**THE DISTRICT OF COLUMBIA**

**BEFORE**

**THE OFFICE OF EMPLOYEE APPEALS**

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| In the Matter of: | ) | |
| | ) | OEA Matter No.: 1601-0133-12 |
| GEOFFREY DAVIS, | ) | |
| Employee | ) | |
| | ) | Date of Issuance: December 12, 2014 |
| v. | ) | |
| | ) | |
| D.C. FIRE & EMERGENCY MEDICAL SERVICES DEPARTMENT, | ) | |
| Agency | ) | |
| | ) | |
| | ) | Arien P. Cannon, Esq. |
| | ) | Administrative Judge |

Geoffrey Davis, Employee, *Pro se*
Kevin Turner, Esq., Agency Representative

## INITIAL DECISION

### INTRODUCTION AND PROCEDURAL BACKGROUND

Geoffrey Davis ("Employee") filed a Petition for Appeal with the Office of Employee Appeals ("OEA" or "Office") on July 3, 2012, challenging the D.C. Fire & Emergency Medical Services Department's ("Agency") decision to suspend him for two hundred and four (204) duty hours based on four (4) separate charges. Agency filed its Answer on August 6, 2012. Employee's position of record is a Paramedic/Firefighter. This matter was reassigned to me in April of 2014.

A Prehearing Conference was held on July 8, 2014. Subsequently, a Post Prehearing Order was issued on July 11, 2013, requiring the parties to submit legal briefs addressing the issues in this matter. After Agency was granted an extension of time to file its brief, both parties submitted their briefs accordingly. Because this matter is being reviewed under the analysis set forth in *Pinkard v. D.C. Metropolitan Police Department*[1], an Evidentiary Hearing was not convened. The record is now closed.

[1] 801 A.2d 86 (D.C. 2002).

## JURISDICTION

This Office has jurisdiction in this matter pursuant to D.C. Official Code § 1-606.03 (2001).

## ISSUES

1. Whether the Fire Trial Board's decision was supported by substantial evidence;

2. Whether there was harmful procedural error; or

3. Whether Agency's action was done in accordance with applicable laws or regulations.

## UNDISPUTED FACTS

On November 17, 2011, Employee responded to a call in his capacity as a Firefighter/Paramedic on Paramedic Engine Company 11. Upon arrival, units found an elderly female lying on the ground, conscious and alert. Employee, along with Emergency Medical Technicians ("EMT") Mark Luckett and Matthew Kueppers, helped the patient onto a stretcher and into the ambulance, where her vital signs were taken. The patient was transported to Howard University Hospital where she later died. Whether the proper procedures were followed by Employee in his role as a paramedic throughout this ordeal is at issue.

The following charges were levied against employee:

Charge 1: Violation of D.C. Fire and EMS Order Book, Article VII, Section 2 which states, "Any on-duty or employment-related act or omission that interferes with the efficiency and integrity of government operations." This misconduct is further defined in D.C. Fire and EMS Rules and Regulations, Article VI, Section 2, which states, "Members shall devote proper attention to the service, exert their greatest energy and full ability in the performance of their duties, not perform their duties in a spiritless, lax, surely, or careless manner, not neglect nor fail to perform any portion of their duties required by rule, regulation, order, common practice or the necessities of the situation involved;…be efficient; exercise proper judgment in the performance of their duties." This misconduct is defined as cause to wit: "Neglect of Duty," in 6B D.C.M.R. § 1603.3 (f)(3), 55 DCR 1775 (February 22, 2008).

Specification 1: On the morning of November 17, 2011 at 09:23:24 a 911 call was received for an elderly female at the intersection of 15th and U Streets, N.W. (Incident No. 110154996). The matter was dispatched as a Priority 1. You were the Paramedic assigned to Engine 11 and at 09:27:45, the first provider to arrive on the scene. The EMT's from Ambulance 9 arrived at 09:28:44. The EMT's took the patient's vitals

and determined that the heart rate was 116 beats per minute (BPM). According to the ePCR, completed by EMT Kueppers, the patient complained of abdominal pain. While you performed glucose monitoring, you did not conduct a complete patient assessment. The D.C. Fire & EMS Department's Pre-Hospital Treatment Protocols (PHT Protocols) note that the presence of abdominal pain in females and the elderly can be indicative of a myocardial infraction. Therefore, a 12 Lead EKG should have been performed on this patient. Your failure to provide care as set forth in the PHC Protocols is a neglect of your duties as a Paramedic.

Charge 2: Violation of D.C. Fire and EMS Order Book, Article VII, Section 2 which states, "Any on-duty or employment-related act or omission that interferes with the efficiency and integrity of government operations." This misconduct is further defined in the D.C. Fire and EMS Special Order No. 7, Series 2010 (March 12, 2010), which states in relevant part, "Each unit dispatched on a medical incident will be required to execute an Electronic Patient Care Report (ePCR). This misconduct is defined as cause, to wit: "Neglect of Duty" in 6B DCMR § 1603.3(f)(3), 55 DCR 1775 (February 22, 2008).

Specification 1: Based upon the investigation into the facts surrounding Incident No. 110154996 and review of documents submitted following the incident, you failed to execute an ePCR in violation of Special Order No. 7, Series 2010 (March 12, 2010).

Charge 3: Violation of D.C. Fire and EMS Order Book, Article VII, Section 2 which states, "Any on-duty or employment-related act or omission that interferes with the efficiency and integrity of government operations." This misconduct is further defined in D.C. Fire and EMS Rules and Regulations, Article VI, Section 2, which states, "Members shall devote proper attention to the service, exert their greatest energy and full ability in the performance of their duties, not perform their duties in a spirtitless, lax, surely, or careless manner, not neglect nor fail to perform any portion of their duties required by rule, regulation, order, common practice or the necessities of the situation involved;…be efficient; exercise proper judgment in the performance of their duties." This misconduct is defined as cause to wit: "Neglect of Duty," in 6B D.C.M.R. § 1603.3 (f)(3), 55 DCR 1775 (February 22, 2008).

Specification 1: Incident No. 110154996 was dispatched as a Priority 1 matter. According to the PHT Protocols, after completing an assessment, the Advanced Life Support (ALS) or Basic Life Support (BLS) provider must assign a treatment priority. The ePCR filed by EMT Kueppers lists the patients as a Priority 2, which would have

required you to remain with the patient during her transport to the hospital. You, however, cleared the patient from further ALS treatment and directed Ambulance 9 to transport the patient to the medical facility without you. You neglected your duty as Paramedic when you downgraded the level of care from ALS to BLS in violation of PHC Protocols.

Charge 4: Violation of Article VII, Section 2 of the D.C. Fire & EMS Order Book which states, "Any on-duty or employment related act or omission that interferes with the efficiency or integrity of government operations." This misconduct is further defined in D.C. Fire and EMS' Order Book, Article XXIV, Section 2(4), which states in part, "The EMS Provider with the highest certification will be designated the ACIC and the other members as ACA. When both personnel have equal certification, the member possessing the greatest seniority at that certification level shall be designated the ACIC." This misconduct is defined as cause to wit: "Neglect of Duty" in 6B D.C.M.R. § 1603.3(f)(3), 55 DCR 1775 (February 22, 2008).

Specification 1: In accordance with the D.C. Fire & EMS Order Book, you were the ACIC of Incident No. 110154996. As the member with the highest level of certification you were required to remain with this Priority 1/Priority 2 patient and render the necessary care during her transport to the medical care facility. Your decision to abandon your duties as the ALS provider and to leave the patient in the care of the BLS providers is a violation of PHT Protocols and is a neglect of your duties as ACIC.

Employee was found "guilty" on all four (4) charges. The penalty imposed against Employee was as follows: Charge 1: one hundred and thirty two (132) duty-hour suspension; Charge 2: twenty-four (24) duty-hour suspension; Charge 3: twenty-four (24) duty-hour suspension; Charge 4: twenty-four (24) duty-hour suspension. In total, Employee was suspended for two-hundred-four (204) duty hours.

## SUMMARY OF TESTIMONY

On April 4, 2012, Agency held a Trial Board Disciplinary Hearing.[2] The following represents a summary of the relevant testimony given during the hearing as provided in the transcript (hereinafter denoted as "Tr.") which was generated following the conclusion of Employee's proceeding. Both Agency and Employee presented documentary and testimonial evidence during the course of the hearing to support their position.

[2] It is noted that the transcript filed with Agency's Answer (Tab 3) on August 6, 2012, reads that the Trial Board Hearing was held on April 4, 2011. However, because it would be impossible to hold the Trial Board prior to the incident on November 17, 2011, the undersigned is able to discern that the actual date of the Trial Board was April 4, 2012, not 2011.

Agency's Case in Chief

***Dr. David Miramontes ("Dr. Miramontes")*** *Tr. 29-75.*

Dr. Miramontes testified, in relevant part, that: he is the Assistant Chief of Fire and EMS and the EMS Medical Director with Agency. At the time of the Fire Trial Board Hearing, Dr. Miramontes had been with Agency for 8 months. Dr. Miramontes has a background in Fire and EMS that began in high school. He became a certified EMT in high school and is also a certified firefighter and a Hazmat Operations tech. Dr. Miramontes has incident response command team training and periodically does such work for the federal government. Dr. Miramontes has an Associate's Degree in registered nursing and also a degree in human physiology. Dr. Miramontes received his medical degree from the Medical College of Ohio for his physician's license. He is also an emergency medicine and disaster medicine specialist.

In his capacity with Agency, Dr. Miramontes supervises quality care for the EMS side of Agency, which he described as being very complex to ensure quality of care is provided in the District by EMS. The quality of care unit is designated as a peer review body. Dr. Moramontes testified that to his knowledge, Employee has had contact with the quality control unit five times. Dr. Miramontes described the circumstances under which Employee had contact with the quality control unit, which include: (1) problems with electronic patient record keeping during his probationary period; (2) an issue with downgrading patients from Advanced Life Support (ALS) to Basic Life Support (BLS); and (3) documentation issues.

Although Dr. Miramontes discussed the general accusations in which Employee had contact with the quality control board, he stated that he was unable to go into the specifics of each instances as it was prohibited by the peer review statute. He did state that one of the previous incidents was very similar to the facts of the instant case. Dr. Miramontes further stated that the primary purpose for quality assurance is to recognize, remediate, and analyze an individual's performance so that they may continue to improve.

Dr. Miramontes testified that Agency issues protocols for general patient management which guide the medics and EMTs in the field. In the field, "medics must decide the care that's provided based on reasonable training, protocols, additional training, [and] experience…they have to do an appropriate history, physical and utilize diagnostic equipment to make decisions."[3] He also stated that medics "have to take a patient care encounter in perspective of the totality of the situation."[4] When asked about whether there was anything in Agency's protocols that state that a 12 Lead EKG must be performed, Dr. Miramontes responded that "a paramedic with similar training in similar circumstances should have done a 12 Lead EKG for an 88-year-old female patient who had abdominal pain and tachycardia."[5] He further stated that "in the context of protocol, the paramedic has to use training, judgment and experience to decide as needed."[6]

[3] Tr. at 43.
[4] Tr. at 51
[5] Tr. at 54.
[6] Tr. at 70.

Dr. Miramontes acknowledged that in the General Patient Management Protocols, paragraph 8, contains the language "as needed," "which leads the paramedic to make a decision whether it is appropriate or not appropriate to do that," meaning whether or not the paramedic should perform additional skills to assist with a patient's assessment.[7] There is no mandatory language in paragraph 8 of the General Patient Management Protocols.

***Henry L. Small ("Chief Small")*** Tr. 75-152

Chief Small testified, in relevant part, that: he has been with Agency over twenty-five (25) years and has held the position of EMS Battalion Chief for nearly three (3) years. Chief Small was asked by the fire chief to assist the deputy on his shift in preparing a report and endorsing the special report submitted by members involved in this incident related to the instant case.

Chief Small described the difference between a BLS unit and an ALS unit: a BLS unit is staffed by two nationally-register EMTs, which is the lowest level of emergency medical technician; whereas, the ALS is staffed by an intermediate paramedic or a paramedic. The ALS unit has a LIFEPAK, certain drugs, and other equipment that can be used in assessing and treating patients.

Chief Small also described the ePCR, or electronic patient care report, as a tool that Agency uses to document all medical runs, identify what the medics find, and the outcome of the run. A copy of the report is printed and left with the hospitals and then electronically transmitted to the system. In writing his endorsement, Chief Small reviewed the special reports associated with the instant case, and noted that the patient was elderly and was found lying on the ground. His review also revealed that a basic assessment was done in the rear of the ambulance, which included vital signs and a blood glucose reading. There was no indication that an attempt was made to monitor the patient's cardiac status. The patient's pulse ox read 96 and she was on a non-breather mask, which delivers one-hundred percent oxygen. The pulse ox should read one hundred if there is no precipitating event occurring. A pulse ox is a machine that gauges the saturation of blood level. Generally, an adult should read between 94 and 100 if there is no precipitating event going on.

Based on the patient's ox read of 96, Chief Small stated that "maybe a more thorough assessment should have been done…to make sure there was no cardiac event occurring."[8] Chief Small was able to discern that there was no cardiac monitoring because the LIFEPAK 12 on board Engine 11 was checked and it was noted that there was no record of the equipment being used on the particular incident surrounding this case. In Chief Small's opinion, based on the totality of the circumstances, Employee should have conducted cardiac monitoring. Based on his review, Chief Small also believed that Employee did not follow the protocols based on the patient's present condition.

[7] Tr. at 70. *See* Agency's Exhibit 1, Bates number 29.
[8] Tr. at 84.

Chief Small described the priority levels in which calls are dispatched: Echo is the highest level, which generally means that someone is in cardiac arrest; Delta means there is a life-threatening emergency (i.e. shooting or heart attack); and Charlie means there is a grey area. The instant matter was dispatched as a Charlie level priority, which requires ALS intervention. Sometimes when dispatchers are unsure whether to make the call a Delta or not, they will dispatch the call as a Charlie and send an ALS unit to cover themselves. PEC 11, the unit Employee was on, was dispatched on the call in the instant case. Employee is trained as an ALS provider. Chief Small noted that there was no record of Employee preparing an ePCR with the call in this matter, despite him being required to prepare one. Although EMT Kueppers prepared an ePCR, that did not eliminate the need for Employee to complete an ePCR.[9] Every unit that responds to the scene is required to do an ePCR.

A Priority 2 (second highest priority) call is a call that meets certain standards and it specifically states that there is a possibility that the patient may deteriorate. A Priority 1 call means that the patient's conditions are life-threatening. A Priority 2 call could also mean that there is an indication that the patient could easily go into a life threatening condition. A Priority 2 call would allow an ambulance to use its lights and sirens when transporting a patient, something a Priority 3 call would not. The instant case was a Priority 2 transport to the hospital by the ambulance. Employee did not accompany the patient to the hospital although he held the highest level of certification among the responding members. Chief Small opined that Employee should have applied the LIFEPAK to the patient to rule out any type of cardiac event. Being the member with the highest level of certification, Employee would have been the one to make the final decision whether or not he would transport the patient to the hospital. Once Employee decided he was not going to accompany the patient to the hospital, he should have let his officer know, complete a report, and then go back into service. Although no report was done by Employee, the special report submitted by the lieutenant indicated that Employee told him that he was not going to go the hospital to transport the patient.

On cross-examination Chief Small further testified regarding the general patient management protocols in place to provide guidance to medics and the EMTs. The protocols are guidelines that should allow paramedics to work in the framework and to look at a patient and determine whether or not they are to be applied. Chief Small also stated that these guidelines are to be utilized as needed. In addition to obtaining the patients vital signs in this case, blood glucose monitoring and pulse oximetry were also used.

Chief Small gave testimony that he sensed that EMT Luckett had some reservations about transporting the patient to the hospital without Employee accompanying them. Chief Small believed that Employee's decision not to accompany Ambulance 9 to the hospital was improper because he (Chief Small) sensed that EMT Luckett's statement, "are you sure?," should have lead Employee to believe that there was reservation on A-9's decision to transport the patient without Employee. Based on Chief Small's 20 years of experience, he believed that Employee should have used the LIFEPAK and 12 Lead EKG.

[9] *See* Agency's Exhibit 1, Bates number 35-36.

Outside of what the members of Ambulance 9 put in their special report that Employee took the patient's glucose levels, it is unknown exactly what Employee did at the scene. Based on the patient's age, pulse rate, and blood pressure, Chief Small stated that the patient was hypertensive, and that ruling out a cardiac event should have been done.

Chief Small did not personally interview any members involved in this incident, so his endorsement was based on the special reports and the audio transmission that was made by the Office of Unified Communications to the ELO (Emergency Liason Officer).

***EMT Mark Luckett ("Luckett )*** Tr. *152*-198

Luckett is a Firefighter/EMT with Agency. Luckett prepared a special report regarding the incident that occurred on November 17, 2011, involving the instant case.[10] Luckett drove the ambulance to Howard University Hospital as a Priority 2. Luckett believes that it depends on the situation for who determines the priority level of a transport to the hospital. Luckett has transported numerous Priority 2 calls without a paramedic, but never a Priority 1 call without a paramedic. He is unsure of the protocols for whether a medic should be present when transporting a Priority 2 call.

Luckett stated that he would not have transported that patient if he had felt uncomfortable without a paramedic. Luckett further testified that he has told paramedics before that he would not transport a patient without an accompanying paramedic, but did not make that request in this case.

Based on his knowledge and experience, Luckett did not believe the patient was experiencing cardiac arrest during her time in the ambulance based on his observations.

Employee's Case in Chief

***Chief Robert Mullikin ("Chief Mullikin")*** Tr.200-221

Chief Mullikin had been with Agency for twenty-six (26) years at the time of the Fire Trial Board. Roughly two weeks after the incident giving rise to this matter, Chief Mullikin received a request to do an investigation of the incident through his deputy fire chief. During his investigation, Chief Mullikin spoke with Captain Scelzo and Chief Small primarily because of their medical backgrounds.

Chief Mullikin recommended that Employee receive corrective action for the incident. Corrective action includes a suspension of 72-hours or less.

***Firefighter Paul Brooke ("Firefighter Brooke")*** Tr. 221-236

[10] Agencys's Answer, Tab 2, Bates Number 42 (November 6, 2012).

At the time of the Fire Trial Board, Firefighter Brook had been with Agency for eight (8) years, and the last three (3) years with Engine 11. Firefighter Brooke served as a character witness for Employee.

***Lieutenant Jerry Wilhelm ("Lt. Wilhelm")*** Tr. 236-244

At the time of the Fire Trial Board, Lt. Wilhelm had been with the Agency for approximately twenty (20) years and with Engine 11 for a little over five (5) years. Lt. Wilhelm served as a character witness for Employee.

***Firefighter Geoffrey Davis ("Employee")*** Tr.244-360

At the time of the Fire Trial Board, Employee had been with Agency nearly five and a-half years. Prior to working with Agency, Employee worked with the City of Fairfax Fire Department for two years. Employee is registered on a national level and in Virginia as an EMT intermediate, which by hierarchy, is between an EMT basic and paramedic.

Upon arriving on the scene, Employee was able to get very little information out of the patient other than her stating that she "did not feel well." The patient repeatedly stated she did not feel well once the ambulances arrived on scene and throughout her interaction with the members involved. Employee further described his interaction with the patient and his observations that she was alert and conscious but "did not feel well." After making an initial assessment of the patient, Employee continued to question the patient but was not getting any information from her. After ruling out any trauma, Employee, Firefighter Davis from Engine 11, Firefighter Kueppers, and Firefighter Luckett helped the patient to the cot and into the back of the ambulance. As Luckett and Kueppers continued to take the patient's vitals, Employee continued to try and ascertain what was wrong with the patient. Employee testified that he did not feel that the patient was incapable of answering his questions, but rather she was not giving direct answers to his questions.

Employee testified in regards to the vital signs taken on the scene from patient which were as follows: Bloods sugar: 82, which Employee states is completely normal, even with an 88-year-old-female; Blood pressure: 138/72, which Employee stated was above normal and known as pre-hypertensive. Employee stated that a blood pressure reading of 138/72 in his setting is nothing that he would be concerned about;[11] Pulse: 116, which Employee said was a little high given that 100 is the typical limit for a normal pulse. The patient's pulse gave Employee a little concern, but given the situation, he did not believe it was alarming enough to perform any further actions. Employee further stated that there are a number of reasons for an elevation in heart rate to 116, such as stress, being annoyed, or being nervous.

Employee explained his reasons for not conducting further monitoring as set forth in the charges against him. Employee's impression was that the patient was not interested in participating in an assessment, but rather wanted to go to the hospital as expressed multiple times throughout their interaction. Employee was aware of his close proximity to Howard University

[11] *See* Tr. at 256.

Hospital and believed that the patient may have been more apt to speak with someone at the hospital where they were better equipped for more thorough diagnostics. Employee had no concerns or beliefs that the patient was experiencing a cardiac event. If Employee had any belief that the patient was experiencing a cardiac event, Employee stated that he "would have absolutely attempted to do a 3 or 12 Lead EKG."[12]

Based on Employee's understanding of protocols, paramedics have the discretion to downgrade from operating under ALS procedures to BLS procedures. Paramedics also have the discretion to administer diagnostics such as a 12 Lead EKG. Employee made the decision to downgrade to BLS and not accompany Ambulance 9 to the hospital based on his general impressions of the patient: how she looked, how she appeared to be alert and oriented, and the vitals obtained throughout the encounter. Employee also took into consideration the proximity to the hospital and the fact that he (Employee) did not believe it was doing the patient any good to continue assessing her on the scene when the hospital was close by.

Employee also testified regarding his interaction with Firefighter Luckett about downgrading the patient from ALS to BLS. When Employee states, as he often does, "are you guys good" or "you guys are good," it's generally because he has made the determination that he is comfortable having the patient transported with a BLS unit. The protocols for transferring a patient require that the BLS unit be comfortable with the patient's conditions.[13] If a BLS unit has any concerns about transporting a patient, they typically express that they are not comfortable or ask follow-up questions. If Firefighter Luckett or Kueppers asked Employee to ride with them in the ambulance, the Employee absolutely would have accompanied that patient to the hospital.

When asked about why he did not complete an ePCR, Employee was unable to provide a reason for failing to do so, other than his unit was in the middle of a string of five or six runs, and it was an oversight on his part.

While there was testimony from Dr. Miramontes that Employee had approximately five or six dealings with the Medical Director's office, Employee stated that there were actually only two incidents, including the instant matter.

Employee acknowledged that abdominal pain could be indicative of a heart attack. Employee further acknowledged that pursuant to special orders, an ePCR report should be completed after every patient contact.

Employee explained the difference between a cardiac arrest and a heart attack: a cardiac arrest is when the heart stops pumping, whereas a heart attack is when the muscle tissue of the heart is not receiving the proper oxygen due to a blockage.[14]

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[12] Tr. at 262.
[13] Tr. at 265. *See* Bates Number 33, Roman Numeral II.
[14] Tr. at 306.

Employee does not recollect the patient ever mentioning that she had abdominal pain or that he heard the other EMTs mention abdominal pain. Luckett and Kueppers both mention hearing the patient complain about abdominal pain in their special reports.

Employee did not make the decision to make the transport Priority 2 rather it was the other two EMTs that made this decision.

Employee estimated that they were on the scene no more than five minutes before the patient was transported to the hospital.

## FINDINGS OF FACT, ANALYSIS, AND CONCLUSIONS OF LAW

Pursuant to the *Pinkard* [15] analysis, an Administrative Judge of this Office may not conduct a *de novo* hearing in an appeal before him/her, but must rather base his/her decision solely on the record below at the Fire Trial Board ("FTB") Hearing, when all of the following conditions are met:

1. The appellant (Employee) is an employee of the Metropolitan Police Department or the D.C. Fire & Emergency Medical Services Department;

2. The employee has been subjected to an adverse action;

3. The employee is a member of a bargaining unit covered by a Collective Bargaining Agreement;

4. The Collective Bargaining Agreement contains language essentially the same as that found in *Pinkard*, i.e.: "[An] employee may appeal his adverse action to the Office of Employee Appeals. In cases where a Departmental hearing [i.e., Trial Board Hearing] has been held, any further appeal shall be based solely on the record established in the Departmental hearing"; and

5. At the agency level, Employee appeared before an Adverse Action Panel that conducted an evidentiary hearing, made findings of fact and conclusions of law, and recommended a course of action to the deciding official that resulted in an adverse action being taken against Employee.[16]

Based on the documents of record and the position of the parties as stated during the Prehearing Conference, I find that the aforementioned criterion is met in the instant matter. Therefore, my review is limited to the issues as set forth in the "Issues" section of this Initial Decision. Further, according to *Pinkard*, I must generally defer to the [Trial Board's] credibility determinations when making my decision.[17]

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[15] *Metropolitan Police Department v. Pinkard*, 801 A.2d 86 (D.C. 2002).
[16] *See Id.*
[17] *Id.*

**Whether the Trial Board's decision was supported by substantial evidence.**

Substantial evidence is defined as evidence that a reasonable mind could accept as adequate to support a conclusion.[18] If the [Trial Board's] findings are supported by substantial evidence, I must accept them even if there is substantial evidence in the record to support contrary findings. *See Metropolitan Police Department v. Baker*, 564 A.2d 1155 (D.C. 1989).

*Charge 1*

Charge one is based on a "neglect of duty" charge for Employee's failure to perform a 12 Lead EKG in an elderly patient who indicated she was experiencing abdominal pain. Agency asserts that Employee's failure to provide care as set forth in the PHC Protocols amounts to Employee neglecting his duty. Dr. Miramontes testified that in the field, "medics must decide the [level of] care that's provided based on reasonable training, protocols, additional training, [and] experience…they have to do an appropriate history, physical and utilize diagnostic equipment to make decisions."[19] Dr. Miramontes further stated that medics "have to take a patient care encounter in perspective of the totality of the situation. [20] Dr. Miramontes opined that a paramedic with similar training as Employee should have performed a 12 Lead EKG on an 88-year old female patient who had abdominal pain and tachycardia. The patient's vital signs taken on the scene revealed that her heart rate was 116 beats per minute (BPM), which Employee described as "a little high" given that the typical limit for a normal pulse would be 100.[21] Employee acknowledged that the patient's pulse gave him a little concern, but was not alarming enough to perform further actions. Although Employee provided viable reasons for a patient to have an elevated pulse, I find that there is substantial evidence in the record to support Agency's finding that a 12 Lead EKG (cardiac monitor) should have been administered to the 88- year old female patient who complained of abdominal pain and had pulse of 116 BPM.

Furthermore, based on the patient's ox read of 96, Chief Small believed that "maybe a more thorough assessment should have been done…to make sure there was no cardiac event occurring."[22] While Employee acknowledged that abdominal pain could be indicative of a heart attack, he stated that he did not recall the patient ever mentioning that she had abdominal pain or the other EMTs mention abdominal pain. EMTs Luckett and Kueppers both indicated in their special reports that they heard the patient mention that she was experiencing abdominal pain.[23] It

[18] *Black's Law Dictionary*, Eighth Edition; *Mills v. District of Columbia Department of Employment Services*, 838 A.2d 325 (D.C. 2003); and *Black v. District of Columbia Department of Employment Services*, 801 A.2d 983 (D.C. 2002).
[19] Tr. at 43.
[20] Tr. at 51
[21] Tr. at 257.
[22] Tr. at 84.
[23] See Agency's Exhibit 1 (Tab 2), Bates Numbers 42 and 46.

is also undisputed that the patient's pulse was 116 BPM (above the normal limits for an adult patient). Accordingly, I find that there is substantial evidence in the record to support Agency's "guilty" finding for charge 1; specifically, for Employee failing to perform his duties as required by the necessities of the situation involved.

*Charge 2*

Charge two is based on a "neglect of duty" charge for Employee's failure to execute an ePCR (Electronic Patient Care Report) as required by Special Order No. 7, Series 2010 (March 12, 2010). It is undisputed that Employee did not complete an ePCR. Based on Employee's own admission, he did not execute an ePCR. While it is commendable that Employee took responsibility by acknowledging that he did not complete an ePCR, I must find that there is substantial evidence in the record to support Agency's "guilty" finding for Charge 2.

*Charge 3*

Charge 3 is also based on a "neglect of duty" charge for Employee's failure to remain with the patient during transport to the hospital, despite the patient being listed as a Priority 2 transport. This charge also stems from Employee's decision to downgrade the patient's level of care from ALS to BLS.

Agency's contention that Employee was required to remain with the patient during her transport to the hospital is addressed in EMT Mark Luckett's testimony. Luckett testified that he has transported numerous Priority 2 calls without a paramedic, but never a Priority 1 call without a paramedic. Although Luckett was unsure of the protocols for whether a paramedic should be present when transporting a Priority 2 call, Agency did not cite to any rule or regulation in its brief, or throughout the Trial Board, that required a paramedic to be present when a Priority 2 patient is being transported. EMT Luckett's testimony only supports Employee's position that it is common practice that EMTs transport a Priority 2 call without a paramedic.

Agency further asserts that Employee neglected his duty when he downgraded the patient's level of care from ALS to BLS. The only evidence in the record that addresses the transfer of the level of care from ALS to BLS is in Agency's Exhibit 1, page 23.[24] This documentary evidence is from Agency's General Patient Management Protocols, which enumerates seven (7) bullet points for when an ALS provider may transfer care to a BLS provider.[25] All seven points require the provider to use his or her discretion in making a professional judgment call when downgrading a patient to BLS care. While Agency argues that "[b]oth BLS providers indicated that they questioned Employee about his decision to downgrade the patient's status," there is nothing in the record to support that the BLS providers were uncomfortable with transporting the patient under her conditions. EMT Luckett testified that he would not have transported that patient if he had felt uncomfortable without a paramedic. Luckett further testified that he has told paramedics that he would not transport a patient without an accompanying paramedic, but did not make such a request in this case. Although EMT

[24] *See* Agency's Response to Petition for Appeal, (Tab 2/Exhibit 1 at p. 23), Bates Number 33.
[25] It is noted that the entire General Patient Management Protocols is not a part of the record. Presumably, only the pertinent parts of the protocols were included in the record.

Luckett may have asked Employee if he was "sure" about not accompanying them on their transport to the hospital, there is no indication that the EMTs on the scene were uncomfortable transporting the patient without Employee, or another paramedic, being present. Accordingly, I find that there is not substantial evidence in the record to support a "guilty" finding for charge 3, "neglect of duty."

*Charge 4*

Charge 4 for "neglect of duty" is similar to Charge 3, to wit Agency asserts that Employee failed to "remain with the Priority 1/Priority 2 patient and render the necessary care during her transport to the medical care facility." The direct examination of Chief Small addresses Charge 4. The direct examination testimony provides, in pertinent part, the following:

> Q: Okay. Did you learn whether or not Firefighter Davis accompanied the patient to the hospital?
>
> A: No, he did not.
>
> Q: And in your view, was that a violation of the Department's protocols?
>
> A: In my opinion, Paramedic Davis should have applied the LIFEPAK to the patient to rule out any type of cardiac event. And with her heart rate being elevated to that point, he should have at least transported her to the hospital.
>
> Q: On this particular call, who was the staff person with the highest level of certification?
>
> A: It would have been Paramedic Davis.
>
> Q: And with that, would he have been the one that would have been required to accompany the transport?
>
> A: He would have been the one that would have made the final decision whether or not he would transport the patient to the hospital.
>
> Q: Now, if he didn't transport the patient to the hospital, what would he have—he goes on a call, he clears the patient to go with the BSL crew, what is his responsibility then? Does he get back on the apparatus or what—
>
> A: If he decides that he's not going to accompany crew to the hospital, he goes and lets his officer know that I'm not going to the hospital, does a report, and then they go back in service.

Chief Small gave his opinion of whether or not Employee should have accompanied the patient to the hospital. However, Chief Small did not say Employee was *required* by any rule, special order, or protocol to accompany the patient to the hospital on this Priority 2 transport. In fact, Chief Small stated that the decision was Employee's to make and further stated the necessary steps Employee was required to take if he decided not to accompany the patient in transport to the hospital. Furthermore, Luckett testified that he has transported numerous Priority 2 calls without a paramedic, or ALS provider.

There is nothing in the record that supports Agency's assertion that Employee was required to accompany the patient during her transport to the hospital. Although Chief Small gave his opinion about what Employee should have done, Agency does not cite to any rule or regulation that required Employee to accompany the patient during the Priority 2 transport. Therefore, I find that there is no substantial evidence in the record, testimonial or documentary, that Employee neglected his duty when he used his professional judgment and decided not to accompany the patient during her transport to the hospital.

**Disclosure of protected information**

In Employee's brief, he asserts that Dr. Miramontes disclosed protected, confidential information about Employee's contact with the Medical Director's Office and the Continuing Quality Improvement setting.[26] Employee maintains that the introduction of this information from a peer review process was illegal. Employee cites and relies upon D.C. Official Code § 44-805(a) in his argument that protected information was illegally disclosed by Dr. Miramontes at the Fire Trial Board. It is undisputed that Dr. Miramontes discussed Quality of Care reviews performed on Employee; however, he also made it clear that he could not disclose confidential information. Dr. Miramontes provided very little regarding the nature of the incidents in which he was aware of Employee's contact with the Medical Director's Office. He further stated that he was prohibited by the peer review statute in going into further details. Additionally, the Trial Board's findings do not reference any testimony regarding Employee's Quality Care reviews in reaching its conclusions. As such, I do not find that Dr. Miramontes testimony was harmful procedural error.

**Employee's argument relying on *Dietrich v. District of Columbia Bd. of Zoning Adjustment*[27]**

Employee argues that the FTB decision was erroneous in that it did not give "full and reasoned consideration of all material facts and issues" and did not "disclose the basis of its order by an articulation with reasonable clarity of its reasons for the decision." Employee relies on *Dietrich* to support this argument. However, the requirements in *Dietrich* do not apply to the FTB proceedings. *Dietrich* is a contested case within the meaning of the District of Columbia Administrative Procedures Act ("DCAPA"). D.C. Official Code § 2-501, *et seq*. (2001). D.C. Official Code § 2-502(8)(B) excludes matters relating to the selection and tenure of officers and employees of the District of Columbia. The FTB relates to Employee's tenure with Agency;

[26] *See* Brief of Employee, p. 16-23 (September 8, 2014).
[27] 293 A.2d 470 (D.C. 1972)

thus, it is not a contested case within the meaning of the DCAPA, and therefore, the requirements of *Dietrich* do not apply to the FTB.

## ORDER

Accordingly, it is hereby **ORDERED** that Agency's decision is **UPHELD IN PART**, and **REVERSED IN PART**:

1. Agency's "guilty" findings on Charges 1 and 2 are **UPHELD**; whereas the "guilty" findings on Charges 3 and 4 are **REVERSED**;

2. Agency shall immediately reimburse Employee all back-pay and benefits lost from his forty-eight (48) Duty Hour Suspension as a result of the "guilty" findings on Charges 3 and 4; and

3. Agency shall file with this Office, within thirty (30) calendar days from the date on which this decision becomes final, documents evidencing compliance with the terms of this Order.

FOR THE OFFICE:

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Arien P. Cannon, Esq.
Administrative Judge