OFFICE OF THE DEPUTY MAYOR FOR PUBLIC SAFETY AND JUSTICE

REPORT

1309 RHODE ISLAND AVE., NE
JANUARY25, 2014

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Deputy Mayor for Public Safety and Justice

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INTRODUCTION

On the afternoon of Saturday, January 25, 2014, at approximately 2:44 p.m. Mr. Medric Mills, who was accompanied by his daughter, Ms. Marie Mills, collapsed in the parking lot of 1309 Rhode Island Avenue, NE, Washington, D.C. A shopkeeper telephoned 911 and spoke with a call taker at the Office of Unified Communications (OUC) to report the medical emergency. In addition to placing the 911 call, members of the public sought help by yelling and going to the fire station located across the street. Fire and Emergency Medical Services (FEMS) Engine House 26 is located at 1340 Rhode Island Avenue, NE. Five FEMS personnel from Truck Company 15 were present in the house during this emergency. All five employees were aware of a medical issue in which assistance was requested; however, none took any action to provide assistance.

As noted above,the Office of Unified Communications (OUC) received a phone call for an unconscious person in the parking lot of the Brentwood Shopping Center, 1309 Rhode Island Ave. This call was recorded into the Computer Aided Dispatch (CAD) system at 2:44:55 p.m. During the course of the call the 911 call taker did not ascertain whichquadrant of the city the address was in; however, the call taker assigned the call to the North West quadrant of the city. While the caller was still on the line the call taker repeated the address and was immediately corrected that the quadrant was North East as opposed to North West. The call taker created another event in CAD with the correct address and quadrant but the lead dispatcher and radio operators failed to see the updated address with the corrected quadrant.[1]Subsequently Ambulance 12, which was headed to another assignment on Rhode Island Ave., was flagged down by an MPD Officer at 2:55:48 p.m. Ambulance 12 initiated care to Mr. Mills. Paramedic Engine Company 26 (PEC-26)arrived moments later and joined in the care for Mr. Mills.Mr. Mills was transported to the Washington Hospital Center at 3:07:17 p.m. by Ambulance 12 with the paramedic providing emergency care.

Mr. Mills subsequently passed away at the Washington Hospital Center. Due to substantial lapses in judgment and the failure to adhere to established policyand procedures the Deputy Mayor for Public Safety and Justice called for a full investigation into this incident. Chronicled in this report are his findings, disciplinary actions, and remediesthat have been implemented.

[1] Given the nature of the call for assistance it was given the highest priority level. As such, MPD as well as FEMS dispatchers were alerted. When the call taker updated the event in CAD it was again sent to MPD and FEMS dispatchers. The MPD dispatcher properly observed the update and assigned an MPD officer to respond to the appropriate location on Rhode Island Ave. NE.

ACTIONS AT ENGINE HOUSE STATION 26

Engine House 26 is the base station for Paramedic Engine Company 26 (PEC-26), Ambulance 26 (A-26) and Truck 15 (T-15). During the event in question, it was determined that Paramedic Engine 26 and Ambulance 26 were on assignment; therefore, they were not present at the firehouse. Additionally, it was shown that Truck 15 was in quarters at the time of the incident. According to the official roster, there were five individuals present and assigned to Truck 15. The Lieutenant ("Lt."), Firefighter-1 ("FF-1")[2], Firefighter-2 ("FF-2"), Firefighter-3 ("FF-3") and Probationer/Firefighter ("Prob.-FF") were assigned.

As a result, these five individuals from Station 26 were requested to submit special reports, along with other individuals in the chain of command, detailing their actions during the event in question. More than twenty FEMS personnel provided special reports and were interviewed by the FEMS Internal Affairs Division. From these reports, additional documents and witness interviewsobtained during this investigation, the following facts have been established:

- At approximately 2:45 p.m. a civilian approached Station 26's front door stating that he witnessed a man across the street by the liquor store slip on some ice. The individual passed out and was in need of help.[3]

- The Prob.-FF, who was manning the watch desk in the front of the fire station, placed a call on the Public Announcement (PA) system asking for the Lt. to report to the watch desk.[4]Shortly thereafter, the Prob.-FF opened the station's apparatus doors to discover a white Toyota in the driveway and the driver stating "[t]here's a man across the street that needs help." The driver pointed to the area across the street by the liquor store.[5]

- The Prob.-FF made a second announcement, a minute or two after the first announcement, on the PA system asking for the Lt. to come to the floor and that it was urgent.[6]

- The Lt. failed to respond to either request to come to the watch desk for the "urgent" matter.

- FF-1, FF-2 and FF-3,were eachlocated in the kitchen sitting area, near the rear of the station. All three heard both announcements come out over the PA system.[7]

- FF-2 told FF-1 to see what Prob.-FF needed.[8]

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[2] FF-1 was detailed from his assigned Company to fill a vacancy on Truck 15.
[3] Statement of Prob.-FF.
[4] Id.
[5] Id.
[6] Statement of FF-2.
[7] Statement of FF-3.

- FF-1 came out of the sitting room and asked Prob.-FF what was going on.[9]

- Prob.-FF informed FF-1 of the situation across the street and asked if they could assist. FF-1 stated that they were not dispatched to the call and that they needed to inform the Lt.[10]

- FF-1 went to the Lt.'s bunkroom and informed the Lt. that a man across the street was down and asked if the Lt. was going to put them on the run. FF-1 told the Lt. that he thought the address was the 1300 block of Rhode Island Ave., NE.[11]

- The Lt. told FF-1 to get an exact address.[12]

- FF-1 did not come back to the Lt. to provide an address of the incident.[13]

- FF-1 returned to the kitchen area and informed FF-2 and FF-3 that the "rookie had a man down across the street so I let Lieutenant know we should be going on this run."[14]

- FF-1 subsequently gathered his personal items and study books from his car and went to the bunkroom.[15]

- When the Lt. looked for FF-1, the Lt. found FF-1 in his bunkroom lying in bed, studying.[16] When asked why he did not return with the correct address, FF-1 stated that OUC dispatched Engine 16P, EMS-6 (Emergency Medical Supervisor -6) and M-08 (Medic Unit -08) to an incorrect address but he thought it was alright since OUC had finally dispatched Engine 26P to the correct address.[17]

- At this point, the Lt. claims to have gone outside and investigated the scene and observed Police Officers, EMS-1, Engine 26P, Ambulance 26, Ambulance 12 on the scene.[18]

- No one from Truck 15 provided medical care to Mr. Mills, including Lt., FF-1, FF-2, FF-3 or Prob.-FF.[19]

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[8] Id.
[9] Statement of FF-1.
[10] Statement of Prob.-FF.
[11] Statement of FF-1.
[12] Statement of Lt.
[13] Id.
[14] Statement of FF-1.
[15] Statement of FF-1.
[16] Id.
[17] Id.
[18] Id.
[19] Journal for Engine 26/Truck 15

- The Lt. was the Officer in Charge and ranking official of Truck 15 for the entire tour of duty.[20]

- The official FEMS journal for Engine House 26 did not reflect an entry for Truck 15 regarding citizens coming to the station to report the incident or to request medical assistance.[21]

- The Lt. did not inform her superior,the Battalion Fire Chief (BFC),of the incident.[22]

- The BFC was notified of the incident by EMS (Emergency Medical Supervisor) Captain 1 who responded to the scene.[23]

ADDITIONAL FINDINGS

- A station inspection of Engine House 26 revealed that the vocal alarm system was not working in the main bunkroom. Also, it was determined that the speakers were not working in the men's bathroom and truck officer's bunkroom. Further investigation revealed that the speakers had been manually shut off.[24] To turn the speakers back on, all that was required was a pressing of a button on a touch screen system.[25]

- The updated address was sent to the unit that was initially dispatched, Engine 16, through the iMobile device. The iMobile device is a communications device that is installed in every unit and allows the unit to have direct connection with the OUC. Through the iMobile device, OUC can send information to the unit and the unit can update OUC about its status, i.e. en route, arriving at the scene, etc. The iMobile is docked directly in front of the senior officer's riding position. The updated event notification is then displayed in bold black lettering in the comments section of the device, as well as,updated on the screen. The change was not noticed by the members in the unit until they arrived at 1309 Rhode Island Ave. NW.

[20] Id.
[21] Id.
[22] Statement of BFC.
[23] Id.
[24] Statement from Deputy Fire Chief.
[25] It is undetermined whether the Lt. failed to respond to the two Public Address (PA) requests to report to the watch desk because the speakers had been turned off. Under no circumstances should the PA speakers been turned off or disabled prior to 10:00 p.m.

ACTIONS AT OUC

There were four employees with three different work assignments who were involved in the event in question: the 911 call taker, lead fire dispatcher, and two EMS radio operators. To fully understand the call taking and dispatch process, each position will be described. The call taker answers and processes all 911 calls utilizing emergency dispatch protocols through PROQA (a computerized assisted emergency dispatching system) for fire and medical incidents. The lead fire dispatcher assigns the appropriate units to respond to all incidents received for fire and medical services. Also, the lead fire dispatcher ensures the correct response plans are dispatched on each incident and monitors unit availability for the next emergency in the city. Finally, the EMS radio operators ensure that each unit is responding to the incident in which they are assigned. The radio operators relay all pertinent information associated with the incident and assists the units with making any notifications and calling back patients for additional information as needed. There is a radio operator for channel 011, which monitors the NE/SE quadrants of the city and a radio operator for channel 012, which monitors the NW/SW quadrants of the city.

DISPATCH TIMELINE

The incident in question was logged into the Computer Aided Dispatch (CAD) system as an Echo response event which means a FEMS and a MPD dual response is required. The FEMS event was created under event number F-140012512 and the MPD event was created under number I-20140041323.The CAD system records all entries regarding each call event, including radio transmissions and dispatching assignments. The below timeline reflects the entries in CAD for the FEMS event in question.[26]

14:44:55 A call came into OUC for an unconscious person in the parking lot of the Brentwood Shopping Center; 1309 Rhode Island Ave. (No quadrant given).

14:46:11 The CAD EVENT was created using NW as the quadrant of the city and was disseminated to both FEMS and MPD dispatchers.

14:46:23 Engine 16P, Medic 8 and EMS 6 were dispatched to 1309 Rhode Island Ave. NW.

14:46:26 While the call taker was verifying the address, the call taker repeated the address "1309 Rhode Island Ave NW." The caller immediately said North East. The CAD slip was immediately updated by the call taker to reflect 1309 Rhode Island Ave., North East.

14:47:14 Second CAD slip created by call taker with address of 1309 Rhode Island Ave., NE.

[26] Event log for event F-140012512.

14:47:37 Second CAD slip duplicated and cancelled by lead fire dispatcher.

14:48:29 OUC received a second call for Rhode Island Ave., NE. This time a different caller gave 1311 Rhode Island Ave NE. The call taker advised that help is on the way; an update is placed in CAD.

14:49:50 Engine 16Ptransmitted to the Dispatcher on channel 012 advising of a change of address.

14:50:24 Engine 16P advises the Dispatcher on radio channel 012 that he is in the 1300 block of Rhode Island Ave., NW, but the assignment is in NE. The Dispatcher confirms that the address is in NE, so Engine 16 asks if there is a closer unit. The Dispatcher advises Engine 16 to proceed to the run until a closer unit is determined.

14:51:24 Engine 26P is dispatched to 1309 Rhode Island Ave., NE

14:52:39 EMS 6 advised that the call was dispatched as NW and that the other units are now in NW, not en-route to 1309 Rhode Island Ave., NE

14:53:33 Engine 16P is returned to service

14:54:00 The Dispatcher contacted EMS 6 to confirm whether she was in NE or NW. EMS 6 advised that she was responding from NW to NE.

14:54:10 Ambulance 26 was dispatched to 1309 Rhode Island Ave., NE.

14:54:23 Engine 26P arrived on the scene at 1309 Rhode Island Ave., NE.

14:55:29 EMS 1 is dispatched to 1309 Rhode Island Ave., NE.

14:55:51 Ambulance 12 advised that they had been flagged down, and to take them off of the run that they are currently on and to hold them at 1309 Rhode Island Ave., NE.

14:57:21 EMS 6 advises that EMS 1 has been dispatched and askedif EMS 6 should continue on or go in service.

15:07:17 Ambulance 12 transported the individual to WHC.

MPD Event I-20140041323

14:46:11	The Third District (3D) dispatcher receives the CAD event
14:46:26	The 3D dispatcher begins to dispatch the assignment to a 3D unit, when she realizes the assignment is for NE. She announces the assignment is in NE and that she is going to reassign the event to the Fifth District (5D).
14:47:14	The 5D dispatcher receives the CAD event from the second event created by the call taker.
14:48:04	The 5D dispatcher assigns the event to 5044E.
14:52:59	The 5D dispatcher assigns 5011E to the event.
14:53:04	5044E arrives on the scene.
14:53:22	The MPD supervisor, Cruiser 5030 requests a unit with an AED.
14:53:22	MPD 5052E answers the request and is en-route code 1.
14:55:27	Ambulance 12 and Engine 26P are on the scene.
14:55:42	The MPD supervisor Cruiser 5020 is on the scene.
15:02:52	5052E arrives on the scene.
15:04:53	5011E arrives on the scene.
15:07:17	Ambulance 12 transports the individual to WHC.

ADDITIONAL FINDINGS

- The call taker who answered the initial call failed to ask for a quadrant and improperly entered "NW" as the quadrant of the city for the incident upon creation of the event in the CAD system. The call taker did not discover that the proper quadrant of the city was "NE" not "NW" until the address was verified. The initial assignment using the incorrect quadrant had already been made.

- Upon realizing that the quadrant was incorrect the call taker made a change to the original CAD event entry and created a new event entry to capture the correct address and quadrant.

- Anytime an update is made to an event in CAD the new event is distinguished by a highlighted red box icon on the computer screen. Once the dispatcher or radio

operator hits the red icon the updated information is highlighted in a different color.

- The FEMS lead dispatcher did not notice the updated CAD event and failed to dispatch the appropriate units to the correct location.

- A second call was received by the lead dispatcher for 1311 Rhode Island Ave. NE. [27] The lead dispatcher saw the new event with the updated address and deemed it a duplicateof the original event and cancelled the second event. As a result, there were no additional units dispatched.

- The radio operator, who is responsible for direct radio communications with the emergency units for channel 011 failed to monitor the CAD event properly and failed to monitor the event updates correctly.

- The radio operator for channel 012 also failed to monitor the CAD event properly and failed to monitor the event updates correctly.

- The lead dispatcher and the radio operators had the sameupdated informationon their computer screens which were color highlighted to reflect changes to the address.

[27] Event log for event F-140012512.

DISCIPLINARY ACTION

- Unlike the majority of public safety organizations in the country, Captains and Lieutenants within FEMS are members of the same collective bargaining unit as the rank and file members that they are assigned to supervise. They are required to ensure that members comply with policies, authorized practices and general rules of the fire service.In their capacity as supervisory officials, they are responsible for initiating discipline for employees who engage in misconduct. FEMS management has limited authority to discipline the involved FEMS members, irrespective of their rank, other than by way of the collective bargaining agreement. Therefore, the supervisor and subordinates are facing the same disciplinary process under the terms of the collective bargaining agreement.The probationary employee is subject to normal disciplinary rules for DC probationary employees.

- The Fire Trial Board is a panel consisting of 2 Battalion Fire Chiefs and 2 Captains. The Board will hear the evidence, issue findings of fact, determine guilt or innocence of the employee, and make a penalty recommendation to the Fire Chief, ranging from reprimand to removal. The Board may also recommend other non-traditional penalties. The Board's decision does not have to be unanimous, but it must be by the majority. The Fire Chief can adopt the penalty, reduce the penalty or dismiss the case. However, he cannot increase a penalty. If the Fire Chief imposes an adverse action, the employee has the right to appeal to the D.C. Office of Employee Appeals.

- One member has already been charged and is scheduled to appear before the trial board on March 4, 2014. The D.C. Office of the Attorney General will represent the Agency in this matter. Charges against the other members are pending. Finally, the Prob.-FF. is subject to discipline as outlined in the District Personnel Manual Chapter 8. In accordance with the DPM Chapter 8, the employee will be issued a final agency decision letter before the expiration of his probationary period.

- Four OUCemployees have been recommended for disciplinary action. Once an employee has been recommended for disciplinary action, the employee has the opportunity to respond to the charges against them. DC Personnel Rules and applicable laws mandate that discipline must be progressive in nature. The employees' prior work and disciplinary history must be taken into account when recommending disciplinary sanctions. The recommendation, along with the employee's response, is then provided to an impartial decision maker within the agency. This decision maker is typically a manager from a different unit to maintain the impartialness of the decision. The decision maker can affirm, reduce, or deny the disciplinary actions recommended for each individual. The disciplinary actions,given the relevant

employment histories of the four OUC employees,can range from reprimand to removal.

REMEDIES

As a result of this incident and the subsequent findings, a number of remedies have been recommended or already undertaken by both OUC and FEMS.

OUC

1. Dispatching protocol – Currently, when a call is dispatched to a unit through the Fire Station Alerting System, it is done through a computerized automated standard voice. The call is audible over the station alerting system and heard throughout the fire house. A scroll bar reader board publishes the call so that it is visible as well as audible. At the same time, an electronic message is sent to the iMobile lap top computer that is in every FEMS apparatus. Any updates to assignments in iMoble are accompanied by an audible alert as well as a color change reflecting the updated information. The unit hears the dispatch and signals "En route" via the iMobile system within the vehicle. Improvement:In addition to the above notifications the dispatcher will now verify the address with the unit over the radio. Also the unit will be required to repeat the destination address back to the dispatcher to ensure that the unit has the correct address.

2. In service refresher training – Additional training will be provided to all call takers and dispatchers at OUC. The training will focus on targeting update buttons and adding notes and comments to the event slips. This will help ensure that information is properly communicated to the assigned units from the dispatcher.

3. Technology updates – OUC will work with its vendor to see what changes can be made to the iMobile system so that updates are more noticeable to the individuals in the vehicle.

4. Status updates –Currently, once a call has been dispatched, the dispatchers do not check on the status of the unit to see if the unit has left the station or arrived on scene. This information is provided electronically by GPS.Improvement: Dispatchers are now responsible for orally checking on the status of any unit taking more than two minutes to leave the station and eight minutes to arrive on scene.

5. Review of entire dispatch process - A taskforce Chaired by the Deputy Mayor for Public Safety and Justice has been created with key stakeholders from FEMS, OUC and outside subject matter experts to analyze the current dispatch process. This taskforce will look at the dispatch process in its entirety and produce recommendations for a more seamless and effective dispatch process.

FEMS

1. Simulator Training – The simulator refresher training will focus on awareness of the members while in a vehicle. It will require the members (non-driver) to focus on situational awareness while enroute as well as updates on the iMobile device.

2. Memorandum regarding assisting the public – The memorandum is an official order instructing members to provide assistance wherever possible to individuals in need, regardless of whether they were dispatched to the scene.

3. Speaker volume in the stations - Amemorandum has been issued to remind members of the prohibition against turning off the PA system in the various rooms of the station prior to 2200 hours, so that announcements can be clearly heard. Also, BFCs will be instructed to check the PA systems during their daily visits to the stations.

4. iMobile Monitoring – FEMS has issued a memorandum reminding employees to properly monitor their iMoble devices constantly because of potential changes occurring after the initial assignment.