STATE OF RHODE ISLAND

DEPARTMENT OF HEALTH
DIVISION OF PREPAREDNESS, INFECTIOUS DISEASES AND EMERGENCY MEDICAL SERVICES
CENTER FOR EMERGENCY MEDICAL SERVICES
IN THE MATTER OF: MICHAEL J. MONTEIRO
LICENSEE NO.: EMT14792
COMPLAINT ID #: C21-0319(B)

SUMMARY SUSPENSION OF EMERGENCY MEDICAL TECHNICIAN--CARDIAC LICENSE

Michael J. Monteiro ("Respondent") has been licensed as an Emergency Medical Technician—Cardiac pursuant to R. I. Gen. Laws §§ 23-4.1-1 *et seq.* since December 20, 2011. Complaint ID #C21-0319(B) (the "Complaint") recently came before the Rhode Island Department of Health, Division of Preparedness, Infectious Diseases and Emergency Medical Services, Center for Emergency Medical Services ("RIDOH") alleging that Respondent had engaged in behavior that constituted "cause" for taking action against his Emergency Medical Technician--Cardiac license pursuant to R. I. Gen. Laws § 23-4.1-9. This Summary Suspension of Emergency Medical Technician—Cardiac License (this "Order") is issued related to the Complaint and pursuant to R. I. Gen. Laws § 42-35-14(c) and § 2.5(G)(1) of the Emergency Medical Services Rules and Regulations, 216-RICR-20-10-2 (the "EMS Rules"). After careful consideration and further investigation by RIDOH, the following constitute the findings of fact and conclusions of law with respect to the allegations against Respondent in the Complaint:

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. That Respondent is an Emergency Medical Technician—Cardiac licensed to practice in the State of Rhode Island under License Number EMT14792 (the "License").

2. That, at all times during which the incidents described in this Order took place, Respondent was an employee of the Warwick Fire Department located at 111 Veterans Memorial Drive, Warwick, RI 02886.

3. That on or about March 1, 2021, RIDOH received notice that Respondent had performed emergency medical services for Patient I, a 44-year-old woman who passed away at Kent Hospital on February 10, 2021, in the hours that preceded her death.

4. That, upon further investigation of Patient I's death, it was discovered that Respondent was called to Patient I's residence at 11:37 am; after arriving at 11:49 am, Respondent found Patient I quiet/partially asleep, checked her pulse, and spoke to a nurse who was familiar with Patient I's medical issues. At no point during this assessment did Patient I and Respondent have a conversation to establish her mental capacity. Although Respondent was advised that Patient I had experienced a seizure with subsequent breathing difficulty shortly before her sleep-like state and urged by residents to transport her to a hospital, Respondent concluded that there was no reason to do so. Respondent consulted with no other health care provider before coming to this conclusion. Instead,

Respondent surmised that Patient I was 'not in acute distress' and advised the concerned residents to follow up with Patient I's primary care physician if trouble recurred.

5. That shortly after Respondent left, Friend I paid Patient I a visit, arriving just after 12:30 pm. Friend I determined that Patient I did, in fact, need to go to the hospital, so Friend I transported her to Kent Hospital herself at approximately 12:45 p.m. The emergency staff at Kent Hospital assessed Patient I as having tachycardia; after various life-saving attempts, she died at 2:20 pm on February 10, 2021. The Rhode Island Department of Health, Office of the State Medical Examiners reviewed the case in the ordinary course; however, given her short stay at the hospital and a present physician's willingness to sign the death certificate, the circumstances did not warrant an autopsy.

6. That Respondent's treatment of Patient I constituted cause to summarily suspend the License for the following reasons:
   A. Respondent's care failed to comply with several *Rhode Island Statewide EMS Protocols*, including
      I. Protocol 1.01 – Routine patient care
         a. Transport the patient to the nearest appropriate hospital emergency facility. Patients in respiratory or cardiac arrest should be transported to the nearest hospital unless otherwise directed by medical control; Respondent neither transported Patient I to a hospital nor did he seek (or receive) any direction from medical control
         b. Perform primary and secondary assessments, and obtain vital signs.
            i. The primary assessment of a patient includes: forming a general impression of a patient; assessing the patient's (x) mental status, (y) airway, (z) breathing adequacy, rate, and rhythm, and (z) circulation; and making a decision on the priority or urgency of transport.
            ii. The steps in a secondary assessment are the same as those in the primary assessment; however, a secondary assessment often consists of a focused examination for isolated injuries (instead of a general inventory).
            iii. Obtaining vital signs should include, at a minimum, collecting blood pressure, palpated pulse, respiratory rate, and oxygen saturation as measured by oximeter. Temperature (oral, rectal, axillary, or esophageal probe) should be obtained and documented when available and in all critically ill or injured pediatric patients.
            iv. Respondent failed to perform a primary or secondary assessment, nor obtain vital signs, in the course of Patient I's care.
      II. Protocol 2.19 – Seizures
      This protocol requires EMS to perform blood glucose analysis on patients who have had seizures. Respondent knew that Patient I had experienced a seizure but did not perform a blood glucose analysis.
      III. Protocol 6.04 – Refusal of patient care or transport
      This protocol requires three components for the patient to satisfy – competence, capacity, and informed refusal –to refuse evaluation, care, or transport.
      A competent patient who is determined to have present mental capacity that meets the following criteria may refuse evaluation, care or transport by EMS:
         a. The refusal is solely initiated by the patient, not suggested/prompted by EMS providers;
         b. The patient is oriented to person, place, time and situation;
         c. There is no evidence of altered consciousness resulting from head trauma,

medical illness, intoxication, dementia, psychiatric illness or other etiologies;

d. There is no evidence of impaired judgement from alcohol or drug influence;
e. There are no language communication barriers; and
f. There is no evidence or admission of suicidal ideation resulting in any gesture or attempt at self-harm and no verbal or written expression of suicidal ideation regardless of any apparent inability to complete a suicide attempt.

EMTs must document the refusal of care/transportation by having the patient sign (or, in the case of a minor patient, the minor patient's parent, legal guardian, or authorized representative sign) a refusal of care statement on the patient care report or a standalone, service-specific refusal of care form. Documentation should include, when possible, a signature by a witness, preferably a competent relative, friend, police officer, or impartial third party.

EMTs must provide documentation on the patient care report supporting the presence of mental capacity and specific information provided to the patient/guardian regarding their condition and risks associated with the refusal of evaluation, treatment and/or transportation by EMS.

In this case, none of the components were met (nor could they have been, since Patient I's unconscious/semi-conscious state would not allow for the necessary inquiries to take place). Of course, no signature of Patient I is captured to acknowledge refusal of transport, as is required.

B. Respondent filed a patient care report regarding Patient I and the events of February 10, 2021 that lacked an appropriate level of detail and contained erroneous information
   i. "Transport Mode" was listed as "emergent (warning lights & sirens used)" in the patient care report, but Respondent never transported Patient I
   ii. The incident location was listed on the patient care report as a single-family residence (however, the location was not a single-family residence)
   iii. The patient care report narrative indicates that, during the time that Respondent visited Patient I at her residence, Patient I was asleep but also alert and awake
C. Moreover, Respondent's actions violated the following sections of the EMS Rules
   i. § 2.5(G)(1)(b) prohibits gross negligence in providing medical care
   ii. § 2.5(G)(1)(d) prohibits severe mental incompetence
   iii. § 2.5(G)(1)(e) prohibits unprofessional conduct related to current standards of EMS practice
   iv. § 2.5(G)(1)(f) prohibits the violation of federal or state law

7. That the RIDOH director (the "Director of Health") has reviewed the facts and conclusions in this case and finds that public health, safety, or welfare imperatively requires emergency action.

ORDER

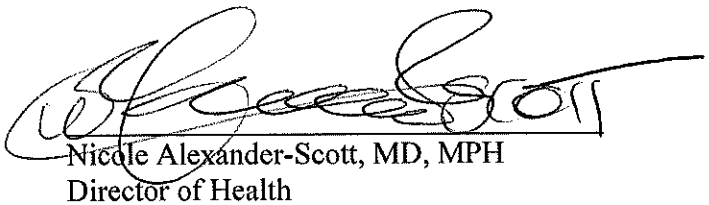
8. Based on the foregoing and pursuant to R. I. Gen. Laws §§ 23-4.1-9 and 42-35-14(c), and EMS Rule 2.5(G)(1), the License is hereby SUSPENDED until further order of RIDOH.

9. A written request for hearing may be filed with the Director of Health within ten days after service of this Order. If a hearing is requested and held, an Administrative Hearing

Officer shall preside over such hearing. As a result of the hearing, discipline may be imposed on the License (for example, it may be suspended or revoked), or no discipline may be imposed on the License.

10. This Order shall become a permanent part of Respondent's record maintained by RIDOH and a part of a public record of this proceeding.

Ordered this 4th day of March, 2021.



Nicole Alexander-Scott, MD, MPH
Director of Health
Rhode Island Department of Health
Cannon Building, Room 401
Three Capitol Hill
Providence, Rhode Island, 02908

CERTIFICATION

I hereby certify that a copy of this Order was delivered via constable to Michael J. Monteiro on this _____ day of March, 2021.

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