away from all the people. EMT 2 stated that it is easier to do assessments inside the ambulance. The firefighter/EMTs did not relay to him significant medical information about the patient, such as his bleeding head wound. In addition, they did not give EMT 2 any written documentation of the patient's vital signs. EMT 2 determined they needed to take the patient to the hospital. EMT 1 came over to the patient with a yellow blanket from the ambulance and wrapped the patient in it. Firefighters helped EMT 2 move the patient onto a cot and move the cot into the ambulance. A MPD Officer asked what hospital they were going to, and EMT 2 told him they were going to Sibley Hospital because they were not that far from Sibley. EMT 1, however, said, "No, not Sibley. We are going to Howard."

At 9:58 p.m., Ambulance 18 left the Gramercy Street scene with EMT 1 driving. EMT 2 asked where they were, and EMT 1 told him she was trying to get back to Connecticut Avenue. EMT 1 told him she did not know where



they were, and it took a bit to get to Connecticut Avenue.<sup>46</sup> EMT 2 radioed Communications and told them they were taking the patient to Howard as a Level 3. EMT 2 took the patient's pulse and blood pressure and recorded them on the 151 Run Sheet. <sup>47</sup> EMT 2 tried to put the oxygen mask on the patient, but the patient took it off. EMT 2 performed a Glasgow Coma Scale (GCS) <sup>48</sup> assessment. He stated that the GCS is a way to measure a patient's level of consciousness. He assessed the patient as having a low GCS, which he stated meant that something was wrong. The patient started vomiting, so EMT 2 moved the stretcher into an upright position. EMT 2 checked the patient's head and checked his pupils by using his thumb and forefinger to open the patient's eyelids, letting the overhead ambulance light shine in his eyes. The pupils were reactive. EMT 2 did not document the pupil test results. He did not undress the patient, but checked the patient's legs, pelvis, and abdomen by palpating those areas through his clothing.

EMT 2 stated that it took 20 minutes for Ambulance 18 to get to Howard. According to the Event Unit Information, Ambulance 18 arrived at Howard at 10:18 p.m. As Ambulance 18 was pulling into the hospital, EMT 2 took the patient's vital signs and performed a second GCS assessment, which was the same as his first assessment. He noticed that the patient's blood pressure had fallen. EMT 2 told the triage nurse the patient was intoxicated. The triage nurse took the patient's blood pressure and walked away. When she returned, she told EMT 2 and EMT 1 to put him in the hallway. EMT 1 and EMT 2 moved the patient onto a hospital stretcher in the hallway. EMT 1 went outside to smoke, and EMT 2 went into a room in the Emergency Department to document the patient's pre-hospital care on the 151 Run Sheet. EMT 2 then took the 151 Run Sheet back to the nursing area and asked a nurse to sign it.

The nurse who signed the 151 Run Sheet as the Person Receiving Patient, was not the triage nurse who received the patient on his arrival. EMT 2 left a copy of the 151 Run Sheet with the nurse who signed it. EMT 2 acknowledged to the OIG team that the 151 Run Sheet was not filled out completely, which was a violation of FEMS protocol. EMT 2 stated that he cleaned Ambulance 18 prior to leaving Howard.

Ambulance 18 left Howard with EMT 1 driving. EMT 1 drove to Massachusetts Avenue, N.W., where one of her children brought medication from an apartment to the ambulance. According to EMT 2, EMT 1 told him the medication was Tylenol 3 for her toothache. EMT 1 intended to go to an ATM, but Ambulance 18 was dispatched to a call in the Trinidad area of the city. After completing the Trinidad call, Ambulance 18 returned to the firehouse at 8th and Pennsylvania Avenue, S.E. Shortly after arriving at the firehouse, telephone calls started coming in about the Gramercy Street incident. EMT 2 and EMT 1 were told the patient's condition had worsened, and Ambulance 18 was taken out of service. EMT 2 was reassigned to a fire truck and finished his shift. EMT 2's supervisor told EMT 2 and EMT 1 that they had to prepare special reports on the Gramercy Street incident. Subsequently, EMT 2 had to appear before the FEMS interview panel to answer questions.

EMT 2 stated that FEMS Acting Medical Director required that he and EMT 1 go to the FEMS Fire Academy for 2 days of classroom and skills training on altered mental status and proper completion of paperwork. They were the only two people in the class. The retraining included instruction on assessment for altered mental status, the Glasgow Coma Scale, head trauma, and proper documentation. EMT 2 received a FEMS protocol manual for the first time since he had been employed at FEMS.

## ISSUES AND FINDINGS

### *Did the Ambulance 18 EMTs follow all applicable rules, policies, protocols, and procedures?*

¶ **Highest-trained EMT not in charge of patient.** General Patient Care Protocols: Patient Care, states at page A1.5, [t]he provider with the highest level of pre-hospital training and seniority will be in charge of patient care. On Ambulance 18, EMT 1, who was an EMT-Advanced, had the highest level of pre-hospital training. In addition, both EMT 2 and EMT 1 considered her to be the Ambulance Crew member in Charge. However, EMT 1 delegated patient care duties and responsibilities to EMT 2, an EMT-Basic. It is unclear to the OIG team why an EMT-Advanced working with an EMT-Basic would not consider herself responsible for anything other than driving the ambulance. In fact, EMT 1 made a point of distancing herself from the care of the Gramercy Street patient. She told OIG interviewers explicitly that, It wasn't my patient. She neither assessed the patient herself, nor helped her partner assess him. When firefighter/EMTs offered very little

information about the patient, other than his presumed intoxication, she failed to question them about the patient's vital signs or other aspects of his condition. EMT 1 also failed to inquire about the care and treatment they had provided. EMT 1 told the OIG team that she assumed the patient was a drunk because he was covered in vomit.

¶ **Glasgow Coma Scale assessment result disregarded.** General Patient Care Protocols: Adult & Pediatric Clinical Priority and Transport Decision Chart identifies a patient with a GCS assessment of less than 13 as unstable. EMT 2 assessed the patient's GCS twice: once after departing Gramercy Street en route to Howard and again as the ambulance was arriving at the hospital. The first reading was described by EMT 2 as low and meaning that something was wrong. The second reading was the same as the first. However, neither EMT increased the patient's priority, or informed Howard Emergency Department personnel about the low GCS scores.

¶ **Incorrect clinical priority assigned.** The General Patient Care Protocol: Patient Care, Initial Assessment section requires that after the EMT conducts an initial assessment, he or she must assign a clinical priority. The Adult and Pediatric Clinical Priority and Transportation Decision Chart protocol sets forth a list of conditions for each clinical priority. For example, Priority 1 Medical<sup>49</sup> includes patients with cardiac arrest, GCS of less than 13, and multiple trauma. The Gramercy Street patient's GCS was less than 13, but he was incorrectly categorized as a stable patient, or Priority 3.

¶ **Failure to comply with extended on-scene service policy.** An August 24, 2005, FEMS memorandum, Chute Times and On Scene Times, states that [a]ll providers are responsible for assessing, treating, transporting, and returning to service in an expedient manner. The memorandum goes on to provide that any foreseen extended on-scene time that may be greater than 20 minutes requires the unit to notify a supervisor and document the cause of the extended time. According to the Event Unit Information record, Ambulance 18 arrived at Howard at 10:18 p.m. A photocopy of the 151 Run Sheet shows the ambulance as back in service at 23:26" (11:26 p.m.), indicating that Ambulance 18 was out of service for more than 1 hour without notifying a supervisor or documenting the cause of the extended time on the scene. However, the original 151 Run Sheet is blank in the area for InService time. Did Ambulance 18 arrive with all due and proper haste?

¶ **Confusion about the route to Gramercy Street prolonged the trip.** The ambulance crew left Providence Hospital prior to obtaining adequate directions to the Gramercy Street emergency. EMT 1, the self-designated driver, got lost after being dispatched from Providence Hospital at 9:30 p.m. She and EMT 2 were confused about the route, could not immediately locate the ambulance map, started driving in a direction that was the opposite of their intended destination, and had to contact Communications for assistance.

¶ **In addition, Ambulance 18 did not take a direct route from Providence Hospital, located at 1150 Varum Street, N.E., to the Gramercy Street, N.W. address.** This trip is approximately 5.67 miles, with an estimated driving time of 17 minutes.<sup>50</sup> I-Tracker indicated that Ambulance 18 took a route from Providence to Gramercy Street which, according to MapQuest, added 1.59 miles and 6 minutes to the trip. According to the Event Unit Information, Ambulance 18, which was using flashing lights and sirens, arrived at Gramercy Street at 9:53 p.m., 23 minutes after dispatch.

¶ **Discrepancy regarding Ambulance 18's en route time.** There is an unexplained 10-minute gap between the time Ambulance 18 was dispatched at 9:30 p.m. to Gramercy Street, and the time EMT 1 engaged the DEK at 9:40 p.m. to show that they were en route.

¶ **Confusion about the route to Howard prolonged the trip.** According to MapQuest, the trip from Gramercy Street to Howard is an estimated 4.81 miles, with an estimated driving time of 15 minutes. According to I-Tracker, EMT 1 drove Ambulance 18 from Gramercy Street in the opposite direction from their destination. Consequently, Ambulance 18 arrived at Howard 20 minutes after leaving Gramercy Street.

*Did Ambulance 18 EMTs properly assess the patient?*

¶ **A thorough patient assessment was not conducted.** General Patient Care Protocols direct a comprehensive

initial assessment of every patient to form a general impression of needs and priorities. EMT 1, who had the highest level of pre-hospital training and was the senior crew member, did not take charge of patient care as required by FEMS protocols. Although EMT 2 stated that he conducted some of the required assessments, he did not document all of them on the 151 Run Sheet. Some of the assessments that were not performed included a capillary refill test,<sup>51</sup> assessing the patient for injuries with his clothing removed, pulse oximetry,<sup>52</sup> and a blood glucose test. The pulse oximetry and blood glucose tests would indicate if the patient's inability to speak was related to oxygen deprivation or a diabetes-related condition. As an EMT-Advanced, EMT 1 was trained to perform the blood glucose test and should have done so prior to Ambulance 18's departure for Howard.

¶ **Pupil check not properly performed.** Based on his own statement, EMT 2 did not conduct a proper pupil check. He stated that he used his thumb and forefinger to let the overhead ambulance light shine in the patient's eyes rather than using a penlight or other focused light source.

¶ **Patient's clothing not removed for a thorough examination.** General Patient Care Protocols state, "[t]o assess the patient's injuries, remove clothing as necessary, considering condition and environment. EMT 2 stated that he did not want to assess the patient on the sidewalk because of the cold weather. However, when the patient was moved into the ambulance, EMT 2 did not remove any of the patient's clothing in order to examine his body for possible injuries.

*In summary, the patient could not speak, did not respond to oxygen delivery, had vomited several times, had a dangerously low GCS as well as an elevated pulse rate. All of these assessed clinical signs were indicators of a more serious condition than ETOH, which the EMT wrote on the 151 Run Sheet and communicated to the Howard Emergency Department staff.*

*Did the Ambulance 18 EMTs select an appropriate hospital?*

¶ **The transport decision was not based on FEMS Protocol.** The FEMS protocol for Adult Medical Emergencies: Altered Mental Status (NonTraumatic) requires that EMTs "[t]ransport patient to the closest appropriate open facility. Sibley Hospital was the closest appropriate open hospital from Gramercy Street.<sup>53</sup> The decision to transport Mr. Rosenbaum to Howard rather than Sibley, however, was not based on his medical needs or an assessment that he was a trauma patient who required a trauma center such as Howard. Mr. Rosenbaum was transported to Howard based on personal reasons, which delayed the emergency hospital care that would have been available minutes earlier.

Although not a trauma center, Sibley Hospital has emergency and imaging departments that could have provided initial medical emergency assessment and diagnostic services to Mr. Rosenbaum. Preliminary medical interventions (e.g., laboratory tests, intravenous fluids, medications, spinal stabilization, xrays, and a MRI and CT scan) could have been expeditiously provided in a hospital setting within a matter of minutes had Mr. Rosenbaum been transported to the nearest facility, as required by FEMS protocol. We recognize that the discovery of Mr. Rosenbaum's head injury may have necessitated his transfer from Sibley to a facility more appropriate for the trauma care and neurosurgical intervention he needed.

EMT 2 told a MPD officer that the patient was being transported to Sibley, but he was overruled by EMT 1, who said they were going to Howard. According to EMT 2, before they arrived at the Gramercy Street incident, EMT 1 had told him twice that she wanted to go to Howard for personal reasons.

*Were written reports and oral communication by FEMS employees adequate during and after the incident?*

¶ **Ambulance 18 EMTs did not properly document their actions.** A July 1, 2005, Special Order, EMS 151c Form Modification, signed by FEMS Chief Adrian Thompson underscores the importance of the FEMS 151 Run Sheet. This Special Order states that the patient-care portion of the form 151 is a discoverable medical-legal record, and the primary document pertaining to the care provided any patient by the Department. It states further that the form 151's contents are a direct reflection of the Department's competence, commitment and professionalism with

regards to patient care. According to a Patient Care Protocol Note Well, the 151 Run Sheet is not considered complete until it is filled out in its entirety. However, the 151 Run Sheet completed by EMT 2 was not completely or properly filled out. For example, he did not document on the first page of the 151 Run Sheet that he administered oxygen and performed a pupil response test, although he stated during his interview that he had carried out these activities. In addition, no times are documented to show when any treatment, care, or testing was provided or performed. Finally, the second section of the form related to patient care was left blank.

¶ **Transfer of patient from FEMS to Emergency Department Staff faulty.** After arriving in the Emergency Department with the patient, EMT 2 transferred care to the triage nurse and gave her an oral report on the patient's condition. He did not give her the patient's 151 Run Sheet because it had not been completed. After completing the 151 Run Sheet, EMT 2 presented it to a different nurse, who had not seen or assessed the patient and had not been given a report on the patient's condition. EMT 2 accepted this nurse's signature as the Person Receiving Patient.

*Are there any identifiable improvements to rules, policies, protocols, and procedures?*

The OIG team determined that the findings cited above are attributable to individual failures to adhere to existing policies, procedures, and protocols during the Gramercy Street incident on January 6, 2006. Consequently, because the OIG team's focus was on this singular event, we do not conclude that these failures are necessarily systemic. They do, however, indicate possible areas of concern related to management oversight of personnel, accountability for performance, and quality assurance. Therefore, the OIG team makes the following recommendations for FEMS management:

## RECOMMENDATIONS

¶ **That FEMS ensure all personnel have current required certifications prior to going on duty.** The OIG team determined that EMT 1's EMT certification expired in May 2005, and she was not re-certified until July 2005. The OIG team reviewed Ambulance 18's log book at the Ambulance 18 firehouse and 151 Run Sheets for May to July 2005. The team found that EMT 1 continued working and providing pre-hospital care during the period in which she was not certified.<sup>54</sup>

¶ **That FEMS take steps to comply with its own policy on evaluating EMTs on a quarterly basis.** The OIG team was told that non-firefighter EMTs have performance measures and are given performance reviews. However, a battalion fire chief stated that although FEMS policy requires quarterly EMT evaluations, officials are not meeting that schedule because there are too many EMTs to evaluate four times per year. Consequently, supervisors evaluate EMTs' performance when time permits, and some have not been evaluated in years. FEMS officials stated that they are trying to improve their record on completing performance evaluations, at least annually.

¶ **That FEMS move promptly to reassign, retrain, or remove poor performers.** The OIG team reviewed personnel files of all FEMS personnel involved in the January 6, 2006, Gramercy Street call. This review indicated that infractions have been committed by FEMS personnel for which no disciplinary action was taken. In other instances, disciplinary action was recommended but not carried out for several months. While there were disciplinary actions in the files of firefighters and one EMT for serious infractions, none of these files involved issues related to pre-hospital patient care.

¶ **That FEMS assign quality assurance responsibilities to the pre-hospital provider with the most advanced training.** This report documents numerous failures to follow FEMS protocols that provide guidance for all aspects of the duties performed during emergency incidents. The OIG team recommends that FEMS consider designating the most highly-trained responder on each emergency call as the Quality Assurance Officer, who would be required to: have in-depth knowledge of the most current protocols, General Orders, Special Orders, and other management and medical guidance that govern emergency response activities; monitor compliance with FEMS protocols by all personnel at the scene, and provide on-the-spot guidance as necessary; and include the results of on-scene compliance monitoring in those reports already required, and in any other reports required by management. Monitoring for quality assurance would not be burdensome and is already an inherent responsibility of the person in charge.

This recommendation has the potential to provide management with timely feedback on the quality of the services

rendered by individual emergency responders, as well as a larger picture of the effectiveness of protocols, policies, and procedures, and any changes that might be required.

¶ That FEMS consider installing global positioning devices in all ambulances to assist EMTs in expeditiously arriving at destinations in response to emergency calls.

## **Howard University Hospital Emergency Department Personnel Response**

### **Ambulance 18 Arrives at Howard University Hospital**

Five Howard Emergency Department nurses and an Emergency Department physician had responsibility for Mr. Rosenbaum's care in the Emergency Department on January 6. All of the nurses are registered nurses, with current licenses issued by the District of Columbia. Licenses are renewed every 2 years, with proof of 24 hours of continuing education during the prior 2-year period.

### **Hospital Personnel Interviews**

All of the interviewees emphasized how busy the Emergency Department was on the evening of January 6, and all stressed that they were short staffed. Optimum staffing is 13, including nurses and Emergency Department technicians. On January 6, there were 10 staff members working in the Emergency Department. The doctors and nurses interviewed stated that all of the rooms were occupied, and patients were lined up on both sides of the hallways during the period that Mr. Rosenbaum was a patient.

Nurse 1 has worked at Howard for approximately 5 years. She works a regular 12-hour shift of 7:30 a.m. to 8:00 p.m., sometimes working overtime until midnight. On January 6, Nurse 1 worked from 4:00 p.m. to 12:00 a.m. as a triage nurse in Howard's Emergency Department. Nurse 1 started the shift working in the walk-in triage areas. Nurse 1 was told to cover for the nurse at the ambulance triage area while that nurse went on a break. She described the patient flow in the Emergency Department, which starts with an assessment by the triage nurse. If the patient needs treatment in the Emergency Department, the triage nurse asks the charge nurse to assign the patient to a team. The charge nurse alternates patient assignments between the teams.

If there is no room available, the patient waits in the waiting area. If the patient is on a stretcher, the patient is wheeled into one of the hallways of the assigned team. Once the triage nurse gives information about a patient to the charge nurse and completes the top portion of the triage form, HUH EMERGENCY NURSING DATA BASE M.R., 59 she has no further responsibility for the patient. The paperwork goes into a chart rack located in one of the Emergency Department hallways. The chart rack is divided into sections for the Red and Blue teams. The chart does not stay with the patient who might be moved to a different location in the Emergency Department.

Nurse 1 remembered the patient who was brought in by ambulance. He was signed in at 10:30 p.m. and presented as an ETOH, or intoxicated person. She recalled that a male EMT told her the patient was drunk and had fallen on the street. Nurse 1 could not recall if the EMT told her the patient's vital signs. Nurse 1 did not see or sign the 151 Run Sheet. She stated that sometimes EMTs will give the triage nurse a blank 151 Run Sheet and ask a nurse to sign it. The EMT will then fill in the run sheet before leaving the hospital.

Nurse 1 recalled that she already had three patients in the ambulance triage area. The Ambulance 18 patient was one of two. Does. 60 The stretcher was upright, with the patient in a sitting position. He was covered with a yellow FEMS blanket. He had no blood on his face and had a large amount of vomit on his shirt which smelled of alcohol. He was not talking and looked as if he was asleep. She thought he had been talking to the FEMS staff and was now asleep, so she just let him sleep. Nurse 1 recalled performing a triage assessment of the patient by taking his vital signs, including his oxygen saturation level, temperature, blood pressure, and heart rate. She took an axillary<sup>61</sup> temperature, recognized that the temperature reading was low, and circled the reading on the triage form. Nurse 1 assumed that his temperature was representative of the temperature outside because it was a cold night. When Nurse 1 was asked what she did to address the patient's low temperature, Nurse 1 stated that she did not retake the temperature, nor did she use another thermometer or site,<sup>62</sup> to ascertain a second reading. Instead, she stated that she put a Howard hospital blanket on him.<sup>63</sup> Nurse 1 then stated that she circled the temperature on the

triage form so that one of the nurses assigned to his care would put a blanket on him. According to Nurse 1, the patient was not in respiratory distress, had no blood on him, and was not really that sick. She did not check his pupils because she thought he was asleep and did not want to bother him. The EMT told her that they had spoken with the patient earlier, so she indicated that he was awake and alert, even though she did not speak to him, hear him talk, or see any sign that he was awake or alert. Nurse 1 decided not to wake him because, according to her, sometimes medical staff has to restrain intoxicated patients when they wake up and want to leave the Emergency Department. If the patient's gait is not steady, medical staff cannot let patients leave. Nurse 1 did not want this to happen with this patient.

When asked if she considered the patient to be responsive, Nurse 1 responded, I saw he was not in distress so I did not wake him. He just fell asleep so I did not want to wake him. When asked how she would know if he was in distress, Nurse 1 stated, It would show in his oxygen saturation, 64 which she considered normal. When questioned further about retaking vital signs because they may appear inaccurate or alarming, Nurse 1 stated she never retakes, even if [she has] reservations about the readings. When asked who determines the level of care assigned to a patient, Nurse 1 stated the level of care is determined at triage before the charge nurse gets the paperwork. She stated that an intoxicated patient is usually considered a Level III.<sup>65</sup> She determined this patient was a Level III and circled that designation on the triage form.

Nurse 1 signed the triage form at 10:36 p.m., and then gave it to the charge nurse, Nurse 2. Nurse 1 told Nurse 2 the patient was intoxicated and asked where he was to be assigned. Nurse 2 had just assigned an intoxicated patient to the Red Team, so this patient was assigned to the Blue Team. Nurse 2 told Nurse 1 to put the patient in Hallway D. Nurse 2 has worked at Howard for 17 years, the first 6 years on medical surgical floors, and the past 11 years in the Emergency Department. She is licensed as a registered nurse in the District of Columbia and Maryland. Nurse 2 usually works from 7:30 p.m. to 8:00 a.m. When she arrived for work at 7:30 p.m. on January 6, she assumed charge nurse duties from the Assistant Clinical Manager. As charge nurse, Nurse 2 takes reports about patients from the triage nurse, and makes decisions regarding patient assignments.

Nurse 2 stated that the triage nurse usually gives the charge nurse the triage form with the top part of the form filled in with information on the patient. In addition, the charge nurse may get patient information verbally from the triage nurse. Nurse 1 was assigned to walk-in triage, but was also covering ambulance triage while the ambulance triage nurse took a break. Nurse 1 gave Nurse 2 a triage form on the Ambulance 18 patient. Nurse 2 stated she did not look at the form in detail. She remembered specifically that he was a Doe, and Nurse 1 saying, We have another ETOH. Nurse 2 had just given the Red Team an ETOH, so this patient went to the Blue Team. Nurse 1 told Nurse 2 that the patient did not give his name, was not talking, and was classified as a Doe. The EMT from Ambulance 18 also said the man was intoxicated. Nurse 2 described a man on a stretcher in an upright position. He was breathing, had vomit on his clothes, was dressed, and was covered with a yellow FEMS blanket.

Nurse 2 said Nurse 1 did not tell her that the patient was awake and alert. If Nurse 1 had told her that, she would have questioned why he was considered a Doe. If he had been awake and alert, he should have been able to give his name. Nurse 2 also stated that Nurse 1 did not tell her about the patient's low temperature. Nurse 2 did not notice the temperature reading on the triage form. She said if she had known about the low temperature reading, which was abnormally low, she would have instructed Nurse 1 to retake the temperature. Nurse 2 stated that the triage nurse assigns the priority level, I-IV. Hospital protocol calls for an intoxicated patient to be considered a Level II patient. In this case, Nurse 1 classified the patient as a Level III. Nurse 2 would have considered this patient a Level II and had no explanation for why he was classified as a Level III in triage.

The bottom of the Doe's form was not completed with the required assessment information, because the assessments were not done. The patient became a trauma team patient and the trauma flow sheet was used instead. When asked about the assessment information required on the form (e.g., GCS, pupil checks, skin integrity, breath sounds), Nurse 2 stated that it would provide a lot of information about a patient's condition if the tests were timely performed. Nurse 2 could not explain why no one had filled in this information, even though the patient had been in the Emergency Department for some time. According to Nurse 2, the charge nurse is responsible for informing the team leader about the patients. The nurse that Nurse 2 thought was the team leader (Nurse 4) was with a trauma patient, so Nurse 2 could not tell him about the new patient on his team. Nurse 2 stated that the other nurse on the Blue Team, Nurse 3, knew about the patient.



The nurse who is assigned to a patient finds a room, cleans the patient, performs a finger stick to check for hypoglycemia, administers oxygen if a person is breathing abnormally, and performs neuro checks.<sup>66</sup> Nurse 2 acknowledged that no one looked at this patient. The Emergency Department was understaffed and very busy. Nurse 2 stated that a patient waiting ??hours for treatment is unusual and not normal. Nurse 2 repeated that the Emergency Department was understaffed.

The OIG team sought assistance with reading the Howard Emergency Department medical record for the Doe because of illegible handwriting. Nurse 2 was asked to read the EMERGENCY PHYSICIAN RECORD I and II in order to inform the OIG team about the content of the doctor's notes. Nurse 2 could not read many of the notes, but knew the writing belonged to Doctor 1. She stated that Doctor 1 is notorious for her unreadable handwriting, and explained that, No one can read it. Nurses must read doctor's orders, which detail necessary treatment for a patient.

Nurse 3 has been an registered nurse since 1996. She has worked in various clinical areas at Howard since 1999, and began working in the Emergency Department in 2002. Her shift is 7:30 p.m. to 8:00 a.m. On January 6, Nurse 3 arrived at work at 8 p.m. and was the team leader for the Blue Team. Sometime after 10 p.m., she noticed a patient in the triage area with a lot of vomit on him. She asked the triage nurse what was wrong with the patient, and the triage nurse told her, EMS noted ETOH. Nurse 3 stated that she left it alone and went back to work. The other nurse on her team, Nurse 4, was with a trauma patient, so Nurse 3 was alone on the Blue Team.

Doctor 1 asked who was going to clean the patient in the hallway, referring to the patient that Nurse 3 had seen in the triage area earlier. Nurse 3 had not received any information from the charge or triage nurse about this patient. Because he had not been able to give his name, he was considered a Doe. The patient was fully dressed and wrapped in a yellow FEMS blanket. The stretcher was in an upright position, and the patient was slumped to one side with his eyes open. He was covered with vomit but she did not notice a smell. According to Nurse 3, it looked like he had just eaten dinner. Nurse 3 did not perform an assessment because she had been told the patient was ETOH. She assumed that was why the patient had vomited. The patient was not in respiratory distress, so he was not a priority at that time. The other Blue Team nurse came back to the Emergency Department but had to deal with another patient. Thirty minutes after she asked the first time, Doctor 1 asked again who would be cleaning the patient. Nurse 3 responded, When we get someone free, we will.

At approximately 11:30 p.m., when the night shift was arriving and after Nurse 4 was finished with his patients, Nurse 3 asked him to help her clean the patient in Hallway D. Nurse 3 was going to put a screen around the patient in the hallway and clean him up there, but Nurse 4 wanted to put him in a room. Nurse 3 stated that she was pulling the stretcher down the hall and noticed that the patient's breathing had changed to a snoring noise. It did not appear to be a sleeping snore. She could tell his breathing had changed since her earlier observation of him, and the change was for the worse. It did not sound like shortness of breath. It was more like a growl. Nurse 4 performed a sternum rub, and the patient flipped his arms and legs inward. She demonstrated this movement by rotating her arms and legs inward toward her body.

Nurse 3 began to undress the patient by removing his pants, and noticed that the back pocket of the pants was ripped or torn. Nurse 3 did not notice any bruising on his body. Nurse 4 removed the patient's jacket. His clothes were put in a bag and moved with him. Nurse 3 left his wedding ring on, but took off the watch and put it in her pocket. Nurse 3 later gave the watch to a Surgical Intensive Care Unit nurse. She stated that it was an expensive watch and she did not want to leave it in the bag with his clothes. Nurse 3 saw Nurse 4 repeat the sternum rub and the patient responded with the same movements. They knew, based on this response, that he probably had a head injury. Nurse 4 found a laceration to the man's head and went to get Doctor 1. Nurse 3 went to get IV equipment and when she returned to the room less than 5 minutes later, Nurse 4 and Doctor 1 were moving the patient to the resuscitation room. By then, Nurse 4 or Doctor 1 had called the trauma team. Doctor 1 started to intubate<sup>67</sup> the patient. Nurse 3 did an EKG.

Nurse 3 never saw the 151 Run Sheet or the triage form. The OIG team sought assistance from Nurse 3 with reading the Howard Emergency Department medical record for the Doe. She was asked to read the EMERGENCY PHYSICIAN RECORD I and II in order to inform the OIG team about the content of the doctor's notes. The OIG team showed her several documents with handwriting that she recognized as Doctor 1's, which she described as

terrible. She tried to read the writing but could not.

Nurse 4 has been a registered nurse and a staff nurse at Howard Emergency Department for 2 years. His shift is 7:30 p.m. to 8:00 a.m. On January 6, Nurse 4 arrived at work at 7:30 p.m. Nurse 3 was the team leader on the Blue Team. Nurse 4 took a patient to the Intensive Care Unit, and when he returned to the Emergency Department, another patient was assigned to him. Nurse 4 saw the patient in Hallway D, and Nurse 3 told him that the patient was brought in for ETOH. The stretcher was upright so the patient was sitting up. The patient's eyes were closed, and he was not talking. He was not actively vomiting and did not vomit at any point while they were caring for him.

Doctor 1 had asked the nurses more than once to clean up the patient in the hall so that she could examine him. Doctor 1 had looked at the patient, but had not examined him. Nurse 4 and Nurse 3 put the patient in Room 9. The patient was nonverbal. He had vomit on his shirt. It was noticeable and hard to miss. Nurse 4 did not smell alcohol. Before they moved the patient, he was breathing normally; then, the patient began snoring respirations, which concerned Nurse 4 because some people snore when they have head trauma. Nurse 4 pinched the patient and he evidenced posturing. 68 Nurse 4 could not believe it because he thought the patient was in the emergency department for ETOH. Nurse 4 pinched him again, and the patient postured again. Nurse 4 called out to Doctor 1 that the patient in Room 9 was posturing, and Nurse 4 and Doctor 1 moved the patient to the resuscitation room.

Nurse 4 felt the back of the patient's head and found a small amount of blood in his hair. Nurse 4 found a small laceration measuring 1 centimeter or less. Nurse 4 did not recall seeing any bruising anywhere on the patient's body. When asked if he saw or completed any portion of the triage form, Nurse 4 stated that he did not see the triage form before he started caring for the patient. Consequently, he did not know the patient's vital signs or what priority level he had been assigned. When shown the patient's triage form, indicating the Doe's low temperature, Nurse 4 stated that a patient with such a low temperature has to be warmed. In addition, an EKG should be performed. Nurse 4 stated that if he obtained that temperature reading, he would retake the temperature. If a patient has low body temperature, he should be placed in a room so that a rectal temperature can be obtained. If the patient still has a low temperature, the nurse has to start warming the patient. According to Nurse 4, intoxicated patients should be considered a priority Level II, unless they need assistance with respirations; otherwise, they can be a Level III. Even if FEMS personnel say that a patient is intoxicated, the nurse is required to shake the patient and make sure the patient is alert and awake. Even if patients are sleeping, the nurse is required to wake them.

The OIG team sought Nurse 4's assistance in reading the Howard Emergency Department medical record for the patient. OIG team members showed Nurse 4 several documents with handwriting that he identified as Doctor 1's, based on the signature. He tried to read the writing but could not.

Nurse 5 is an Assistant Clinical Manager of the Emergency Department. She has been a registered nurse since 1969 and a staff nurse at Howard for 13 years. According to Howard's guidelines, Nurse 5 functions as charge nurse if there is a need for back up or if there is inadequate staffing. Her shift is usually 3:30 p.m. to midnight. On January 6, Nurse 5 was charge nurse until 7:30 p.m., when Nurse 2 arrived and took over. Nurse 5 then took over as ambulance triage nurse. According to Nurse 5, EMTs bring a patient in, get them triaged, complete the 151 Run Sheet, and then take it to the triage nurse to be signed. Nurse 5 assessed an ETOH patient in the ambulance triage area who had a bandage on his head. He was sitting and talking on the end of a stretcher. She sent him to the waiting room. Between 10 and 10:15 p.m., Nurse 5 decided to take a break and told Nurse 1, If it's not that busy, cover ambulance triage. Nurse 5 ate and headed for her office to do some paperwork.

On her way to her office, Nurse 5 saw an EMT pushing a patient down the hall to Hallway D. The patient was sitting upright, but slumped with his head to the side. He had vomit on him. Nurse 5 returned to the ambulance triage area, where there were four to five ETOH patients waiting. A white male EMT (EMT 2) handed her a 151 Run Sheet. Nurse 5 stated that she did not read it because the EMT told her it was for the ETOH patient you just did. She took that to mean the man with the bandage on his head whom she had triaged earlier and sent to the waiting area. Nurse 5 stated that she signed and dated the 151 Run Sheet without reading it. The night was very busy. Nurse 5 was leaving at the end of her shift and saw Nurse 3 putting on a disposable hat and gown so she could clean the patient with vomit on him. Nurse 3 was preparing to take the man into a room, and Nurse 5 asked if she needed help. Nurse 3 said, No, because Nurse 4 was going to help her.



Nurse 5 was off on January 7 and 8. When she returned to work on January 9, she was told that she had signed a 151 Run Sheet for the Doe who turned out to be Mr. Rosenbaum. Nurse 5 stated that she initially said, No, I didn't. After being shown the 151 Run Sheet by a Howard official, she said, sure enough, I signed it.

The OIG team showed Nurse 5 the triage form for the Doe, and Nurse 5 stated she had never seen it. She stated that if a patient had that same low temperature, she would recheck the patient's temperature or take it rectally. Nurse 5 would let the doctor know about the low body temperature, and start warming the patient. According to Nurse 5, Emergency Department nurses do not have to wait for doctors to tell them to go to the next step in treating a patient. In addition, an ETOH patient is supposed to get a neuro check. After reviewing the triage form, Nurse 5 stated that she would have considered this patient a Level II who needed immediate intervention. She would not have considered him a Level III. A Level III designation, which Nurse 1 had assigned to the patient, allows patients to be seen within 2 hours or as soon as possible.

The OIG team showed Nurse 5 the 151 Run Sheet for the patient later identified as Mr. Rosenbaum. Nurse 5 said that if she had read it on January 6, she would have questioned it. She stated a GCS of less than 8 requires that EMTs call the hospital to advise them that they are bringing in this patient. Nurse 5 looked at Emergency Physician Record I, but could not read most of the writing. She could only read cc: and unable to obtain. Nurse 5 stated that Doctor 1's handwriting is terrible. Nurse 5 also stated that she has to ask Doctor 1 what she has written on a document and then must write it separately in her own handwriting so that she can read it.

Doctor 1 has been a medical doctor for 8 years. She has been an Assistant Clinical Professor at Howard since June 2002. In addition, Doctor 1 works full-time as an Emergency Department physician where she schedules the medical staff for their shifts. There are 27 Emergency Department full-time physicians, and some part-time physicians. An Emergency Department physician's start time determines to which team, Red or Blue, they are assigned. The arriving physician relieves one who is completing a shift. Doctor 1 believes she worked the 4 p.m. to 1 a.m. shift on January 6. Even though the shift ends at 1 a.m., they usually leave early, as soon as the 12 midnight person gets there, and they are all set. Doctor 1 remembered January 6 as a moderate night, with nursing staff probably short. There were only two nurses on the Blue Team. Doctor 1 remembers that Doctor 2 was working in the Emergency Department that evening and was assigned to the Red Team. Doctor 1 stated that a male Caucasian came in a yellow bag with vomit all over his face and his chest. The bag was an FEMS blanket. FEMS usually uses this bag to keep the person warm or if they have body fluids on them. Doctor 1 described the man as very disheveled, unkempt, his hygiene wasn't the best. He looked dirty. He looked like our typical alcoholic.

Doctor 1 asked the nurse why the patient in Hallway D was there, and the nurse told her ETOH. Doctor 1 performed a brief focused exam at around 11 p.m. that consisted of head to toe, heart, lungs, pupils. Doctor 1 did not find any hematoma, swelling, or injury to the patient's head after performing this head to toe examination. Doctor 1 stated that the patient's pupils were fine at that time; they were normal reaction. She listened to his lungs through his clothed chest. Doctor 1 stated that the patient smelled like alcohol.

When the OIG team asked Doctor 1 about the patient's clinical presentation (e.g., slumped, unresponsive, not talking), Doctor 1 stated, It doesn't tell me anything. It tells me he has been drinking. I saw an unresponsive person who didn't respond like a person who is drunk. She stated she did noxious stimuli. When asked to clarify what that means, she stated, I pinched his nipples and he grimaced. Doctor 1 stated that she told the nurses to put the patient in a room and undress him. She stated that while she was at the nursing station, she saw the patient posturing as the nurses were taking his clothes off. Doctor 1 knew right away that posturing was a bad sign. She stated that posturing is a sign of intracranial insult, and that, I have a patient like this every shift. I intubate them and they leave with vital signs.

The patient needed breathing assistance. Consequently, they took him to the resuscitation room so Doctor 1 could intubate him. Doctor 1 stated that if she did not intubate the patient right away, he would die. You want to decrease the pressure to the brain. It is her practice to move a patient to the resuscitation room because it is a larger room and better equipped for emergency care. When Doctor 1 intubated the patient, she noted that he had a hematoma. She then called for the trauma team.

Doctor 1 estimated that from the first time she saw him until the posturing in Room 9 was 15-20 minutes. She did a more complete exam and saw that his pupils now were unequal and sluggishly reactive. The patient's breathing was

shallow. When asked if he was pale, Doctor 1 stated, I am not a good judge of that. He looked like most Caucasians. Doctor 1 did not note any bleeding or any trauma to his body. She noted a small bump on the right side of his head; it was quarter sized and just slightly stuck out from his head.

When asked about the GCS, Doctor 1 said she never does it because it is a very complicated test and she does not have time to do all the calculations necessary. She stated, you have to write the numbers next to everything. Doctor 1 explained the GCS by stating that a result of 6-8 means that a person can move one side. Less than that means a person cannot move at all. With a result of 14, the person would wake up. She stated that she likes the AVPU test<sup>69</sup> better because it is more accurate.

Doctor 2 is a part-time Emergency Department physician at Howard who works a 10 a.m. to 10 p.m. shift, 3-5 times per month. Doctor 2 began working at Howard in October 2002. He also works at Providence Hospital part-time in the Emergency Department. In addition to working at the hospitals, Doctor 2 is employed as the Acting Medical Director for FEMS. As Acting Medical Director, he is responsible for creating and updating patient care protocols, reviewing 151 Run Sheets and other documentation, interacting with FEMS employees, and overseeing medical quality assurance and other patient care issues, including investigations of protocol violations.

On January 6, Doctor 2 was working at Howard Emergency Department on the Red Team. Doctor 2 stated that January 6 was busy but not any busier than any other night. Doctor 2 remembers Doctor 1, the physician for the Blue Team, saying she needed help with a patient. In response, after ensuring that his own patient in the resuscitation room was stable, Doctor 2 pulled his patient from the room. He then helped place Doctor 1's patient in the resuscitation room. Doctor 2 described the room as equivalent to an operating room in terms of size, equipment, and lighting. Doctor 2 assisted in rolling Doctor 1's patient on his side in order to place a long spine board underneath him. According to Doctor 2, the patient was fully dressed when he saw him. When asked if he saw any injuries to the patient, Doctor 2 stated that he noticed that the patient did not have much bruising. He saw only a quarter-sized bump on the back of the patient's head and only because of the floodlights that are located in the resuscitation room.

When Doctor 2 was asked if he leaves his shift early, he replied that he does not. This contradicts Doctor 1's assertion that all physicians leave their shifts early. Doctor 2 said he had several critical patients under his care and said he did not leave them until he was sure they were stable and their care has been fully assumed by the next person on duty. In addition, Doctor 2 had paperwork to complete.

Doctor 2 did not learn until after he assisted Doctor 1 that her patient had been transported to Howard by FEMS. Doctor 2 reviewed the 151 Run Sheet and noticed it had not been completed. He called the FEMS on-duty supervisor and advised that all FEMS personnel involved in the Gramercy Street call needed to write special reports right away. Doctor 2 ordered Ambulance 18 out of service. It is standard procedure to take a unit out of service for any matter in which a special report is needed. Doctor 2 did not participate in the FEMS investigation of the Gramercy Street incident because he had been in the Emergency Department at Howard on January 6, 2006, and had contact with the patient involved in the matter. Doctor 2's involvement was limited to requiring special reports from all FEMS personnel involved and placing Ambulance 18 out of service.

A D.C. Department of Health physician participated in the FEMS interview panel. Doctor 2 reviewed the 151 Run Sheet for the Gramercy Street patient. Doctor 2 believed that EMT 2's GCS assessment was not accurate. According to Doctor 2, localized movement (removing the oxygen mask), spontaneous eye opening, and verbal responses (moaning) should have resulted in a higher GCS score. Doctor 2 would have scored the patient at a 13. Doctor 2 stated that he does not rely on the EMTs' scoring on the GCS because they do it wrong.

## ISSUE AND FINDINGS

*Did Howard employees properly triage and assess Rosenbaum upon his arrival at the hospital?*

¶ **Critical patient assessments not performed. The triage nurse, Nurse 1, did not properly assess the patient presented to her.** She relied on the FEMS assessment of the patient's clinical signs and did not perform basic

assessments that could have indicated the serious nature of his injuries. For example, she did not do a pupil test, which is a basic test relied upon to indicate brain function and consciousness. In addition, she obtained a temperature reading which was critically low, yet did nothing to reassess the patient or communicate this abnormal finding other than to circle the temperature reading on the triage form.

¶ **Triage policy for intoxicated patient not followed.** Although Mr. Rosenbaum was incorrectly characterized as an intoxicated patient (ETOH), Nurse 1 did not follow the policy and algorithm for assessing a patient with alcohol intoxication in order to determine the level of care necessary. Nurse 1 incorrectly categorized the patient as Level III, despite abnormal vital signs. This categorization violated hospital policy on treating alcohol intoxication, which classifies such patients as Level II. Nursing staff that assumed care of the patient relied on the triage nurse to make a correct assessment of the patient in order to prioritize patient care management.

¶ **Triage form inaccurate.** Nurse 1's documentation inaccurately represented the patient's level of consciousness as awake and alert. As a result, care givers who received the form from her had misinformation about the patient's mental status.

¶ **Charge nurse failed to review triage form.** The Charge nurse, Nurse 2, did not review the triage form given to her by Nurse 1. Nurse 2 did not note the subnormal temperature, the patient's (incorrect) level of consciousness, and that the patient was designated as a Doe. Nurse 2 also did not note that Nurse 1 had designated the patient as a Priority III, in violation of hospital triage policy.

¶ **Triage form information not conveyed to staff.** Nurse 2 failed to convey information about the patient to Blue Team nurses. She incorrectly believed that Nurse 4, who was busy with a trauma patient, was the team leader rather than Nurse 3. Consequently, Blue Team nurses were not aware of the patient's abnormal vital signs and altered mental status and, as a result, did not immediately assess or care for the patient, or call for physician intervention.

¶ **151 Run Sheet signed without review.** The Assistant Clinical Manager, Nurse 5, failed to review the 151 Run Sheet, but signed the form as the person receiving patient. Nurse 5 apparently thought that this was the Run Sheet for another ETOH patient who was alert and talking. The 151 Run Sheet she signed, however, described a patient with a low GCS, abnormal vital signs, and repeated vomiting—all signs of a serious medical condition. As the Assistant Clinical Manager, she should have ensured that the patient whose run sheet she signed was appropriately prioritized and treated.

¶ **Standard of care not followed.** Howard Patient Care Standards, standard of Care: Care of the Patient with Alcohol Intoxication was not followed by any of the nurses in the Emergency Department. The standard includes directives to: assess and monitor airway and breathing, assess for evidence of trauma, notify MD of the patient's condition if unstable; obtain routine labs; monitor vital signs every 15 minutes until stable; perform neuro checks every 30 minutes until stable. None of these care standards was followed. Although alcohol intoxication was not a correct diagnosis or valid assessment of the patient's condition, it was the diagnosis that the nurses accepted. Therefore, that diagnosis should have dictated how they provided care.

¶ **Physician's poor handwriting impeded nurses' ability to read documentation.** Emergency Department staff complained consistently that Doctor 1's handwriting is extremely difficult to read. When the OIG team told her about this complaint, she stated that she can read her writing, and if someone has a question about what she has written, they could come and ask her. Doctor 1 said, "They work with me, they must can read it. People ask me to interpret if they can't read it." She stated that nurses follow order sheets, so they do not have to read the Emergency Physician Record.

The OIG team could not read Emergency Department documents written by Doctor 1 related to Mr. Rosenbaum's care and had to ask her to decipher the writing. For example, the Emergency Physician Record I, Chief Complaint, section is not legible. When shown the document, Doctor 1 read it for the interviewers, indicating that the text noted the patient's mental status and that his HPI<sup>70</sup> could not be obtained, he was uncommunicative, and he had vomit on his clothing.

¶ **Doctor 1's recollection of her actions not supported.** Ambulance 18's patient was signed in at Howard at 10:30 p.m. Doctor 1's interview statements indicated that she assessed the patient much earlier than documented in the

Emergency Department Record and reported by nursing personnel. For example, Doctor 1 stated that she initially examined the Doe in Hallway D at approximately 11 p.m. However, on the Emergency Physician Record I that she completed, Doctor 1 indicated that she saw the patient 45 minutes later. The OIG team showed this document to Doctor 1. She stated that despite the fact that she had written a different time in the TIME SEEN section of the form, she actually saw the patient at 11 p.m.

There is an additional discrepancy between Doctor 1's interview statements and Howard's written documentation. Doctor 1 stated that she saw the patient and ordered lab tests and IV fluids at 11 p.m. However, her written notations describe her examination and her orders for the patient occurring 50 minutes later. Nursing documentation indicates that they complied with the orders at 12 a.m. and thereafter. Doctor 1 stated to the OIG interviewers that she saw the patient at 11 p.m., and 15-20 minutes later, she noted posturing, intubated him, and called the trauma team. Medical documentation, however, indicates that vital signs, IV, and other interventions were not initiated until approximately 12:00 a.m. and that the patient was intubated after 12:00 a.m. The trauma team signed on to take over the patient's care at 12:15 a.m.

## **RECOMMENDATIONS**

¶ **That Howard develop a color coding or other system that will enable staff to readily identify the priority level of patients awaiting care in the Emergency Department hallways.** In Mr. Rosenbaum's case, there was no indicator on his stretcher or on his person to inform a passing care giver about his assigned priority level.

¶ **That Howard consider adopting a patient records system that would enable nursing and medical staff to review documents when they are at a patient's side.** The current system, which maintains Emergency Department documents in a chart rack far removed from patient locations, prevents staff from gaining information regarding a patient's status in a timely manner. For example, the nurses and the physician passed Mr. Rosenbaum in the hallway several times, but had no ready access to information regarding his altered mental status, subnormal temperature, or pre-hospital condition.

## **Office of the Chief Medical Examiner Response**

### **Autopsy of David E. Rosenbaum**

The OIG team interviewed the Deputy Chief Medical Examiner, who conducted the autopsy on Mr. Rosenbaum. The Deputy Chief Medical Examiner has worked at OCME since 2001. The Rosenbaum autopsy began on January 10, 2006, and concluded on January 13. The Deputy Chief Medical Examiner indicated that the autopsy produced some significant findings. The Deputy Chief Medical Examiner described how a pattern of injury to the brain indicates what happened to cause the injury. The Deputy Chief Medical Examiner stated that the patient's vomiting was an important sign that should have alerted medical personnel that there was a brain injury. The very low Glasgow Coma Scale was another indicator that there was a serious injury. The initial interview was not completed because some of the autopsy photographs, which had been taken with a 35 mm camera, had not been developed into slides.

The team viewed all of the slides except those of Mr. Rosenbaum's brain. Consequently, the OIG team arranged a return visit to OCME on March 27 to review the entire set of slides from the Rosenbaum autopsy. The team asked to view the complete set of slides in order to select some for duplication. The team wished to show photographs of Mr. Rosenbaum's injuries to the various health and emergency care providers who had contact with Mr. Rosenbaum to determine when his injuries first became noticeable. However, the Deputy Chief Medical Examiner stated that some slides were not immediately available because they had apparently been misfiled in another decedent's record. Later, the Deputy Chief Medical Examiner advised the OIG team that OCME technicians had not located the slides. The Deputy Chief Medical Examiner stated that she would look for the slides herself and advise the OIG team when they were located. To date, the slides have not been provided.

## **ISSUE AND FINDINGS**

***Did the OCME promptly and completely discharge its review of and report on Rosenbaum's death?***

The OCME conducted the autopsy expeditiously and issued a report soon thereafter. At the time of the OIG team's interview with the Deputy Chief Medical Examiner, OCME was not using digital photography, which would allow fast and easy electronic storage, retrieval, and duplication of autopsy photographs. The film-based technology being used prevented ready access to the entire set of autopsy photographs sought by the OIG team because of the need to send the film out for processing. In addition, duplicated prints and slides can be misfiled and difficult to locate, as happened in this case.

**RECOMMENDATION**

**¶That the OCME consider using digital camera technology to photograph all autopsies to improve the processing speed, accessibility, and retrieval of autopsy photographs.** The OIG team was unable to review requested autopsy photographs because of photo processing delays and mislaid slides.

**Conclusion**

The OIG team concludes that personnel from the Office of Unified Communications properly monitored the 911 call from Gramercy Street and immediately dispatched adequate resources to respond to the emergency. However, FEMS, MPD, and Howard personnel failed to respond to David E. Rosenbaum in accordance with established protocols. Individuals who played critical roles in providing these services failed to adhere to applicable policies, procedures, and other guidance from their respective employers. These failures included incomplete patient assessments, poor communication between emergency responders, and inadequate evaluation and documentation of the incident. The result, significant and unnecessary delays in identifying and treating Mr. Rosenbaum's injuries, hindered recognition that a crime had been committed.

On January 6, 2006, David E. Rosenbaum consumed alcohol, both before and during dinner prior to leaving home for a walk. Neighbors discovered Mr. Rosenbaum lying on the sidewalk in front of their home and called 911. Upon assessment, emergency responders concluded that Mr. Rosenbaum's symptoms, which included poor motor control, inability to speak or respond to questions, pinpoint pupils, bleeding from the head, vomiting, and a dangerously low Glasgow Coma Scale, were the result of intoxication.

Hospital laboratory and other tests, however, confirmed that Mr. Rosenbaum's symptoms were caused by a head injury. Emergency responders' approach to Mr. Rosenbaum's perceived intoxication resulted in minimal intervention by both medical and law enforcement personnel.

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 EMTs did not take the patient to the nearest hospital. Because of that decision, it took twice as long for Ambulance 18 to reach Howard than it would have taken to get to Sibley 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. MPD officers initially dispatched in response to the Gramercy Street call failed to secure the scene, collect evidence, interview all potential witnesses, canvass the neighborhood, conduct other preliminary investigative activities, or properly document the incident. Both FEMS and MPD failures were later compounded by similar procedural failures on the part of Howard Emergency Department personnel, who also initially believed Mr. Rosenbaum's condition to be the result of intoxication.

Upon Mr. Rosenbaum's arrival at Howard, Emergency Department personnel failed to properly assess his condition and failed to communicate critical medical information to each other, thereby delaying necessary medical

intervention, all in violation of Howard's own patient care standards. Further, a number of Emergency Department staff members passed Mr. Rosenbaum in the hallway and neglected to provide clinical and therapeutic care.

The Office of the Inspector General's review indicates a need for increased oversight and enhanced internal controls by FEMS, MPD, and Howard managers in the areas of training and certifications, performance management, oral and written communication, and employee knowledge of protocols, General Orders, and patient care standards. Multiple failures during a single evening by District agency and Howard employees to comply with applicable policies, procedures, and protocols suggest an impaired work ethic that must be addressed before it becomes pervasive. Attitudes of apathy, indifference, and complacency apparent even during some of our interviews with care givers 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.

Accordingly, while the scope of this review was limited, these multiple failures have generated concerns and perceptions about the systemic nature of problems related to the delivery of basic emergency medical services citywide. Such failures mandate immediate action by management to improve employee accountability. Specifically, we believe that several quality assurance measures may assist in reducing the risk of a recurrence of the many failures that occurred in the emergency responses to Mr. Rosenbaum: systematic compliance testing, comprehensive and timely performance evaluations, and meaningful administrative action in cases of employee misconduct or incompetence.

## Appendices

### Appendix 1 Interviewees Contradictory Statements

The OIG team noted multiple discrepancies in statements made by interviewees. Not only did some statements on the same subject differ from person to person, but also, in some instances, statements made to the OIG team differed from what interviewees told FEMS, MPD, and DOH reviewers.

**Smell of alcohol.** Neighbors 1 and 2 stated that they did not smell any alcohol on Mr. Rosenbaum. All of the firefighters claimed to have smelled alcohol. The MPD officers stated they did not get close enough to Mr. Rosenbaum to smell alcohol. EMT 2 stated that the patient's vomit did not smell like anything. EMT 1 stated that she did not get close enough to the patient to smell alcohol. EMT 1 also stated that when she cleaned Ambulance 18, she smelled neither vomit nor alcohol. The Howard Emergency Department triage (Nurse 1) stated that the patient's vomit smelled like alcohol. Emergency Department Nurse 4 stated that he did not smell alcohol. Howard physician Doctor 1 stated that she smelled alcohol.

**Patient vomiting.** Neighbors 1 and 2 stated that Mr. Rosenbaum started vomiting when the firefighter/EMTs administered oxygen. FF/EMT 1 stated that there was vomit on Mr. Rosenbaum when Engine 20 arrived. FF stated that Mr. Rosenbaum started vomiting after they arrived and treatment started.

**Patient bleeding.** When FF was interviewed by the FEMS Interview Panel on January 18, he did not mention any use of gauze in treating Mr. Rosenbaum. He initially told the OIG team that FF/EMT 2 or FF/EMT 1 used gauze on the back of Mr. Rosenbaum's head. FF then stated that his colleagues only used gauze pads to clean the vomit from the patient's face. FF/EMT 2 told the FEMS Interview Panel that he did not observe any injuries or bleeding on the scene. He told the OIG team, however, that he placed a 4x4 gauze pad on the patient's head, and applied pressure that stopped the minimal bleeding. All three MPD officers stated to the OIG team that they saw firefighter/EMTs holding a white bandage to the back of the patient's head. Officer 2 described seeing blood on the bandage.

**Patient's ability to sit up.** FF/EMTs 1 and 2 and FF told the FEMS Interview Panel that Rosenbaum could sit unassisted. However, they all told OIG team that the patient was propped up against FF/EMT 1's legs. FF/EMT 1 said they took turns holding him up in a sitting position.

**Patient's vital signs.** FF stated that FF/EMT 2 or FF/EMT 3 gave the female EMT (EMT 1) the patient's vital signs, which had been written on one of the firefighter's gloves. FF/EMT 2 stated that he wrote both his and FF/EMT 3's

vital signs readings on a piece of paper which he gave to FF/EMT 3. FF/EMT 3, however, stated that FF/EMT 2 wrote the vital sign readings on a glove. EMT 2 stated that he received an oral report of one vital signs reading from FF/EMT 3, but received no written report on vital signs from any of the first responders. EMT 1 stated none of the firefighters were wearing gloves, and no one gave her any medical information.

**Lower body assessment.** FF/EMT 2 stated that FF/EMT 1 performed an assessment of the patient's lower body. FF/EMT 1, however, denied doing any assessment of the patient. He stated that he concentrated on giving him the oxygen and that "was hard enough."

**Crime suspicions not mentioned to FEMS Interview Panel.** During his interview with the OIG team, FF/EMT 3 stated that he had expressed suspicions to his colleagues in the presence of a MPD officer that Rosenbaum, who had no wallet or ID, had been robbed. FF/EMT 3 told the OIG team that his colleagues agreed with him, and the MPD officer standing nearby just shrugged. Neither FF/EMT 3 nor the other firefighters gave this information to the FEMS Interview Panel.

**MPD officer activities.** Officer 3 gave the OIG team differing versions regarding her arrival at the Gramercy Street call: she first stated that Officers 2 and 1 arrived before she did. She later stated that she saw them arrive. Officers 1 and 2 stated that Officer 3 was at the scene when they arrived. According to the MPD General Order Field Reporting System, the first officer on the scene, regardless of assignment, must conduct the preliminary investigation. Officer 3 stated to the OIG team that she interviewed the male neighbor who called 911. Officer 1 stated to the OIG team that Officer 3 interviewed Neighbor 1. Officer 1's signed and sworn statement to the MPD Second District investigator regarding this incident, however, indicates that Officer 3 only talked to the Engine 20 personnel regarding the identification of the man down. Two of the Engine 20 personnel, FF and FF/EMT 3, agreed that Officer 3 stayed in her vehicle after she arrived. Neighbor 1 stated that he was interviewed by a male MPD officer, and he did not see or talk to a female MPD officer at the Gramercy Street scene.

**Physician's description of patient at variance with all other accounts.** All persons interviewed by the OIG team indicated that Mr. Rosenbaum was neatly dressed and looked like he belonged in the neighborhood. He was wearing a watch and jewelry. Doctor 1, however, described the patient as very disheveled, unkempt; his hygiene wasn't the best. He looked dirty. He looked like our typical alcoholic.

## Appendix 2

AMBULANCE 18 from PROVIDENCE HOSPITAL to GRAMERCY STREET Map not copied.

## Appendix 3

Not available online.

## Appendix 4

AMBULANCE 18 from GRAMERCY STREET to HOWARD HOSPITAL Map not copied

## Appendix 5

Not available online.

### Foot Notes:

1 FEMS and MPD also conducted inquiries into the actions of their responders to the Gramercy Street emergency. In addition, the District's Department of Health conducted a complaint investigation into Howard University Hospital's response.

2 The care and treatment provided to Mr. Rosenbaum at Howard University Hospital subsequent to the discovery of his head injury, and the MPD assault and robbery investigation that was opened on January 7, 2006, were not part of the Inspector General's review.

3 Emergency response by fire and ambulance personnel.

4 Heartbeat, breathing, and blood pressure.

5 The process of sorting out and classifying patients to determine the priority of needs and where a patient should be treated.

6 Medical Priority Dispatch System Software (ProQA).

7 Alpha and Bravo are non-critical medical calls. Alpha calls are handled by a Basic Life Support unit. Bravo calls are handled by a first responder and a Basic Life Support unit. Charlie and Delta are critical medical calls requiring first responder and Advanced Life Support response.

8 An engine company has a smaller truck with hoses. A truck company has the larger hook and ladder fire truck.

9 First responders who provide the most extensive pre-hospital care, and have advanced training that allows them to perform more complicated treatments, such as administering IV fluids and drugs, interpreting EKGs, and performing endotracheal intubations.

10 Ambulances have standardized equipment, layout, and capacities. A Basic Life Support ambulance is upgraded to an ALS ambulance when paramedics carry equipment on board that they have special training to use.

11 A first responder trained to provide basic emergency pre-hospital care and to transport patients by ambulance to a hospital. EMTs have the skills to assess patient condition and manage respiratory, cardiac, and trauma emergencies.

12 A face mask and bag device that delivers high concentrations of oxygen.

13 A device that delivers low concentrations of oxygen through prongs that rest in the nostrils.

14 Includes DANIEL LIMMER & MICHAEL F. O'KEEFE, EMERGENCY CARE, (2005).

15 EMT-Advanced skill.

16 EMT-Advanced skill.

17 EMT-Advanced skill.

18 Status levels are: alert, responds to verbal stimuli, responds to painful stimuli, and unresponsive.

19 Note Well is printed in a highlighted area marked with a bold triangle containing an exclamation point, meant to designate an issue of special importance.

20 Except for ambulance patients.

21 Problem-solving procedures.

22 Fainting.

23 A computer-generated, chronological log that documents the activities associated with 911 calls, based on the exchange of communication between the Office of Unified Communications and the fire, police, and emergency response units in the field.

24 These firefighters are referred to as firefighter/EMTs."

25 The actual time the call was received was 9:30 p.m.

26 Prior to interviewing FEMS personnel, the OIG team interviewed MPD officers who stated that they had seen the firefighter/EMTs using gauze on the back of the patient's head.

27 Ethyl Alcohol: the alcohol in wine, whiskey, and other spirituous beverages.

28 FF/EMT 2 is an EMT-Advanced.

29 A form of physical stimulus used to check for consciousness, performed by rubbing knuckles against the patient's sternum (the breast bone).

30 To examine by feeling and pressing with the palms and fingers of the hand.

31 A high-powered flashlight.



32 Extremely contracted.

33 See D.C. Adult Pre-Hospital State Medical Protocols, Skills Procedures, Oxygen Administration Chart at J16.1.

34 See DANIEL LIMMER & MICHAEL F. O'KEEFE, EMERGENCY CARE, 687-88 (2005).

35 A computerized, comprehensive chronology of all FEMS and MPD dispatch communication for a specific incident.

36 A union representative attended the OIG interviews with the MPD officers.

37 Later in the interview, Officer 3 contradicted this statement by stating that she saw the unit 2021 officers arrive.

38 PD Form 251 (Event Report) is to be used for documenting reported incidents or offenses.

39 EMT 1 attended the OIG interview accompanied by a union representative.

40 EMT 1 paused during the interview to ask the union representative what street Providence Hospital was on. The OIG team did not permit the representative to answer EMT 1.

41 Low priority.

[Footnotes 42 and 43 not in original report.]

44 Upon acknowledgement by an emergency responder that it has been dispatched to a call, Communications considers the unit to be en route. FEMS personnel are required to use the DEK to confirm their en route status.

45 According to the vehicle tracking system used by FEMS, the route taken by EMT 2 and EMT 1 was 12th Street to Rhode Island Avenue, Rhode Island Avenue to Florida Avenue, Florida Avenue to Connecticut Avenue, Connecticut Avenue to Fessenden Street, Fessenden Street to Huntington Street, and Huntington Street to Gramercy Street.

46 According to the vehicle tracking system used by FEMS, the route taken by EMT 2 and EMT 1 was Gramercy Street to 39th Street, 39th Street to Fessenden Street, Fessenden Street to Reno Road, Reno Road to Jenifer Street, Jenifer Street to Wisconsin Avenue, Wisconsin Avenue to Nebraska Avenue, Nebraska Avenue to Massachusetts Avenue, Massachusetts Avenue to Florida Avenue, Florida Avenue to Barry Street, and Barry Street to Georgia Avenue.

47 The official FEMS form used to document all aspects of an emergency medical call.

48 A scale that assesses the response to stimuli in patients with head injuries. The areas of assessment are eye-opening, motor response, and verbal response.

49 Unstable patients.

50 Per [www.mapquest.com](http://www.mapquest.com).

51 A simple assessment of whether a patient's blood is circulating well, which is done by pressing the patient's fingernail and counting the time it takes for normal color to return after release.

52 A procedure for measuring the concentration of oxygen in the blood.

53 According to the Communications CAD system, Ambulance 18 was closer to Sibley (2.84 miles), Georgetown (3.52 miles), and George Washington (4.62 miles) hospitals than to Howard (4.69 miles). Washington Hospital Center, which is also closer than Howard, was closed to ambulance patients. According to MapQuest, driving time from Gramercy Street to Sibley is 7 minutes, and to Howard, 15 minutes.

54 Of note, the OIG team's review of Ambulance 18's log entries revealed a derogatory comment regarding an intoxicated person. The same EMTs who responded to the Gramercy Street call on January 6, were also on duty the night a log entry was recorded in which another patient was described as drunk and stupid. (See Appendix 5)

[Footnotes 55-58 are missing in the original/]

59 This form is the beginning of the patient record in the Emergency Department, with a top section for the triage nurse to complete, detailing information such as the patient's name, sex, DOB, date, time in, level of care, allergies, medications, past medical history, vital signs, narrative assessment, means of arrival, and referral site.

60 Persons whose identities are not known.

61 Underarm area.

62 Body temperature can be taken by oral, axillary, or rectal means.

63 All other Howard Emergency Department interviewees denied that Mr. Rosenbaum was covered with a Howard blanket.

64 A measure of oxygen concentration in the blood.

65 Howard University Hospital triage policy designates alcohol intoxication as Level II, requiring that patients receive immediate intervention after triage.

66 Check of the pulses far away from the center of the body, motor function, and sensation.

67 Insertion of a tube to assist breathing.

68 Abnormal body position of two main types, both of which imply severe damage to the brain with a need for immediate medical attention.

69 Alert, Verbal response, Painful response, Unresponsive. A test used to classify a patient's level of consciousness or responsive mental status from most to least reactive.

70 History of Present Illness.