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December 29, 2017

BOARD OF FIRE COMMISSIONERS
FILE NO. BFC 17 - 140

TO: Board of Fire Commissioners

FROM: Office of the Independent Assessor

SUBJECT: REVIEW OF LOS ANGELES FIRE DEPARTMENT EMERGENCY MEDICAL
SERVICE COMPLAINT INVESTIGATIONS CLOSED FIRST QUARTER 2017

FINAL ACTION:	<input type="checkbox"/> Approved	<input type="checkbox"/> Approved w/Corrections	<input type="checkbox"/> Withdrawn
	<input type="checkbox"/> Denied	<input type="checkbox"/> Received & Filed	<input type="checkbox"/> Other

SUMMARY

The Office of the Independent Assessor (OIA) conducted a review of investigations and adjudications in cases the Los Angeles Fire Department (LAFD) categorized as Emergency Medical Service (EMS) complaints, closed during the first quarter of 2017. The OIA assessed the quality of the investigation and the adjudication, identified trends and made recommendations to enhance the manner in which the LAFD handles complaints of misconduct.

RECOMMENDATIONS

That the Board:

1. Approve the OIA's Review of Los Angeles Fire Department Emergency Medical Service Complaint Investigations Closed First Quarter 2017.
2. Adopt the OIA's recommendations.

DISCUSSION

For this review, the OIA analyzed the investigations and adjudications in 10 cases. The following trends were identified. 1. Investigations were neither thorough nor complete. 2. Interviews were not recorded. 3. The Department did not justify adjudications. 4. Members were not advised of their rights nor given the opportunity to assert or waive their rights. 5. Training was not adequately addressed or documented in case files.

The OIA made recommendations to address these issues.

I am available to provide any additional information the Commission may require.

Respectfully submitted,



SUE STENGEL
Independent Assessor
Board of Fire Commissioners

Attachment

c: Ralph Terrazas, Fire Chief

LOS ANGELES BOARD OF FIRE COMMISSIONERS



REVIEW OF LOS ANGELES FIRE DEPARTMENT EMERGENCY MEDICAL SERVICE COMPLAINT INVESTIGATIONS CLOSED FIRST QUARTER 2017



OFFICE OF THE INDEPENDENT ASSESSOR

SUE STENGEL
Independent Assessor

December 29, 2017

I. INTRODUCTION

The Office of the Independent Assessor (OIA) conducted a review of investigations and adjudications in cases the Los Angeles Fire Department (LAFD or Department) categorized as Emergency Medical Service (EMS) complaints, closed during the first quarter of 2017.¹ The OIA assessed the quality of the investigation and the adjudication, identified trends and made recommendations to enhance the manner in which the Los Angeles Fire Department (LAFD) handles complaints of misconduct.

The OIA thanks the Department, especially personnel in the Professional Standards Division (PSD), for their assistance and cooperation in the preparation of this report. The OIA would also like to thank former Student Professional Worker Katy Carlyle for her invaluable contributions, and attorneys in the Office of the City Attorney for their assistance and advice.

II. PURPOSE

The purpose of this audit was to thoroughly review complaint investigations and adjudications for EMS complaints to assess the way the Department handled the allegations of misconduct.

Prior Audits

No prior audits have been conducted focusing solely on EMS cases.

III. OBJECTIVES

1. Assess the quality of the investigation.
2. Assess the adjudication.

IV. SCOPE AND METHODOLOGY

The OIA ran a report in the Complaint Tracking System (CTS), on April 10, 2017, for all cases closed during the first quarter of 2017 which the Department categorized as an EMS case. The result yielded 10 cases. The OIA reviewed the entire file for each case.

V. BACKGROUND

EMS Complaint Classification

While researching the *Audit Of Los Angeles Fire Department Cases Closed in the Complaint Tracking System During First Quarter 2017*, the Department informed the OIA that a case should be categorized “EMS” when the complainant alleged that medical services provided by LAFD were inadequate or improper, such as when vital signs were not obtained, vital signs were recorded improperly, the wrong medication was given to the patient, or the gurney was dropped.

¹ These cases were also part of the OIA’s *Audit of Los Angeles Fire Department Cases Closed in the Complaint Tracking System During the First Quarter 2017*, presented to the Board of Fire Commissioners on September 5, 2017 (BFC No. 17-097).

However, allegations such as “Disrespectful/Insensitive/Negative attitude” or “Theft,” can also be categorized as an EMS complaint in CTS. The OIA noted in the previous audit that this seems to contradict the Department’s explanation that the EMS menu is reserved for complaints related to medical services. The OIA recommended the Department reduce the number of complaint categories, define the categories and train members who enter the information into CTS.

Case Assignment

Whether PSD or the accused’s chain of command (Field) investigates a case is determined by a 2008 Letter of Agreement with United Firefighters of Los Angeles City (UFLAC)² and depends on the nature of the allegations.³

Allegations typically investigated by the Field include:

- Performance
- Behavior
- Punctuality/Absenteeism
- Driving/Parking Violations

PSD investigates allegations of serious misconduct, such as off-duty criminal conduct, Equal Employment Opportunity (EEO) complaints, and extremely serious on-duty misconduct.⁴

In some circumstances, cases are not officially assigned to either PSD or the Field, such as when PSD can handle a case, without a formal investigation, by quickly obtaining or verifying information.

Routine Investigative Activities Performed at Complaint Intake

Complaints entered into CTS are reviewed by personnel from PSD and assigned to the appropriate entity for investigation (Field, PSD or the Alternative Investigative Process). Before a complaint is assigned for investigation, someone from PSD may gather basic information about the case, such as the Incident Details,⁵ Daily Exception and Overtime Schedule (F11)⁶ and Prehospital Care Report Summary (ePCR).⁷ Sometimes the Department believes there is enough information from what has been gathered to adjudicate and close a complaint without additional investigation. If not, that information is uploaded into CTS and is available to the assigned investigator.

² UFLAC is the bargaining unit for rank and file firefighters, through the rank of captain.

³ Letter of Agreement, Disciplinary Guidelines and Investigative Procedures. October 28, 2008.

⁴ PSD may also handle a case for other reasons, such as a member’s discipline history.

⁵ The Incident Details is generated from the 9-1-1 call and includes, among other things, the reason for the call, the location of the incident, time of the 9-1-1 call, which resources were dispatched and time of arrival at the scene.

⁶ The F11 is the daily staff roster for each station and each apparatus at the station.

⁷ The LAFD ePCR contains protected information such as a patient’s age, gender, chief complaint, vital signs and medical history.

Adjudications

A battalion chief (BC) in PSD adjudicates cases whether they are investigated by PSD or the Field.

A complaint can be adjudicated in one of five ways. The following are the definitions for adjudications.

- **Sustained:** Allegations are supported by sufficient evidence to conclude they are true, and an appropriate Departmental action was/will be imposed.
- **Not Sustained:** Insufficient evidence to either prove or disprove the allegations.
- **Exonerated:** Investigation indicates that the incident occurred but was justified, lawful, and proper under the circumstances.
- **Non Disciplinary:** Investigation indicates that the incident relates to the following categories: Alternative Complaint Resolution/Complaint Withdrawn or Retracted/Demonstrably False/Filed with Another Agency/Member Not Involved/Not Misconduct/Policy or Procedure/Referred to Another Bureau, Department, Agency.
- **Unfounded:** Investigation indicates that the allegations are false.
- **Sustained, Non Punitive:** Investigation indicates that the incident occurred, however it did not result in discipline against the member.

Discipline is imposed according to Los Angeles City Charter Section 1060.

Burden of Proof

According to Los Angeles City Charter Section 1060, the Department must prove all charges by a preponderance of the evidence (the evidence that it occurred is stronger than the evidence that it did not occur).⁸

Recommendations from Previous Audits

The BOFC adopted the recommendations made by the OIA in the *Audit Of Los Angeles Fire Department Cases Closed In The Complaint Tracking System During First Quarter 2017*.⁹ The issues identified in this report, reinforced the need for the Department to make the changes previously recommended by the OIA.

⁸ Los Angeles City Charter Section 1060(k).

⁹ BFC No. 17-097. Recommendations:

1. The Department should reduce the number of complaint categories, define the complaint categories (in writing) and train members responsible for entering this information into CTS to ensure accuracy and consistency.
2. Ensure that cases are adjudicated in accordance with adjudication definitions. This includes addressing the issue that findings of false allegations can result in an adjudication of either Non Disciplinary or Unfounded.
3. Create written guidelines for determining the types of cases for which Sustained, Non-Punitive is an appropriate adjudication. When training, counseling or other non-punitive action is taken on a case that was Sustained, Non-Punitive; PSD must receive and document proof of the actions before closing the complaint.

VI. CASES

CASE A

Complaint Summary

The following information was on the CTS face-sheet.

Operations South Bureau (OSB) was made aware of the following complaint in an email from a high-level Department manager.¹⁰

The patient's son called 9-1-1 at approximately 12:20 A.M., and stated that his mother was experiencing chest pains. An ambulance staffed by Firefighter/Paramedic (FF/PM) A and FF/PM B was dispatched to the location. The patient had a history of diabetes, hypertension, asthma and chronic respiratory failure. The narrative on the ePCR said that the patient complained of anxiety; the patient did not have chest pain, shortness of breath, or any other complaint. The patient "refuses transport. She is a medication seeker per her family. No other complaint." The patient was released - without base contact - on her own signature.

At approximately 3:30 P.M. the same day, a second call to 9-1-1 was made because the patient was in cardiac arrest. The patient was pronounced deceased at the scene.

The CTS face-sheet also stated "Based upon the fact that the patient was extremely high risk given her hx [medical history] of DM/HTN/COPD [dementia/hypertension/chronic obstructive pulmonary disease], heart rate of almost 130, and profound hypoxia (pulse ox [pulse oximeter] of 83%), this incident should be entered into CTS for a full investigation."

Investigative Responsibility

The investigation was initially assigned to the Field, but shortly after was reassigned to PSD for investigation.

CTS Complaint Type Classification

Service: EMS: Patient Assessment

Guidelines: Neglect of Duty

Investigative Findings

Incident Details for both responses and an F11 for the first response were in the investigative file.

¹⁰ The email was not in the investigative file and PSD could not produce the email for the OIA.

Quality of the Investigation

Further investigation was not completed in this case. Interviews were not conducted, relevant policies were not gathered, and neither ePCR was included in the file. Evidence of the patient's signature refusing treatment or transportation was also not included in the file.¹¹

Adjudication

Sustained, Non-Punitive.

A memo written to the Commander of PSD by a captain assigned to PSD indicated that the high-level Department manager who originally notified OSB about the complaint indicated "training that was giving [sic] to FF/PM B and FF/PM A regarding the incident was sufficient enough to close the case."

A note in the Comments section of CTS said, "Complaint closed as Sustained, Non-Punitive. Training was provided to Members regarding the incident per [the high-level Department manager]."

The OIA was unable to determine what allegation(s) was sustained or against whom. Additionally, there is no evidence in the investigation demonstrating the Department evaluated the medical treatment that was provided to the patient and whether it complied with Department policies and medical protocols.

Also, there was no information about the type of training provided, to whom it was provided, why that particular type of training was necessary to remediate an unidentified problem, who provided the training, or when or where it was given.

In the original email to OSB, the high-level Department manager indicated that this case warranted a full investigation. However, the same person later determined training was the appropriate way to address the complaint, even though there was no evidence that an investigation was conducted. There was no explanation for this decision.

Other Issues

The incident in this case occurred on February 28, 2016. The complaint was filed on March 3, 2016. The case was closed on February 28, 2017, one year from the date of the incident. From the date the case was assigned to a PSD investigator, March 21, 2016, until the date of the PSD Memo, February 28, 2017, five automatically generated e-mails were sent to the PSD investigator and his/her supervisors to remind all them of the impending statute of limitations

¹¹ PSD located and provided the ePCR after the OIA requested the information. The patient appeared to have signed the ePCR in the area indicating "I Refuse Treatment/Transportation"

date. There were no other entries in the Comment section during that period of time and nothing in the file to suggest that the case was being investigated or reviewed in any way.

In BFC No. 16-049, the OIA recommended that the Department create a system of accountability for investigators and supervisors to ensure all cases are thoroughly investigated and adjudicated within the (one year) statute of limitations. This included evaluating and enhancing the effectiveness of the email notification system.¹² More than a year has passed since the Department last presented to the BOFC on this issue and the final implementation of this recommendation has not been completed.¹³

Although this case was closed within the one year statute of limitations, five automatic emails were sent over the course of five months and no work was documented in the case file within that time.

CASE B

Complaint Summary

The complainant (the patient's son) alleged the subject (FF/PM B) was rude, condescending and unprofessional to the patient's caregiver. The subject reportedly told the caregiver that she was not qualified to tell him how to do his job and refused to transport the patient to the hospital where the patient's primary care physician and medical records were located.

The complainant reported that, as a result of the subject's lack of compassion and poor decision making, the patient received inadequate medical care and suffered a setback.

Investigative Responsibility

Field

CTS Complaint Type Classification

Service: EMS: Disrespectful/Insensitive/Negative Attitude

Investigative Findings

FF/PM B and FF/PM C responded to a "sick" incident.

During his recorded interview, FF/PM B said that he did not remember the incident at all. However, after a follow-up question, FF/PM B acknowledged that he "vaguely remembered" an

¹² BFC No. 16-049; Audit of Los Angeles Fire Department Out of Statute Cases, Page 18, May 2, 2016.

¹³ In BFC No. 16-064, the Department reported to the BOFC that "[T]he automatic email notification system currently employed to 'tickle' important deadlines is working, but will be reviewed to see if it can be improved." In BFC No. 16-099, the Department stated, "[t]he Department is reviewing ways to ensure that supervisors follow up on the automatic notification system in CTS." Finally, in BFC No. 17-004, the Department wrote, "[T]he Department is creating an internal audit system to review effectiveness of the automatic notification system in CTS."

incident occurring within that time frame that involved a caregiver. FF/PM B said that the caregiver did not seem familiar with the patient so he did not feel comfortable letting her make a request on behalf of the patient. Additionally, the patient did not have any medical complaints and did not want to be transported to the hospital. The patient was ultimately transported to a local hospital, but not the requested hospital.¹⁴ FF/PM B did not recall any argument or “negative banter” with the caregiver.

FF/PM C vaguely remembered the incident but did not recall any negative comments or arguments. It was difficult to understand the questions and answers of the majority of FF/PM C’s interview because of the number of inaudible words, phrases and questions in the transcription of the interview.

Quality of the Investigation

The Department did not interview the complainant, the patient, or the patient’s caregiver.

According to a summary in the file, “[t]he complaining party did not respond to multiple requests for interview.” Entries in the Comment section in CTS reflected multiple failed attempts to contact the complainant for an interview. There were no entries referencing any attempt to contact the patient, or the patient’s caregiver.

There was an allegation that the patient suffered a medical setback as a result of the subject’s actions. That allegation was not investigated. Furthermore, the ePCR was not included as part of the investigation.

The incident occurred on March 10, 2016. The subject was interviewed on October 9, 2016 (212 days later) and the witness member was interviewed on October 24, 2016 (228 days later). Field Investigation Case Steps is a Department document available to all members investigating cases. The document provides a timeline for interviews which results in a completed investigation within 90 days. These steps were not completed in this case and there was no explanation in the file justifying a deviation from these procedures.¹⁵

Additionally, the subject was interviewed before the witness. The Department’s Frequently Asked Questions within the CTS Guide for Field Investigations under the HELP tab in CTS states,

Q. Why can’t I interview the subject first?

¹⁴ The investigation did not reveal the circumstances under which the patient was transported if he did not want to go to the hospital.

¹⁵ PSD reported to the BOFC in BFC No. 16-064, in August, 2016, “the Department has adopted a 90 day benchmark from the dates that cases are referred to the Field for completing the investigations and submitting them for adjudication.”

A. The facts of the case will not be revealed until you interview the complainant (if identified) and the associated witnesses. Until you have an understanding of the allegations and the facts surrounding the subjects' alleged actions interviewing the subject first will lead to a re-interview of the subject once all witnesses have been interviewed.

Finally, FF/PM C's interview was difficult for the transcriber to understand. All Department members who conduct investigations should be trained in the proper use of Department recording devices so that all recordings are clear.

Adjudication

Not Sustained

PSD did not provide a justification for the adjudication, so the OIA could not assess the decision.¹⁶

Other Issues

The transcribed interviews reflected that the members were read their rights¹⁷ however; the signed admonitions were not in the file. This issue is discussed in Section VII; Trends.

CASE C

Complaint Summary

According to the 9-1-1 call transcript and the complainant's interview, the complainant/patient called 9-1-1 on March 30, 2016, because she recently had plastic surgery and she was overheating and sweating. She had a severe headache and she was clammy. She fell to the floor and did not know if she had passed out. After calling 9-1-1, the complainant walked to the front gate to meet the responding LAFD members. The complainant had a cast on her nose and a bandage on her face. She alleged that a member told her she was suffering from anxiety and that members see this all the time with Beverly Hills housewives who have plastic surgery. She also reported that she was told "you're working yourself up. This is anxiety. Just take a deep breath." The complainant further alleged that nothing was done. The members did not take her pulse, did not offer to lay her down, and "didn't hook me up to anything." Upon arriving at the hospital, the complainant alleged that the members did not offer to help her out of the ambulance. As she was walking into the hospital on her own, the members saw an available wheelchair and allegedly said "I guess we should get you a wheelchair." Once she was seated,

¹⁶ The captain who investigated this complaint found that "[a]t no time per FF/PM B or FF/PM C was there any disrespectful language or tone to any conversation. The demeanor of the patient and caregiver at time of arrival to hospital did not reflect any prior or continuing negative verbal altercation. The complaining party did not respond to multiple requests for interview." It is unclear whether the Department meant this to be the justification for the adjudication. PSD adjudicates cases, not the investigator.

¹⁷ The Firefighter Bill of Rights (California Government Code Section 3250 et seq.) and LAFD Memoranda of Understanding with sworn bargaining units, afford members rights when they are a subject or witness in an investigation.

the complainant reported that a member said “something to the effect of, ‘Why don’t you push yourself? It will give you something to do.’” Further, at the hospital she was put in a hallway where she was crying and holding her head. A member said “Well I guess we’ll look for someone to help you” and eventually someone came. No treatment was given while she waited.

According to the complainant, because of the lack of treatment, she called “right away” (three weeks later) to obtain her medical record and was told it was completely blank. However, when the complainant received the record, approximately two weeks before her interview (around the beginning of May) the records were filled out. The complainant said the information in the records was “completely inaccurate” and “completely fabricated.” For example, the records showed a pain level of seven. The complainant said she never told the members that. Additionally, the records showed she was transported in “semi-fowler” position, but she was not.¹⁸ Also, her weight was inaccurate and they never pricked her finger to get blood for a glucose test.

After her interview, the complainant wrote a letter to the Department disputing the ambulance bill due to “lack of services provided.”

Investigative Responsibility

Field

CTS Complaint Type Classification

Service: EMS: Disrespectful/Insensitive/Negative Attitude

The complainant alleged that she did not receive proper medical care; however, this is not reflected in the complaint classification.

Investigative Findings

FF/PM C and FF/PM E responded to the 9-1-1 call and were on an ambulance. An engine company also responded to the call.

FF/PM C explained that he had no recollection of the incident. Upon reviewing the ePCR, FF/PM C restated that he had no recollection but that he did everything expected of him, according to the completed ePCR.

¹⁸ According to Medilexicon, at <http://www.medilexicon.com/dictionary/71359>, the Semi-Fowler position is an inclined position obtained by raising the head of the bed 25–40 cm, flexing the hips, and placing a support under the knees so that they are bent at approximately 90°, thereby allowing fluid in the abdominal cavity to collect in the pelvis.

FF/PM E reviewed the complaint, the journal,¹⁹ the F11 and the ePCR from the date/incident in question. FF/PM E remembered working but he did not recognize the ePCR and did not remember the incident at all. According to the ePCR, FF/PM E was the attendant. FF/PM E did not remember anything about the call.

A civilian witness who had been in the sales office at the location of the incident, was interviewed, however the interview was not recorded. Notes of the interview in the Comments section in CTS indicated that the witness was in his office behind a glass window. He could not hear anything from outside. He saw the complainant walking back and forth in front of the building. He then left his office and when he returned, the complainant was gone. He did not see the ambulance, engine or the complainant when he returned.

Quality of the Investigation

During her interview, the complainant indicated that either a brunette doctor or a blonde nurse was the first to accept the complainant and greet the Department members at the hospital. There was no evidence or documentation that any effort was made to locate or interview either of them.

The Department did not attempt to locate or interview the person with whom the complainant spoke when she called to obtain her medical record, who allegedly said the documents were blank. Furthermore, the Department did not attempt to obtain the referenced medical record.

An engine company was at the scene; however, those Department members were not interviewed.

The allegation that someone falsified the ePCR was never investigated.

FF/PM C was interviewed approximately eight months after the incident and FF/PM E was interviewed more than 10 months after the incident. Similar to Case B above, there was no explanation in the file justifying a deviation from the procedures for completing an investigation within 90 days.

The findings of the investigation stated there was “no validity to the claim that medical intervention was deficient.” All members were reminded “that we are all expected to behave professionally and treat the public with respect.” However, the evidence (or lack of evidence) did not support this conclusion.

Adjudication

Not Sustained.

¹⁹ The journal page was not included in the investigative file.

PSD did not provide a rationale for the adjudication, so the OIA could not assess the decision.

Other Issues

The complainant initially filed a complaint on April 12, 2016 via the internet. The file did not include a copy of that complaint.

CASE D

Complaint Summary

The complainant was the patient's daughter and a nurse practitioner. In her interview, the complainant explained that the patient had a brain tumor and was in a rehabilitation facility. The patient also had partial complex seizures.²⁰

On the date of the incident, the complainant received a phone call from a nurse at the rehabilitation facility and recognized the patient was having a complex partial seizure. The complainant directed the nurse to call 9-1-1. The nurse from the rehabilitation facility called the complainant later and said that LAFD members responded, but left. According to the complainant, the members described the patient's situation to the nurse as, "It's muscle jerking" and left without treating or transporting the patient. The complainant then called 9-1-1 herself. According to the complainant, the call taker at the LAFD 9-1-1 call center said "Well somebody already responded. And if she's [the patient] in a rehab center, you don't need to worry about it."

When the complainant arrived at the rehabilitation center the patient was still "jerking." Then the complainant's husband called 9-1-1 and "spent a few minutes trying to convince the paramedics to turn back [to the rehabilitation facility]." When the members arrived the second time, the complainant said, "Look, please take my mom [to the hospital]." After, more conversation with the members, one member allegedly said, "[o]h they're gonna call back. They're going to call us again anyway. Let's take her." The complainant further reported that an "I/V" [intravenous] was not started, the patient was not treated at all, and the members had no sense of urgency. When the complainant asked that the patient be taken to a particular hospital, the members said it was full. When the complainant asked to ride with them because the patient did not speak English, the members would not allow it. A member also told the complainant that the patient was not exhibiting seizure behavior and if the patient was having a seizure, "she

²⁰ According to John Hopkins Medicine, complex partial seizures can begin in any lobe of the brain, but cause alteration of awareness due to spreading of seizure activity. Complex partial seizures are often preceded by a simple partial seizure (aura). An aura is often described as a warning and can manifest in several different ways, such as a sense of fear, a funny feeling in the body, déjà vu, etc. Patients experiencing a complex partial seizure may stare blankly into space, or experience automatisms (non-purposeful, repetitive movements).
https://www.hopkinsmedicine.org/neurology_neurosurgery/centers_clinics/epilepsy/seizures/types/complex-partial-seizures.html

wouldn't be responding." The complainant reported that she explained it was a partial seizure, but the members would not listen to her. The complainant believed that Department members lacked education and sensitivity and that their actions delayed care and exhibited an overall lack of professionalism.

Investigative Responsibility

This case was initially assigned to PSD and subsequently assigned to a geographic bureau. Then, eight months after the complaint was received and six months after the complainant was interviewed, the case was assigned to a different geographic bureau.

CTS Complaint Type Classification

Service/Personnel: EMS: Improper Patient Care/Treatment

Guidelines: Improper Remark or Gesture (Non-EEO)

Investigative Findings

An engine company and an ambulance responded to the patient twice. FF/PM F and FF/PM I were staffing the ambulance. The engine company and ambulance personnel completed an ePCR for each response. All ePCRs said "N/A" in the location on the ePCR which states "# of Patients at Scene."

FF/PM F was interviewed, but the interview was not recorded and there was no indication that the interviewer advised FF/PM F of his/her rights. According to the summary of the interview, FF/PM F was working overtime and had never before worked with the crew that responded to this incident. FF/PM F obtained the patient's information while FF/PM I spoke with the facility's staff. FF/PM F recalled that FF/PM I told the staff that this was "a private ambulance call." FF/PM I also said the facility should have called a private ambulance company and not LAFD. FF/PM F also reported that someone on scene "maybe his partner [FF/PM I]" told him they "had no patient" and "let's go." FF/PM F said he was not thinking and was somewhat confused and responded "Okay, no patient." FF/PM F did not take the patient's vital signs because his attention was focused on getting the patient's information. FF/PM F did not recall if the engine company left at the same time as the ambulance.

FF/PM F said that during the second response to the patient, the complainant was present, identified herself as "some type of RN [Registered Nurse]" and said the patient was having a seizure. FF/PM F explained to the complainant why he did not believe the patient was having a seizure. The complainant insisted the members take the patient to the hospital so FF/PM F told FF/PM I they should "just transport or we will get called out again."

Upon arrival at the hospital, FF/PM F transferred care and gave a report about the patient to a nurse at the hospital who said, "She isn't having a seizure."

FF/PM F was remorseful about how he handled the situation and stated that if he was able to do it again he would have been more involved in patient care and been more forceful when recommending transporting the patient.

The captain who was on the engine was interviewed. The first time members responded, the captain said the patient was not jerking and did not appear to be having a seizure. FF/PM F and FF/PM I told the engine company they could handle the call without them. The engine company left.

According to the captain, during the second response the patient was having “muscle tremors. No visible medical emergency, family requested transport for suspected seizure. PMS or positive motor sense --sensory. No evidence of seizure.” The captain said that he told the complainant which hospital they were taking the patient to. Also, he asked the complainant if she wanted to ride in the ambulance, but she preferred to take her car. The captain said it was possible that someone else told the complainant she could not ride in the ambulance.

In his interview FF/PM I said [during the first response] he completed the patient assessment, he took vital signs, but did not offer to take the patient to the hospital. FF/PM I said it did not appear the patient was actively seizing. Further, FF/PM I determined that the patient’s needs could be met by the facility. The second time FF/PM I took the patient’s vital signs and offered to take the patient to the hospital. It did not appear at any point during either response that the patient was seizing. Further, FF/PM I did not remember FF/PM F ever saying “Let’s just take her, otherwise they will call us back.” FF/PM I was asked if he offered the patient’s family member(s) the opportunity to ride in the ambulance. FF/PM I said he did not recall. FF/PM I was also asked if he denied anyone transportation to the hospital. FF/PM I’s answer to that question is recorded on the transcription as “inaudible.” The patient was alert and oriented the entire time.

Quality of the Investigation

FF/PM F explained that patient care was transferred to a nurse at the hospital who also commented that the patient was not having a seizure. However, the nurse was not interviewed for this investigation.

The patient, the nurse at the rehabilitation facility, the complainant’s husband, and the remaining members riding the engine on the date of the incident were not interviewed.

The complainant alleged that the actions of the members delayed care for the patient, but this allegation was not investigated. Furthermore, medical policies and protocols related to the complaint were not explored during the investigation.

The incident occurred on April 4, 2016²¹ and the complaint was entered into CTS on April 20, 2016. The complainant was interviewed in June, 2016. The Department members were not interviewed until February and March of 2017.

Adjudication

Sustained, Non-Punitive

The member who interviewed FF/PM F recommended training. It is unclear if the member(s) received training and if this was considered by the adjudicator.

PSD did not provide a justification for the adjudication. It is unclear which allegations were sustained, against whom they were sustained, and why.

CASE E

Complaint Summary

The complainant/patient called 9-1-1 because she injured herself while climbing through a window after locking herself out of her home. LAFD members arrived and took the patient's blood pressure. The patient told the members that, in the past, she had an aneurysm. Allegedly the members recorded this as "a history of aneurysms." She also alleged that a member did not believe she had an aneurysm.²² She asked the members if they ever had an aneurysm and they responded "No, but neither have you!" She said the members were laughing at her and making fun of her.²³ The patient reported that a female member (who was staffing the ambulance) was very nice and very professional and that the male members watched as the female did all the work.

Upon arrival at the hospital, a male member told the ER staff that he did not believe the patient had an aneurysm and that the patient was "koo-koo."

Investigative Responsibility

Field: This case was originally assigned to a captain/paramedic I and a captain II. Five months later, a BC was also assigned to the case.

CTS Complaint Type Classification

Service/Personnel: EMS: Disrespectful/Insensitive/Negative Attitude

Guidelines: Neglect of Duty

²¹ The CTS face-sheet indicated that the incident date was April 1, 2016.

²² The complainant did not know the name of the FF nor what he looked like.

²³ The paraphrased statement of the complainant's interview said the FFs were talking to each other and then started laughing.

Investigative Findings

Members on the engine:

Captain I

Engineer

FF D

FF E

Members on the ambulance

FF F

FF G

An engine and an ambulance responded to the 9-1-1 call. According to members who staffed the engine, the patient met the engine company outside at the curb. They had the first contact with the patient who told them that she locked herself out of the house and injured herself when she entered through a window and fell. According to the Captain and FF E, the complainant said she did not have a medical history, but later said she had a history of aneurysms and that she thought she had another aneurysm when she fell. Another member from the engine company reported that the patient initially said she was not injured. Two members said the patient appeared to be in mild to no distress. The FFs told the patient that her vital signs did not evidence an aneurysm. FFs F and G arrived on the ambulance. The engine company reported their findings to the ambulance crew, helped put the patient on the gurney and load the gurney into the ambulance.

Upon arrival at the hospital, FF F gave a report to the triage nurse and moved the patient from the gurney to the hospital bed. FF F denied saying the patient was “koo-koo.” FF G said that FF F was professional when giving his report to the hospital staff. FF G stated she formed a good rapport with the patient.

FF D said neither he nor FF E laughed at the patient. FF E said he did not remember any member behaving inappropriately or unprofessionally. The Captain said he did not remember anyone laughing and that he would not allow his crew to be unprofessional.

Quality of the Investigation

Although the investigator spoke to most of the involved parties, the one person who was independent, the nurse at the hospital, was not interviewed. The nurse was the person who allegedly heard the comment that the patient was “koo-koo.”

None of the interviews were recorded.²⁴ Therefore, the OIA could not determine if the interviews were thorough or if all allegations were addressed during the interviews. The OIA was also unable to determine if the paraphrased statements were an accurate representation of what was said during the interview. From the paraphrased statements, it appeared that some of the allegations were not addressed in every interview.

²⁴ The complainant did not want the Department to record her interview.

The investigative report stated the Captain said “[t]hey were trying to calm her throughout the assessment.” This was not reflected in the Captain’s paraphrased statement. Further, the paraphrased statement said there appeared to be some miscommunications with the patient concerning her history and what was going on tonight.” The OIA could not determine if the Captain was ever asked to elaborate about this.

Adjudication

Unfounded

PSD did not provide a justification for the adjudication. Therefore, the OIA could not assess the decision.

The BC/investigator in this case stated in the report that he/she was able to determine that the members handled this incident in a professional manner, that the patient was thoroughly assessed and was assisted to the gurney. The BC’s report went on to say “[i]t appears that that [sic] may have been some miscommunication between FF E and the Complainant/Patient when the subject of the patient having an aneurysm came up in the medical history. Firefighter E stated to the patient that he felt she was probably not having an aneurysm right now, due to her stable condition and stable vitals when they met her at the curb. I believe the confusion arose when [FF E] misinterpreted Complainant/Patient advising the firefighters that she had a history of an aneurysm and she felt her fall earlier in the evening may have aggravated the aneurysm.”

The investigative file does not provide evidence to support the conclusions that the BC articulated.

The report continued that the BC “was unable to ascertain from hospital staff if Firefighter F gave a derogatory statement to the triage nurse upon transfer of care. However, since Complainant/Patient was very happy with Rescue [Rescue number] and the treatment she received from them, I do not believe one of the members would treat the patient with disrespect upon arriving at the hospital.” This was not an accurate representation of the paraphrased statement. According to the paraphrased statement, the complainant said the only person who was professional and kind was the female on the ambulance. Further, there is no evidence in the file that the BC attempted to speak with the hospital staff.

CASE F

Complaint Summary

The complainant wrote a letter to the Department on the patient’s behalf (three months after the incident). The patient was the complainant’s brother-in-law. The complainant reported that the night before the incident, the patient had a severe headache. The patient went to bed and woke up at approximately 2:00 A.M., said the pain was worse, and took Tylenol. At approximately

4:00 A.M., the patient stood up, told his wife to call 9-1-1 and collapsed to the floor. The patient began vomiting and became totally incapacitated, confused and less responsive. The patient's wife called 9-1-1.

LAFD members responded and, at the same time, the patient's next door neighbor (a nurse practitioner) arrived. The neighbor believed the patient had suffered a major brain event, possibly a stroke, aneurysm or meningitis.

The ePCR was attached to the complainant's letter. Written in the Narrative History Text on the ePCR was,

"PT [patient] AT HOME NAUSEA, VOMIT, WEAK
JUST HAD THE FLU FOR A WEEK
FELT GOOD THIS WEEKEND, EAT SEAFOOD.
HEADACHE, MOVING ALL 4 [moving all four extremities] NO SLUR SPEECH OR [facial]
DROOP,
NO PN [pain], NO TRAUMA
PT FOLLOWING COMMANDS AND RESPONDING
PT CONDITION WORSENING AT ED [emergency department]. DIFFICULT TO WAKE UP,
BP [blood pressure] ELEVATING AND O2 SAT [oxygen saturation] AT 91"

In the letter, the complainant made several allegations: 1. Members focused on the vomiting and missed the chief complaint of progressive, severe headache. 2. LAFD members told the patient's wife they thought he had food poisoning, but the patient's wife had eaten the same seafood as the patient and she was not ill. 3. The patient's initial vital signs were blood pressure 170/112 and pulse 58. 12 minutes later the patient's blood pressure was 176/88 and pulse 64. The complainant reported that the members either did not recognize abnormal vital signs or were not concerned. Also, the members told the neighbor "they don't stroke out until 180 systolic." 4. The ePCR showed the patient was "alert" but the complainant stated the patient had an "altered mental state. Within less than 40 minutes, patient would be totally unresponsive. This erroneous assessment and continued BLS [Basic Life Support] status failed to recognize that Patient was in critical condition." 5. The complainant asked why the members did not contact the "base station/IC"²⁵ medical back up to report findings and ask for medical treatment. 6. The complainant alleged that the members were not going to transport the patient to the hospital until the neighbor insisted, and that the family requested the patient be taken to a particular hospital (because of his insurance), however one member told the patient that the requested hospital was not open overnight. 7. The complainant said that the members failed to recognize the severity of the patient's condition and his declining mental status. 8. The patient was transported without lights and sirens, and the rescue ambulance stopped at every red light even though the ePCR

²⁵ LAFD EMS Bureau personnel reported to the OIA that "base station/IC" is an unfamiliar term. The Department did not make any effort to clarify the complainant's use of the term(s).

indicated that the patient's condition was worsening at the ED [Emergency Department]. 9. The hospital records and the LAFD records conflicted regarding the time the patient was transferred from LAFD's care to the hospital's care. LAFD's record states 06:07:00 and the hospital record states 05:00:00.

Further, according to the complainant, the timestamps on the ePCR for several assessments reflected times after the patient was transferred to the hospital and conflicts existed between the ePCR and observations of the neighbor who was present during the incident.

The complainant indicated that at the hospital the patient was intubated, an external ventricular drain was inserted; the patient had surgery, and was in the Intensive Care Unit for three weeks. According to the complainant, the patient's final diagnosis was Nontraumatic Subarachnoid Hemorrhage, ruptured Cerebral Aneurysm.

Investigative Responsibility Field

CTS Complaint Type Classification Service: EMS: Patient Assessment

Investigative Findings
An F11 was in the file, but no other investigation was conducted.

Quality of the Investigation
An investigation was not conducted.

Adjudication
Sustained, Non-Punitive.

PSD did not provide a rationale for the adjudication. The OIA could not determine which of the numerous allegations in this case were sustained. Furthermore, it is unclear how a preponderance of the evidence existed to sustain the allegations when an investigation was not conducted.

On a Complaint Intake Worksheet, dated more than eight months after the complainant contacted the Department, a note stated, "Member referred to training."

A member of PSD told an Assistant Chief via email that the case could be closed upon receipt of confirmation "that the members involved have either received training or are scheduled to

receive training.” The Assistant Chief responded, “The case in question has been assigned to one of the EMS educators who will train the members in question.”

There was no information about why training was the appropriate response to this complaint, the type of training provided, to whom it was provided, why that particular type of training was necessary to remediate an unidentified problem, who provided the training, or when or where it was given.

CASE G

Complaint Summary

Two hours into a lengthy overseas flight from Los Angeles, the complainant (a physician) and a nurse responded to a flight attendant’s request for a medical professional to assist a passenger on board. After the passenger was treated and the captain of the flight conferred with additional medical professionals, the flight returned to Los Angeles because the patient’s condition was not manageable for the length of the flight. When the plane landed, LAFD personnel arrived and walked the patient off of the aircraft. The complainant provided the LAFD members with a verbal and written report of the patient’s condition.

15 minutes later, when the complainant left the plane (all passengers disembarked), the patient was still near the ticket counter and was released by LAFD in front of all of the plane’s passengers. When the complainant later spoke with the patient’s mother, the mother stated that the LAFD members said the patient was “faking it or was just really sleepy.”

The complainant alleged LAFD personnel abandoned the patient, were reckless in their actions, failed to continue adequate care for the patient, disregarded the events leading up to their contact with the patient, and disregarded the medical opinions of the professionals on board. Finally, the complainant alleged the actions of LAFD personnel were completely callous and disrespectful to all the people on the flight when the patient/passenger was allowed to leave in front of all the inconvenienced passengers.

The complainant also said that he possessed written statements from other passengers.

Investigative Responsibility

This case was never assigned for investigation.

CTS Complaint Type Classification

Service: EMS: Improper Patient Care/Treatment

Investigative Findings

An ePCR, F11 and Incident Details were in the file. It appeared the patient signed the box indicating his/her refusal of treatment and transportation. The Narrative History Text portion of the ePCR said: "PT [patient] FOUND AOX3²⁶ ON PLANE RETURNING TO GATE. PT HAD FAINTING EPISODE DURING FLIGHT APPX [approximately] 3 HOURS AGO. PT VOMITING X1 NEG ORTHO²⁷ ON SCENE NO CP [chest pain] OR SOB [shortness of breath] PT AMA [refused treatment and transport against medical advice] AND IS GOING TO PMD [private medical doctor] IN SAN DIEGO."

No vital signs were on the ePCR.

Quality of the Investigation

Collecting the ePCR and F11 was the only investigative effort in this case. The complainant, patient and patient's mother were not interviewed. Neither were the responding members. Further, the complainant's written report about the patient's condition was not in the file. Neither were the written statements of the passengers on the plane that the complainant said he collected.

Adjudication

Not Sustained.

A note in the Comments section in CTS indicated "Not Sustained; Patient refused transport." No other justification for the adjudication was provided.

It appeared the Department determined that the patient's signature refusing treatment and transport was enough information to adjudicate the case. If true, the most fitting adjudication was Exonerated; the investigation indicated that the incident occurred, but was justified, lawful, and proper under the circumstances. However, the OIA would have supported a decision to conduct a more thorough investigation. Additionally, the Department did not address the other allegations made by the complainant.

CASE H

Complaint Summary

The Department received a written complaint from the patient's parents, who were upset with the treatment their daughter received after she was involved in a traffic accident. The patient was hit from behind and called 9-1-1 because she had upper back and neck pain. Allegedly, the

²⁶ According to the Medical Dictionary - Free Dictionary, this refers to a patient who is responsive to his or her environment (alert), and knows who he or she is, where he or she is, and the approximate time. <https://medical-dictionary.thefreedictionary.com/alert+and+oriented+x+3>

²⁷ A representative from LAFD's EMS Bureau explained that there were no changes in the patient's vital signs when lying down or sitting up.

members who responded did not stabilize the patient's neck. Complainants said a nurse at the hospital asked a member why the patient's neck had not been stabilized, the member "lied" saying the neck brace was too uncomfortable for the patient. The patient claimed a neck brace was never offered. The nurse supposedly told the complainants that the patient's neck was not stabilized until after a scan at the hospital.

Investigative Responsibility

This case was never assigned for investigation.

CTS Complaint Type Classification

Service: EMS: Documentation Issue

Investigative Findings

Two ePCRs and two F11s were included in the investigative file. One ePCR contained a statement "PT [patient] UNABLE TO TOLERATE C-COLLAR."

No further investigation was conducted.

A note in the Comments section in CTS (written two days after the complaint was filed) said, "[A PSD Battalion Chief] to call Battalion to advise that training is needed."

Additionally, when the investigative file was closed, another note in the Comments section of CTS indicated, "Closed, Sustained, Non-Punitive. Battalion was contacted to provide training to members."

Quality of the Investigation

Other than obtaining the ePCRs and F11, no further investigation was conducted. There is no evidence demonstrating that the Department evaluated the medical treatment that was provided to the patient and whether it complied with Department policies and medical protocols.

The complaint was categorized as a documentation issue; however, no information in the file indicated why there was a documentation issue in this case.

The complainants alleged that a member lied. There is some information in the ePCR that appeared related to this allegation, but no further investigation was conducted.

Adjudication

Sustained, Non-Punitive.

PSD did not provide a justification for the adjudication. Therefore, the OIA could not assess this decision.

The Department provided no information as to which allegation(s) was sustained. Furthermore, training was to be provided to the members. There was no information about the type of training provided, to whom it was provided, why that particular type of training was necessary to remediate an unidentified problem, who provided the training, or when or where it was given.

CASE I

Complaint Summary

FF/PMs A and B responded to a 9-1-1 call of “breathing difficulty.”²⁸ Five days later, the patient’s daughter called and alleged that LAFD did not take the patient (complainant’s mother) to the hospital. The complainant said that her mother was short of breath, had pain in her left arm and was dizzy. The complainant thought her mother was having a heart attack and needed a doctor. The complainant took the patient to the hospital a few days later.

Investigative Responsibility

Field

CTS Complaint Type Classification

Service: EMS: Improper Patient Care/Treatment

Investigative Findings

According to FF/PM A, when they arrived, the patient was sitting on the couch where she had walked on her own. The patient said she was tired and unable to sleep. Further, the patient complained of shoulder pain. The patient told FF/PM A that she had slept on her arm and it was numb. She was concerned she was having a heart problem. FF/PM A assessed the patient checked her EKG [electrocardiogram], NSR [normal sinus rhythm], Negative LAPPS [Los Angeles Prehospital Stroke Screen],²⁹ equal grips.³⁰ There were no signs of trauma. The patient said she felt better when FF/PM A palpitated the area on her scapula that was painful. The patient also said that she has had the same shoulder pain with arm numbness many times for several years and that she has seen her private physician for this condition. FF/PM A offered, repeatedly, to take the patient to the emergency room, but she did not want to go. FF/PM A said he explained the risks and consequences. He also indicated that “No AMA [Against Medical

²⁸ According to the Incident Details.

²⁹ According to EMTRsource.com, the Los Angeles Prehospital Stroke Screen is a neurological exam used to assess patients with any suspected signs or symptoms of stroke. <http://www.emtresource.com/resources/scales/los-angeles-prehospital-stroke-screen-lapss/>

³⁰ A representative from LAFD’s EMS Bureau explained that “equal grips” refers to a test where the patient squeezes the fingers of the first responders. If one grip was weaker than the other, it may indicate signs of a stroke.

Advice] was done since the members felt they ruled out cardiac and settled on muscle pain.”³¹ FF/PM A indicated that he listened to the patient’s lungs, but she never complained of shortness of breath.

According to the information in the file, FF/PM B sat through FF/PM A’s interview and FF/PM B was interviewed in the front office while FF/PM A was still present. After FF/PM A’s interview, FF/PM B was interviewed. He did not recall the incident until he reviewed the ePCR.³² FF/PM B indicated he concurred with FF/PM A’s report of the incident.

An investigator spoke with the patient by telephone. The interview was conducted in English. The patient preferred to speak by phone rather than in person. According to the investigation, she was satisfied with the service she received, but when she went to the emergency room (ER) with her daughter the next day, they had to wait for two hours. She and her daughter wanted the Department to know the wait was “not okay with them.” When the investigator asked the patient if the members explained to her what she was signing when she signed the release at the scene, the patient said she did not speak English and told the investigator to speak with her daughter. She refused to continue to speak with the investigator.

The patient’s daughter told the investigator that she filed a complaint with the Department because her mother was not transported to the emergency room. She said that her mother was short of breath, had pain in her left arm and was dizzy. She thought her mother was possibly having a heart attack and needed a doctor to evaluate her. She took her mother to the ER the next day and they waited two hours. At the hospital an x-ray was taken and her mother was given morphine and told she had a pinched nerve. She was given oxycodone, was sent to physical therapy and made a future appointment for Magnetic Resonance Imaging. The complainant said that the members should have taken her mother to the hospital because of her age, and that they should not have believed her when she said she was feeling better and did not want to go to the ER. However, the complainant said that her mother is capable of making decisions. The complainant did not know if her mother had followed up with her private doctor as she was advised. After the complainant was interviewed, the complainant called the investigator later that day, but the investigator was on a run and said he would call back. The investigator left several messages for the complainant who never called back.

³¹ Department of Health Services, County of Los Angeles, EMT, Paramedic, MICN, Reference No. 808, Subject: Base Hospital Contact and Transport Criteria requires paramedics to make base hospital contact for medical direction and/or patient destination when patients meet certain criteria, including shortness of breath, cardiopulmonary arrest and chest pain or discomfort.

³² The ePCR was not part of the investigative file, however it was provided to the OIA upon request. This was a vital piece of evidence because it appeared to contain the patient’s signature in the location stating “I Refuse Treatment/Transportation”

Quality of the Investigation

First, it appeared from the investigative file that the two members who responded to the incident were interviewed together. This is not a preferred investigative technique. In *Managing Accountability Systems for Police Conduct: Internal Affairs and External Oversight*, the authors stress the importance of interviewing witnesses separately. “The purpose of segregating witnesses is to prevent the shaping of testimony by one witness to match that of another, to prevent a witness from hearing the testimony of another witness, to receive the independent recollection of the witness, and to discourage fabrication or collusion.”³³

Additionally, the Department instructs investigators to conduct interviews separately. A list of Frequently Asked Questions in the CTS HELP section states,

Q. Can I interview more than one subject at a time?

A. No. All interviews are to be conducted separately.

Second, the members were interviewed before the patient and her daughter. As discussed in Case B, subjects should be interviewed after all other witnesses have been interviewed and evidence gathered.

Adjudication

Not-Sustained.

The Department did not provide a justification for the adjudication. Therefore the OIA could not assess this decision.

Other Issues

The interviews were not recorded.

Additionally, there was no evidence that members were read their rights.

CASE J

Complaint Summary

The subject (FF/PM B) and another member (FF/PM C) responded to a 9-1-1 call for a sick patient. A complaint was made alleging that the subject was very rude, had a bad attitude and “did not want to be there.” Additionally, it was reported by the complainants that the subject leaned on the wall, was condescending, disdainful, apathetic, and “a real jerk.” The complaint also alleged the subject banged the stair chair hard against the wall and did not care. According to the complaint, FF/PM C was very polite and attempted to overcompensate for the subject. FF/PMs B and C were informed during the incident that the patient’s son-in-law was an LAFD

³³ Noble, Jeffrey J. and Alpert, Geoffrey P., *Managing Accountability systems for Police Conduct: Internal Affairs and External Oversight*. Page 44.

firefighter. Sometime after the incident, the patient and his wife notified their daughter and son-in-law of their concerns. It appeared the Department was made aware of the complaint from the patient's daughter, who was not present at the incident, but communicated her parents' concerns to the Department.

Investigative Responsibility

Field

CTS Complaint Type Classification

Service: EMS: Disrespectful/Insensitive/Negative Attitude

If, as the Department reported, complaints are categorized as EMS when there is an allegation related to the patient's medical care, then this case should not have been labeled an EMS case. All of the allegations related to the subject's attitude and behavior.

Investigative Findings

The patient's daughter and the responding members were interviewed. According to the summary of the subject's statement, the subject recalled being the attendant, in charge of documenting information in the ePCR. The subject also assisted with the stair chair. The subject did not recall being rude or disrespectful, but was "regretful" when told of the complaint. The subject also said that he did not bang the chair against the wall out of disrespect, but may have hit the wall while trying to navigate the chair and patient out of the room. Finally, the subject indicated his commitment to a positive patient care experience and treating all patients with dignity and respect. The subject had been counseled about the incident prior to his interview.

FF/PM C did not observe the subject unnecessarily bang the stair chair into the wall.

Quality of the Investigation

The interview of the patient's daughter is summarized in the file, as is the subject's interview. Although notes in the file indicated that FF/PM C was interviewed, there was no recording or summary of his/her statement in the file, other than what is referenced above.

Neither the patient, nor the patient's wife was interviewed. The file indicated that another member/witness was somehow involved in this case, but was not interviewed.

Adjudication

Sustained, Non-Punitive.

PSD did not provide a justification for the adjudication. Therefore, the OIA could not assess this decision.

In the investigator's report, the investigator states, "no one interviewed mentioned that FF/PM B said or made any rude or disrespectful comments, and it was his body language that made them feel this way." There is no evidence in the file to support this finding. Additionally, the patient and his wife - the two people present during the incident - were not interviewed.

The Department found that a preponderance of the evidence existed to sustain the allegations, however it is unclear which allegations were sustained. Additionally, there is no evidence in the file to support a finding that the allegations were true; the subject denied the allegations, and FF/PM C said that he never saw or heard FF/PM B being disrespectful or unnecessarily bang the stair chair into a wall.

Other Issues

In a previous audit³⁴, the OIA recommended that the Department complete comprehensive chronological logs documenting the progress of case investigations. The chronological log in this case was complete. The OIA applauds the investigators and the Department for the complete chronological log in the case file.

The investigator who interviewed FF/PM B stated that the subject waived his right to representation, however, there is no evidence in the file (such as a recording or Sworn Subject Admonition) demonstrating this.

VII. TRENDS:

1. Investigations were neither thorough nor complete

Every case reviewed for this report had some investigative deficiency. Witnesses were not interviewed and/or documents were not collected. This was the situation in cases investigated by the Field and by PSD.

Furthermore, in most cases that included an allegation related to the quality of the medical care, the Department did not address this issue in the investigation. There was no evidence that the Department evaluated the medical treatment that was provided to the patient and whether it complied with Department policies and medical protocols.

In some cases, no investigation was conducted.

Cases investigated by the chain of command (Field) were submitted to PSD for adjudication. PSD reportedly reviews the investigations and adjudicates the cases. PSD has the authority and the ability to return a case to the Field for further investigation if a determination is made that an investigation is incomplete, however, this was not done in the cases in this report. A case cannot be appropriately adjudicated if the investigation is not complete or thorough.

³⁴ BFC No.16-049, May, 2, 2016.

In a different audit (BFC No. 17-050), the OIA stated,

Every audit and report written by the OIA assessing investigations cited cases in which investigations were neither complete nor thorough.³⁵ In each report at least one recommendation was made related to this issue. In some reports, several recommendations were made in an effort to enhance the quality of investigations. Although the LAFD has presented strategies to the BOFC for improving investigations, this remains a concern.

The OIA recommends that the Department present to the BOFC, a plan to ensure investigations are thorough and complete, including, but not limited to, establishing incident dates and dates of discovery, determining if all witnesses were interviewed, all documentary evidence collected and that all evidence is included in the investigative file. The strategy should include internal evaluations and frequent reports to the BOFC demonstrating tangible improvements.

On April 18, 2017, the BOFC adopted the OIA's recommendation; however, the Department has not presented the BOFC with a plan for implementing the recommendation.

2. Interviews were not recorded

In some of the cases reviewed for this report, interviews were not recorded. "When the organization has the capability for conducting recorded interviews, they should be used as often and practicably possible. The actual word of the complainant, witness and involved personnel are documented verbatim which limits the opportunity for misinterpretation."³⁶

LAFD recorded some interviews, but not all. When an interview is not recorded, it is impossible to assess if the interviewer addressed all the allegations, whether the investigator asked leading questions, the tone of the investigator's questions; such as if the interviewer was respectful or argumentative, if important issues were discussed during the interview, but not included in the paraphrased statement, and if the statement was accurately paraphrased in the investigative report.

All Department employee interviews must be recorded. However, if a non-Department employee prefers not to be recorded, the investigator should try to record their refusal, or at the very least, document this in the file.

³⁵ BFC No. 10-027, BFC No. 13-109, BFC No. 13-039, BFC No. 16-049, BFC No. 17-050.

³⁶ Colaprete, Frank A., ED.D, Internal Investigation: A Practitioner's Approach. Page 92.

3. *The Department did not justify adjudications.*

In *Internal Investigation: A Practitioner's Approach*³⁷, the author states, “[a]t the conclusion of the internal investigation all cases require a disposition (Thernauer 2002). In case disposition, each allegation must also have a finding applied. Cases may involve numerous allegations and each allegation may have separate and distinct findings.”

The Department did not delineate each allegation, nor specify the member(s) against whom the allegation was made. Additionally, the Department did not adjudicate each allegation. Some conclusions were not consistent with the evidence in the file and in some cases the Department adjudicated the case when there was little or no investigation. The Department must adjudicate each allegation consistent with the evidence presented in the investigation and provide a written rationale (supported by the evidence) for the adjudication of the allegation.

4. *Members must be advised of their rights and given the opportunity to assert or waive their rights*

California law affords firefighters certain rights when they are under investigation³⁸ and the Memoranda of Understanding between the Department and UFLAC and the Department and the Chief Officer's Association further define those rights for members on the Department. The Witness Interview Admonition (sworn) and the Sworn Subject - Administrative, are forms the Department generally reads to members at the beginning of each interview to explain their rights. Members acknowledge an understanding of their rights and either waive or assert their rights. In addition to verbally acknowledging these rights, the member is asked to sign the form.³⁹

If interviews were not recorded and admonition forms were not in the file, it was impossible for the OIA to determine if the member was read his/her rights and asserted them, or not.

5. *Training was not adequately addressed or documented in the case files*

When training was recommended in a case, the Department did not document the reason training was recommended. Discipline is defined as “the practice of training people to obey rules or a code of behavior, using punishment to correct disobedience.”⁴⁰ The Department did not document the reason training, rather than discipline, would modify the employee's behavior and remediate identified deficiencies. Further, the Department did not document what kind of training was needed or was given, why that particular training addressed the issues in the

³⁷ Colaprete, Frank A., *Internal Investigation: A Practitioner's Approach*. Springfield Illinois. Charles C. Thomas Publisher Limited. 2007. Page 52

³⁸ California Government Code Section 3250 et seq.

³⁹ UFLAC objects to some of the information on the form and members sometimes decline to sign the admonition form. When this occurs, it should be acknowledged on the record and documented on the form.

⁴⁰ <https://www.google.com/search?q=definition+of+discipline&oq=definition+of+discipline&aqs=chrome..69i57j0l5.4609j0j7&sourceid=chrome&ie=UTF-8>

complaint, who was trained, who conducted the training, and when and where the training took place.

If the Department believes behaviors can be corrected with training rather than discipline, an explanation should be included with the written finding/adjudication memo.

These issues should be reflected in the complaint file and the file should remain open until training is completed.

VIII. RECOMMENDATIONS:

The OIA recommends that the Board of Fire Commissioners adopt the following recommendations and require the Department to coordinate with the OIA and provide progress reports to the BOFC at regular intervals on the implementation of the adopted recommendations.

1. Conduct a thorough and complete (and timely) investigation in every case. Develop a plan to ensure a complete and thorough investigation is conducted in every case, including, but not limited to, interviewing all witnesses, gathering all evidence, and placing all evidence in the case file. The strategy should include internal evaluations and frequent reports to the BOFC demonstrating tangible improvements.
2. Record all interviews. If a non-employee witness does not want to be recorded, capture the refusal in a recording; if that is not possible, document the refusal in the investigative report.
3. In every case, the Department must document the adjudication for each allegation and the justification (supported by the evidence) for the adjudication of each allegation.
4. Employees must be told their rights when a subject or witness in an investigation and given the opportunity to assert or waive them. This must be captured in a recording and/or on the admonition form and included in the investigative file.
5. When training is given as the result of a complaint, the Department must document the following information:
 - a. Type/subject of the training provided.
 - b. Why the particular training was chosen (the nexus between the training and the complaint).
 - c. Why training (rather than discipline) was the appropriate way to remediate the identified issues in the case.
 - d. Who was trained.
 - e. Who conducted the training.
 - f. When and where the training occurred.

A case must not be closed until the training has been completed and all of the information has been included in the case file.