**STATE OF RHODE ISLAND**
**DEPARTMENT OF HEALTH**
**DIVISION OF HEALTHCARE QUALITY AND SAFETY**
**CENTER FOR EMERGENCY MEDICAL SERVICES**

**In the Matter of: WILLIAM TROWBRIDGE**
**LICENSE NUMBER Paramedic EMT09133**

## NOTICE OF COMPLIANCE ORDER

This Notice of Compliance Order is issued pursuant to R.I. Gen. Laws §§ 45-35-14, 23-1-20, 23-4.1-1 *et seq.*, Emergency Medical Transportation Services, and 216-RICR-20-10-2, Emergency Medical Services, regarding EMT Paramedic License 09133 issued to William Trowbridge (Respondent) by the Rhode Island Department of Health (RIDOH).

## FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. Respondent is an emergency medical technician licensed to practice in the State of Rhode Island under Emergency Medical Technician License Number EMT09133.
2. On or about April 23, 2024, the Commissioner of the Department of Public Health for the Commonwealth of Massachusetts issued an immediate suspension of Respondent's Emergency Medical Technician License Number P856245, issued by the Commonwealth, for failure to comply with Massachusetts statutes and regulations (Exhibit 1, attached).
3. That the conduct described in Exhibit 1 constitutes unprofessional practice pursuant to the statutes and regulations promulgated by the State of Rhode Island.

## ORDER

4. Respondent's Rhode Island Paramedic License EMT 09133 is hereby SUSPENDED.

5. Pursuant to R.I. Gen. Laws § 23-1-20, Respondent may request a hearing on this matter within 10 days of service of this notice of compliance order. If no written request for a hearing is made to the director within ten days of service of this notice, this notice shall automatically become a compliance order.

Ordered this 7 day of June, 2024

Jerome M. Larkin, M.D.
Director of Health
Rhode Island Department of Health
Three Capitol Hill, Room 401
Providence, Rhode Island 02908

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
250 Washington Street, Boston, MA 02108-4619

MAURA T. HEALEY
Governor

KIMBERLEY DRISCOLL
Lieutenant Governor

# EXHIBIT 1

KATHLEEN E. WALSH
Secretary

ROBERT GOLDSTEIN, MD, PhD
Commissioner

Tel: 617-624-6000
www.mass.gov/dph

April 24, 2024

**VIA UPS OVERNIGHT: 1Z A3V 757 22 1006 890 1**
**AND**
**CERTIFIED MAIL RETURN RECEIPT REQUESTED: 9589 0710 5270 0429 9647 75**

William Trowbridge
108 School Street P.O. Box 26
Forestdale, RI 02824
billtrow45@gmail.com

Re: Notice of Agency Action: **Immediate Suspension and Proposed Temporary Revocation of Certification as an EMT** (OEMS Complaint No. 24-0209)

Dear Mr. Trowbridge:

For the reasons set forth in the attached Notice of Agency Action, the Department of Public Health ("Department") is immediately suspending and proposing to temporarily revoke your certification as an Emergency Medical Technician ("EMT"), at all levels. As provided in 105 CMR 170.770, this action is subject to the adjudicatory provisions of M.G.L. c. 30A and will be governed by the Standard Adjudicatory Rules of Practice and Procedure, 801 CMR 1.01 *et seq*. Pursuant to 105 CMR 170.750, you may request an adjudicatory hearing on the immediate suspension by filing a request for hearing **within fourteen (14) days** of receipt of this notice. Your request must meet the requirements of 801 CMR 1.01(6) of the Adjudicatory Rules and must be filed with counsel for the Department, **Matt A. Murphy, Deputy General Counsel, Office of General Counsel, Department of Public Health, 250 Washington Street, Boston, MA 02108-4619**. Once a request for hearing is received, the case will be sent to the Division of Administrative Law Appeals located in Malden, MA for docketing and for further proceedings consistent with the Adjudicatory Rules.

If you have any questions regarding this matter, please contact Attorney Murphy, at Matt.A.Murphy@mass.gov. Please note that if you are represented by counsel, all communications with Attorney Murphy should be made through your counsel.

Sincerely,

OFFICE OF EMERGENCY MEDICAL SERVICES,

Susan Lewis, NRP
Director, Office of Emergency Medical Services

Encl.

cc: Regional Directors
Silva Cameron, BHCSQ
Matt A. Murphy, OGC
Michael Pieretti, Chief Quality Officer, Executive Vice President, Clinical Care, Coastal Medical Transportation Services

**COMMONWEALTH OF MASSACHUSETTS**

Suffolk, ss

Department of Public Health
Office of Emergency Medical Services
Complaint Investigation #24-0209

**DEPARTMENT OF PUBLIC HEALTH, OFFICE OF EMERGENCY MEDICAL SERVICES,**
**Petitioner,**

**v.**

**WILLIAM TROWBRIDGE,**
**Respondent.**

**NOTICE OF AGENCY ACTION**

**IMMEDIATE SUSPENSION AND PROPOSED TEMPORARY REVOCATION OF CERTIFICATION AS AN EMERGENCY MEDICAL TECHNICIAN**

## INTRODUCTION

The Commissioner of the Department of Public Health ("the Department"), pursuant to M.G.L. c. 111C, §§2(1), 16 and 105 CMR 170.750, immediately suspends the certification of the Respondent, William Trowbridge, as an Emergency Medical Technician (EMT), P856245, at all levels, effective immediately.

This summary suspension is based upon evidence that Trowbridge, *inter alia* violated the Emergency Medical Services (EMS) System regulations and Statewide Treatment Protocols (STPs) by 1) failing to bring appropriate equipment to the side of the patient; 2) failing to perform a paramedic-level assessment; 3) delaying oxygen administration and cardiac monitoring; and 4) failing to recognize cardiogenic shock and cardiac etiology versus respiratory etiology to a critically ill patient. The Department determined that the Respondent failed to use reasonable care and judgment in his duties and failed to ensure the information in the PCR was accurate. Finally, the Department determined that given the Respondent's compliance history and repeated remediation attempts following sanctions issued by the Department – including a temporary revocation of EMT certification which ended December 15, 2023 – the Respondent represents a public health and safety risk to continue working as an EMT at any level, at this time. In addition to the immediate suspension, the Department proposes to temporarily revoke the Respondent's certification as an EMT at all levels. **Respondent has the right to an adjudicatory hearing on the imposition of the immediate suspension and/or the proposed revocation by submitting a written request for a hearing within fourteen (14) days of receipt of this notice. Failure to make a timely request for a hearing shall constitute a waiver of the right to a hearing with regard to the Department's actions.**

## JURISDICTION

This notice is issued pursuant to M.G.L. c.111C, §§1-24 and the regulations promulgated thereunder, 105 CMR 170.000 *et seq*. The referenced statutes and regulations control the delivery of pre-hospital emergency medical care in the Commonwealth.

## PARTIES

1. The Petitioner is the Department. The Department is responsible for the enforcement of the above-referenced provisions of the Massachusetts General Laws and the regulations promulgated thereunder.

2. The Respondent is William Trowbridge, of 108 School Street, P.O. Box 26 Forestdale, RI 02824 ("Trowbridge" or the "Respondent"). He is certified as a Paramedic, P856245, with an expiration date of March 31, 2026. As such, the Respondent is subject to the above-referenced laws and regulations.

## FACTS

3. The Department, through its Office of Emergency Medical Services (OEMS), is responsible for the certification of individuals who meet specified eligibility and training standards and are otherwise deemed suitable to act as EMTs. M.G.L. c.111C, §9; 105 CMR 170.000 *et seq.* The Department is authorized to suspend, revoke, or refuse to renew an EMT certification on grounds set forth in 105 CMR 170.940.

4. Pursuant to EMS System regulations, EMS personnel are to provide care in conformance with the STPs. 105 CMR 170.800(C). The STPs are the standard of care and require EMT operating procedures to be followed for patient assessment, treatment, and delivery to definitive care.

5. Pursuant to 105 CMR 170.355 of the EMS System regulations, upon receipt of an emergency call, ambulance services and their EMTs must immediately dispatch, assess and treat in accordance with the STPs and transport the patient to an appropriate health care facility.

6. Additionally, under 105 CMR 170.940(C), EMS personnel are required to exercise reasonable care, judgment, knowledge, or ability in the performance of duties or to perform those duties within the scope of his or her training and certification, and in accordance with the STPs.

7. The Department commenced an investigation after receiving a serious incident report on or about February 9, 2024, from Michael Pieretti, Chief Quality Officer for Coastal EMS ("Coastal"), in accordance with regulatory serious incident reporting requirements. Based on his investigation Pieretti wrote, the service determined the following list of clinical deficiencies occurred in this case:

- "Oxygen was not brought to the patient's side.
- Oxygen was not applied promptly.
- Oxygen was not administered at a sufficient flow rate / FiO2 (fraction of inspired oxygen) for the patient's condition.
- Appropriate assessment was not performed in a timely fashion.
- Although a blood pressure may have been unobtainable, an auscultated or palpated blood pressure was never attempted.
- Vascular access was not attempted until after extrication from residence.
- ECG monitoring and 12-lead ECG acquisition was not initiated until after extrication from residence.
- Failure to contact online medical control to consult regarding a critically ill patient; different destination conversation could have resulted in significantly improved patient outcome (e.g., patient brought to CCL [cardiac catheterization laboratory]-capable facility vs. Morton Hospital).
- Failure to recognize patient in shock; failure to recognize cardiogenic shock."

8. Pieretti wrote that upon arrival at Morton Hospital, the patient was reported to have an oxygen saturation and a blood pressure in the 70s and was determined to be critically ill. Pieretti documented that the clinical follow up for this patient revealed that the patient was suffering from severe cardiogenic shock, and laboratory findings determined the patient had a non-STEMI (NSTEMI) myocardial infarction (MI). Pieretti reported the patient suffered cardiac arrest during a subsequent attempt to transfer the patient by air medical helicopter to another hospital. The patient was resuscitated and was transported, but further clinical outcome information was not available.

9. Based on the patient care report (PCR) and dispatch records, on or about February 2, 2024, Coastal dispatched an ambulance staffed by the Respondent and Williams, operating at the paramedic advanced life support (ALS) level, to a patient reported to have respiratory distress and chest pain. Middleborough Fire Department (FD) first responders were also dispatched and arrived just after the ambulance.

Interview: The Respondent

10. On March 26, 2024, the Department conducted an in-person interview with Trowbridge regarding this patient encounter. Pieretti and Patrick Lofgren, Coastal's director of operations, were also present.

11. The Respondent reported that this call occurred during his first shift after completing orientation at Coastal and he had not worked with Williams before.

12. The Respondent stated he and the Williams arrived on the scene, and Respondent grabbed "the bags" to go in the house. When told that the Respondent reported grabbing the monitor and first-in bag but not the airway bag that had the supplemental oxygen in it, Respondent replied that he thought he grabbed some equipment, but maybe he did not. The Respondent said he could not recall.

13. Once in the house, the Respondent stated, they found the patient, "puffing on a can-type thing" of oxygen. The Respondent said he took it away from the patient. The Department asked him if he replaced it with supplemental oxygen. He replied, "No."

14. The Respondent reported that the first responders retrieved the stairchair for them and they began extricating the patient from the house to the stretcher. The Department asked the Respondent if he obtained a set of vital signs or applied the cardiac monitor. The Respondent replied that he did not. The Respondent said that it felt like "things were rushed" and that because he was new to Coastal and had not worked in the Middleborough area before, he just "went with the flow." The Respondent stated he heard that if the first responders started extrication, then it is best to not correct them or fight with them. The Respondent said he "was trying not to step on anybody's toes," so he just went ahead and assisted with extricating the patient.

15. The Respondent stated he was questioning the patient about his medical history and medications and then they extricated the patient from the house to the stretcher. They placed the patient in the patient compartment, and the Respondent got inside to help Williams.

16. The Department asked the Respondent if he did any other interventions or completed an assessment of the patient in the house. The Respondent reported that side stream capnography (EtCO2) was applied through the cardiac monitor but that no supplemental oxygen was initiated. Trowbridge said, "I didn't even think to grab that oxygen bag."

17. Once in the ambulance, the Respondent attempted to obtain intravenous (IV) access. The Respondent said he made two attempts without success, and then Williams tried and was successful. The Respondent reported that supplemental oxygen was also applied by nasal cannula.

18. The Department asked the Respondent if the patient appeared "sick or not sick" to him. He replied that the patient "did not look truly sick, but more like he was unkempt and not taking care of himself."

19. The Respondent stated that once the IV was in place and the oxygen was connected, Williams told the Respondent he was "all set," meaning he wanted to transport. The Respondent reported that before he got out of the patient compartment, Williams obtained a 12-lead ECG tracing and he read it for Williams. The Respondent stated that he told Williams there was some depression but no evidence of STEMI, and then got out of the ambulance to drive.

20. The Respondent said that because he was new to the area, he queried the directions to Morton Hospital and then transported

21. When asked how he thought the care of his patient went, the Respondent said, "I did not think it went awful. The doctor in the ED told us we did everything right."

Interview: Paramedic Charles Williams

22. On March 26, 2024, the Department conducted an in-person interview with the Respondent's partner, Williams, regarding this patient encounter. Pieretti and Lofgren were also present for the interview.

23. Williams stated that he and Trowbridge responded to a location for a patient with respiratory distress and chest pain. Williams reported that he is a new paramedic and has been certified for approximately 8 months. Williams stated this was his first time working with the Respondent, who he knew was a more experienced paramedic and a new employee to Coastal.

24. Williams stated that when they arrived at the scene, Williams grabbed the cardiac monitor and the first-in bag, but did not grab the "airway" bag, which contains supplemental oxygen and airway supplies. Williams stated he and the Respondent did not realize they lacked this equipment until they were at the side of the patient.

25. Williams said that once inside the home, they were met by a family member who directed them to the patient, who was sitting in a chair in the kitchen area. Williams stated the family member said something about the patient having a recent exposure to COVID-19 and was having shortness of breath.

26. Williams reported that he observed the patient to be holding a "can-type" device and was "huffing oxygen" through this device. Williams stated the "can" is apparently compressed air that can be bought over the counter.

27. Williams stated on initial patient contact, he applied the pulse oximetry (pulse ox) probe attached to the cardiac monitor and did not get a reading. Williams said the patient was talking in complete sentences but telling them he felt short of breath. Williams reported the patient looked pale but there was no evidence of cyanosis.

28. Williams reported that the patient did not complain of chest pain. Williams said the patient told him that he has a long history of smoking and felt short of breath. Williams said that he could not get a "good reading" on the pulse ox and "became hyper-focused" on why it was not working correctly. Williams stated he felt he "had to handle [everything] on this call and get through it" and just wanted to get the patient to the hospital.

29. The Department asked Williams whether on initial assessment he thought the patient was "sick or not sick." He replied, "Initially he did not appear sick, sick," meaning Williams did not believe the patient was in critical condition.

30. The Department asked Williams if he listened to lung sounds, obtained a set of vital signs, applied the cardiac monitor, or completed any part of a thorough assessment. Williams replied, "No, I dropped the ball on a lot of things in this call." Williams said, "Because of the increased anxiety I was feeling in the moment, and overthinking the small stuff, I did not recognize the bigger stuff."

31. The Department asked Williams if he wrote the patient care report (PCR) for this patient encounter. Williams replied that he did. The Department noted that he wrote in the PCR that the patient had chest pain and evidence of cyanosis. Williams responded, "I wrote the report disjointedly. I don't know why I wrote that he had chest pain." Regarding the cyanosis, he said that once the patient was in the ambulance, he noticed the patient had evidence of cyanosis on his face, but that he did not see cyanosis while they were in the house.

32. Williams reported that he and the Respondent got the stairchair, extricated the patient to the ambulance stretcher and placed him in the patient compartment. Williams stated once in the ambulance, his first goal was to obtain a 12-lead ECG tracing. Williams said he applied the cardiac monitor leads and the Respondent attempted to obtain IV access. Williams reported that the Respondent was unsuccessful with two attempts and that he himself made a third attempt and successfully initiated IV access in the patient's right arm.

33. Williams stated he never read the results of the first 12-lead ECG he obtained. Williams reported that the Respondent looked at the 12-lead ECG tracing and reported seeing only "depression" in a couple of chest leads. Williams said he was focused again on the pulse ox and could not get a blood pressure reading on the automatic blood pressure cuff. Williams reported this added to his hyper-focused state and he just wanted to get the patient to the hospital.

34. The Department asked Williams if he ever applied supplemental oxygen to the patient. Williams replied that he applied the nasal cannula with EtCO2. Williams stated he applied the cannula in the house only for the purpose of obtaining an EtCO2 reading of approximately 16

mm/Hg but did not add the supplemental oxygen until in the ambulance, which he did at a flow rate of 4 liters, increasing it later during transport to 6 liters. Williams said the patient did not appear to be in distress, so he did not consider changing it to high-flow oxygen by a non-rebreather mask.

35. Williams stated that the family member and the patient requested transport to Morton Hospital. Williams said that when they are on that side of town, they usually transport to BID-Plymouth, but when he mentioned it to the family member and the patient, they told him they wanted to go to Morton Hospital emergency department (ED). Williams reported on the second 12-lead ECG, he did not see evidence of a STEMI, so he believed Morton Hospital was appropriate.

36. The Department asked Williams about the notation on the PCR in the 12-lead ECG notation that he did a "STEMI Alert" to Morton Hospital. Williams replied he does not recall doing that and is not sure now why he wrote that. Williams stated when he interpreted the second 12-lead ECG he obtained, he noticed the depression in the chest leads, administered 325mg of aspirin, and believed the patient was having a possible posterior or right-sided MI. Williams stated he did not obtain those tracings himself, because he was just focused on getting the patient to the hospital. Williams reported he was still hyper-focused on the pulse ox and the lack of a blood pressure reading.

37. With regard to the lack of blood pressure reading, the Department asked Williams if he took a manual blood pressure or attempted to palpate a systolic pressure. Williams replied that he did not. Williams stated in an attempt to correct the pulse ox problem, he applied a pediatric pulse ox probe to the patient's ear, but did not trust the reading he got, which was in the 70s. Williams said with the low oxygen reading and no blood pressure, he increased the supplemental oxygen from 4 to 6 liters by cannula.

38. Williams reported that once they arrived at the ED, they brought the patient inside to a room. Williams stated he gave a report and transferred care of the patient over to the nurses. Williams said the doctor who received the patient told him he did a good job with the patient.

39. Williams stated that after the call was over, he texted Lofgren that he just had his first STEMI patient and they transported the patient to Morton Hospital. Williams said, "I thought I did a good job getting this patient to the hospital and I wanted Patrick to know. I was proud of what I did." Williams stated that he now realizes he failed on several levels and violated the STPs.

Text Messages from Williams to Lofgren; Twiage Report

40. The Department reviewed four screenshots of the text message exchange between Williams and Lofgren, dated and time stamped as corresponding to the completion of this emergency call.

41. The first message from Williams states, "Just had my first left sided MI." In response, Lofgren asked Williams to send a picture of the 12-lead ECG. Williams sent a picture of the 12-lead ECG and wrote, "I didn't end up doing a 4r [a right-sided view of the heart] being so close to Morton when I found it. The hospital took one and was consulting cardiology."

42. In the second message, Lofgren wrote, "You took the patient to Morton?" to clarify the hospital destination, because Morton Hospital is not a cardiac catheterization [cath] facility.

Williams responded, "Yes, not realizing what it was until we were already enroute" to Morton Hospital.

43. In the third message, Williams wrote, "I was proud of myself, but now not so much. I am having a really hard time with doing the right thing for my patients and being proud I found there was an issue and now I feel like I did someone wrong. I [am] not feeling like I am doing the right thing and it's making me second guess myself. I want to learn but given what I had to deal with on this call, I think I did a great job." Lofgren did not respond to this message.

44. In the final message Williams wrote, "The doctor states there is nothing I did wrong. He [the patient] wasn't having a STEMI, she consulted with two cardiologists they think he had an MI 5 days ago. He ended up being in renal failure, having possibly a continuation of the MI. He was there 2 hours and finally coded, had to be intubated and is going with med flight due to how sick he was. The doctor states that I could not have done anything more than I did for him and that if he had gone to a cath lab they couldn't do anything for him with everything else going on."

45. Lofgren reported that based on this text message exchange, he informed Pieretti and they launched an investigation into this patient encounter. Lofgren wrote that due to missteps at Morton Hospital as well, the hospital is doing an internal peer review of the handling of the patient by its staff.

46. Lofgren provided a copy of the Twiage Report that Morton Hospital uses, which is an electronic means of entry notification from an ambulance service to the hospital when they are transporting a patient into their ED.

47. The report, written by Williams indicates the patient is "routine," has a fever, cough, shortness of breath, a sore throat, and lists his age and gender. It states the patient had a "recent exposure," which may be in reference to COVID-19, and also documents, "He has distal cyanosis in his arms. He's got depression in V5, 1 and 2 No reciprocal elevation." It states, "Gave him 324 of ASA," referring to the dosage of aspirin administered.

Patient Care Report, Cardiac Monitor Report

48. The Department's investigator, as well as its EMS medical director, Dr. Jonathan Burstein, reviewed the PCR written by Williams for this patient encounter. The document states under the section labeled Chief Complaint, "general illness-lethargy/malaise (primary)." Under Primary Symptom, it states, "shortness of breath." There is nothing documented for medical history, allergies, or medications in the corresponding sections of the PCR. The document contains 3 sets of incomplete vital signs, with no blood pressure recorded, a pulse of 103-106 "weak," a respiratory rate of 23-34 "shallow," and an oxygen saturation (O2 sat) noted to be between 51% to 78%. The PCR documents delayed capillary refill; lists skin color to be cyanotic and documents the ECG type as a "12 lead-left sided (normal)" in sinus tachycardia. The PCR states, "Interpretation: No ST Elevation" but "STEMI Alert: Yes." It states that the Respondent started an IV in the right arm and administered 324 mg of aspirin. The narrative states that the crew responded to a patient with difficulty breathing and chest pain. It states the patient was conscious and alert, sitting in a chair, complaining of difficulty breathing and intermittent chest pain. It states that vitals on scene were O2 sats in the 60s and heart rate of 104. It states the patient had "peripheral cyanosis and poor perfusion to his extremities[;] BP and O2 saturations were not consistent." It states the patient was moved by stairchair to the

stretcher and placed in the ambulance for transport. It states the patient was placed on the monitor, an IV was established and a 12-lead ECG was obtained. It states the ECG "showed no elevations but started seeing depression in leads 1, 2, v5 and v6." It states aspirin was administered and that the patient denied chest pain. It states the blood pressure and oxygen saturation levels were not accurate during the duration of the transport. It states that EtCO2 reading was 16mm/Hg with a respiratory rate of 24. It states that care was transferred to Morton Hospital ED.

49. The Department reviewed the cardiac monitor summary report for this patient encounter. It documents that the monitor was turned on at 3:08:09 PM, oxygen saturation (SpO2) appears at 3:10:47 PM but no percent value is noted. It also documents that the automatic blood pressure cuff was applied and multiple attempts at a reading occurred, with the first being at 3:11:17 PM, with no value ever obtained. According to the report, EtCO2 was attached at 3:11:37 PM, with a reading of 11mm/Hg and a low waveform, indicating low peripheral perfusion. The first ECG 4-lead tracing appears at 3:21:25 PM; the first 12-lead ECG tracing was obtained at 3:28:58 and the second 12-lead ECG is obtained at 3:41:08 PM. Throughout the report, the vital signs remain a heart rate in the low 100s, an oxygen saturation between 50 to 80%, a low EtCO2 waveform and a reading between 11-17mm/Hg with a respiratory rate in the 30s. The 12-lead ECG tracing indicates the patient is in a sinus tachycardia, no evidence of STEMI, with significant ST depression in lead V5; less so in V6 and leads II and III.

Dr. Burstein's Clinical Review and STPs

50. Dr. Burstein completed a clinical review of this patient encounter. Based on his review of the documentation, Dr. Burstein wrote, "Investigation supports that Trowbridge and Williams failed to bring in all the needed equipment, failed to start treatment at the patient's side, failed to recognize and treat hypoxia, failed to recognize and treat hypotension and failed to recognize cardiogenic shock as a possible cause of the patient's presentation." Dr. Burstein determined that the PCR was "markedly incomplete." Dr. Burstein wrote that "Paramedic Williams seemed to have shown poor understanding of cardiac diagnosis, electrodiagnosis, and pathophysiology" and that "Paramedic Trowbridge appears to have been fairly detached from the situation and did not seem to provide appropriate leadership," given he had significantly more experience as a paramedic.

51. Dr. Burstein determined that both the Respondent and Williams, on initial patient contact, violated the EMS System regulations and the STPs by their lack of assessment and treatment of this patient. Further, Dr. Burstein determined that the Respondent and Williams failed to exercise reasonable care, judgment, knowledge, and ability, with their lack of understanding of the serious nature of the patient's condition, lack of communication with one another, the Respondent's distancing himself from the situation and Williams' becoming hyper-focused on the pulse oximetry – all contributing to the clinical failures that occurred.

52. The Department determined the applicable STPs for this patient encounter are 1.0 Routine Patient Care, 3.1 Acute Coronary Syndrome-Adult, and 2.16A Shock-Adult. Under Protocol 1.0, a paramedic is to "[b]egin assessment and care at the side of the patient; avoid delay" and "[b]ring all necessary equipment to the patient in order to function at your level of certification and up to the level of the ambulance service licensure." Under all these protocols, a paramedic is to conduct a thorough patient assessment and begin treatment as

conditions are found. A paramedic is to obtain a set of vital signs and auscultate a blood pressure if other means are not adequate. A paramedic is to apply the cardiac monitor, obtain a 4-lead and 12-lead ECG tracings prior to extricating the patient to the ambulance. A paramedic is to establish IV access and administer fluid resuscitation if indicated. A paramedic is to administer supplemental oxygen if conditions of hypoxia are discovered and consider applying EtCO2 to determine adequate ventilation and perfusion. A paramedic is to form a general impression and determine the patient's acuity and transport accordingly to the most appropriate hospital.

53. Based on its investigation, the Department found that while treating a patient in respiratory distress with hypoxia and hypocapnia, the Respondent and his partner delayed oxygen administration and cardiac monitoring, and failed to recognize cardiogenic shock and cardiac etiology, versus respiratory etiology.

54. The Department determined that the Respondent and his partner did not bring in all the equipment necessary to treat the patient by not having the airway bag containing the supplemental oxygen and appropriate delivery devices.

55. The Department determined that the Respondent and Williams did not complete a thorough paramedic-level assessment, did not obtain a set of vital signs, did not apply the cardiac monitor, and did not determine the patient's hemodynamic stability on scene, before moving the patient. Instead, while his partner became hyper-focused on the pulse oximetry, the Respondent began extricating the patient without either of them providing any interventions for the patient's respiratory distress.

56. The Department determined that both the Respondent and Williams did not exercise reasonable care, judgment, knowledge, or ability in the performance of their paramedic duties.

57. With regards to the PCR, the Department found Williams documented an incomplete and inaccurate PCR, writing that the patient had "difficulty breathing and chest pain," while later in the report stating the patient "denied chest pain" and noting that the patient was a STEMI alert when he had no evidence of this. In addition, the PCR lacked a number of material data required by the EMS System regulations.

58. The Department found the Respondent also violated the EMS System regulations by failing to ensure the information in the PCR was accurate.

59. The Department determined that Williams lacked knowledge about cardiac conditions and cardiogenic shock, and whether or not the Respondent had such knowledge, he failed to act on it to help this patient.

Respondent's Prior Compliance History

60. On March 15, 2023, the Department issued the Respondent a Notice of Agency Action for Proposed Temporary Revocation of EMT Certification, based on an investigation in which it determined that the Respondent had violated the EMS System regulations and the STPs and providing false or misleading information to the Department and other entities in the EMS System. This determination was based on the Department's findings that the Respondent discouraged the elderly COVID-19 patient in that case from going to the hospital by falsely telling the patient that per service policy, they could only transport him to Tobey Hospital and not the hospital more appropriate to his needs, where his doctors and medical records are. The

Department also found that the Respondent told the patient he would be saving him a $1,000 ambulance transport bill by not being transported and that he would wait a long time in the ED. In addition, the Department found both the Respondent and his partner failed to appropriately follow the STP 7.5 procedures for obtaining a valid patient refusal, by failing to account for the patient's capacity and failing to obtain a valid signature. The Department found both the Respondent and his partner violated its COVID-19 masking requirements for personnel providing patient care, by failing to wear masks and claiming an "exemption" which does not exist. The Department found the Respondent and his partner thereby placed bystanders, the patient, and any other subsequent contacts, including other patients, other EMS personnel and hospital staff, at risk for COVID-19 infection. Finally, the Department found the Respondent and his partner provided false information to both the patient and his family member, as well as the Department in their interviews. The Respondent appealed, and ultimately, on June 6, 2023, entered into a Settlement Agreement with the Department, in lieu of proceeding to an administrative hearing, under which his EMT certification, at all levels, was temporarily revoked for six months, and he was required to complete extensive remediation. The Respondent met the terms of the Settlement Agreement and his temporary revocation was ended on December 15, 2023.

61. On November 4, 2016, the Department issued the Respondent a Letter of Reprimand, based on an investigation following up on a serious incident report submitted by Fall River Fire Department, stating that the Respondent and his paramedic partner had made numerous EMS System regulation and STP violations. Specifically, the service and the Department found that the Respondent and his partner had been dispatched to a patient who had suffered from a mechanical fall while at home and sustained facial trauma. The Department found the patient was walked to the ambulance stretcher by the Respondent and his partner. The patient was non-English speaking and legally blind, and the distance the patient walked was approximately 10 feet, as admitted by the Respondent and his partner. The Department found the Respondent failed to complete a thorough assessment of the patient and did not recognize the seriousness of the patient injury based on the mechanism of impact to the patient's face. Finally, the Department determined that despite what the Respondent documented, the patient did not refuse the initiation of an IV, and that the documentation of such alleged refusal would have been insufficient if he had. The patient was legally blind and told had told Fall River EMS during its investigation that he was unable to sign a document and had not signed documents in years. He told the service he did not get asked about, or refuse, the IV. The patient also was non-English speaking, and unlikely to have understood an explanation of the purpose of the IV, in order to refuse IV care. The Respondent's partner did not see any IV equipment open and out and did not hear any conversation about the IV between the Respondent and the patient. Finally, the PCR contained no documentation of Respondent having provided any explanation to the patient about his medical condition, the need for the IV and the risks of the refusal. Therefore, the Department has determined that the Respondent submitted false information to his ambulance service, by including this document in the PCR, and made false statements to the Department in the course of this investigation, in violation of the EMS System regulations.

Findings in the instant case

62. In reaching its determination in the present case, the Department relied upon the following findings:

a. The Respondent defaulted on his duties as a paramedic member of the dispatched ambulance crew by failing to bring all equipment to the side of the patient to be able to assess and treat at his level of certification; failing to perform a thorough,

paramedic-level assessment of this patient; failing to obtain a set of vital signs; apply the cardiac monitor, and determine the patient's hemodynamic stability on scene, before moving the patient; and ultimately failing to recognize cardiogenic shock and cardiac etiology, versus respiratory etiology, in violation of the STPs, all of which amounted to critical failures to exercise reasonable care, judgment, knowledge, or ability in the performance of duties or to perform those duties within the scope of his or her training and certification, and in accordance with the STPs, in violation of 105 CMR 170.940(C).

b. The Respondent violated the EMS System regulations by failing to ensure the PCR was accurate, without the contradictions it included, and that it included the data elements pertaining to the call as specified in administrative requirements of the Department, as "all EMS personnel on the ambulance or ambulances dispatched to the patient are responsible for the accuracy of the contents of their respective patient care reports, in accordance with their level of certification. document a PCR," in violation of 105 CMR 170.345(B) and 105 CMR 170.940(P).

c. The Respondent's pattern of repeated failures to appropriately assess and treat patients over now three cases determined by the Department, and despite remediation ordered and completed after the first two cases, amount to actions that endanger the health or safety of the public, in violation of 105 CMR 170.940(F).

63. EMTs occupy a position of special public trust within their communities. The Respondent, by his actions, has proven he cannot be trusted to safely care for patients.

64. The Respondent remains certified as an EMT in Massachusetts. However, given the above facts, he cannot safely perform the duties of an EMT.

63. The Commissioner finds that the conduct described herein endangers the public health and safety and that immediate suspension of the Respondent's EMT certification is necessary to prevent endangering the public health and safety.

**WHEREFORE, based upon the Commissioner's findings, it is ORDERED that:**
**The certification of William Trowbridge as an Emergency Medical Technician, at all levels, is suspended immediately.**

## GROUNDS FOR IMMEDIATE SUSPENSION AND TEMPORARY REVOCATION OF THE RESPONDENT'S CERTIFICATION AS AN EMERGENCY MEDICAL TECHNICIAN

The following are separate and independent grounds for the immediate suspension and temporary revocation of Respondent's EMT certification:

A. Respondent's failure to adhere to the STPs constitutes a failure to exercise reasonable care, judgment, knowledge, or ability in the performance of his duties and to perform those duties within the scope of his training and certification, in violation of 105 CMR 170.940(C).

B. Respondent's actions constitute a failure to meet the requirements of 105 CMR 170.800 or 170.900, in violation of 105 CMR 170.940(B).

C. Respondent's actions fail to meet the requirements of 105 CMR 170.800(C) which states, in relevant part "EMS personnel working in connection with a licensed service shall provide care in conformance with the Statewide Treatment Protocols..."

D. Respondent's actions violated the EMS System regulations' duty to assess, treat and transport emergency patients, in accordance with the STPs, as set out in 105 CMR 170.355(A), in violation of 105 CMR 170.940(S).

E. Respondent violated the EMS System requirements addressing complete and accurate documentation of a PCR in 105 CMR 170.345(B), which states in pertinent part, "Each written patient care report shall, at a minimum, include the data elements pertaining to the call as specified in administrative requirements of the Department. All EMS personnel on the ambulance or ambulances dispatched to the patient are responsible for the accuracy of the contents of their respective patient care reports, in accordance with their level of certification...," in violation of 105 CMR 170.940(P).

F. Respondent's failure to provide thorough paramedic-level assessment and treatment to an emergency patient for whom 9-1-1 was called, in this case and in two previous cases determined by the Department, even after completing ordered remediation by the Department after the previous two cases endangers the health or safety of the public, in violation of 105 CMR 170.940(F).

**WHEREFORE** the Department of Public Health respectfully requests that:

A. Respondent's certification as an EMT at all levels, be temporarily revoked, for a minimum of two (2) years ("the temporary revocation period");

B. No sooner than 90 days prior to the end of the minimum temporary revocation period in accordance with paragraph A., the Respondent shall successfully complete three (3) scenarios in a simulation laboratory evaluation ("sim-lab"), demonstrating competency, in a sim-lab of his choosing (with prior Department approval) that includes video and audio. Once completed, the sim-lab must be reviewed by Dr. Burstein to verify competency. **A written description of the sim-lab shall be sent, for prior approval, to Renée Atherton, at OEMS.** It is the Respondent's responsibility to get himself prepared for the sim-lab ahead of time.

C. After completion of the temporary revocation period only, Respondent must submit a written request to OEMS to terminate the revocation of his EMT certification. The request must include:

1. documentation of successful completion of the sim-lab evaluation outlined in paragraph (B) above;

2. documentation of having completed the required continuing education, remediation, and/or re-entry procedures in place at that time termination of revocation is requested;

3. copies of current CPR and ACLS cards; and,

4. certified information from the licensing or certification board for each jurisdiction in which Respondent has ever been licensed or certified as an EMT, sent directly to OEMS, identifying his license or certification status and discipline history, and verifying that his license or certification to function as an EMT is in good standing and free of any restrictions or conditions.

D. Respondent shall bear any costs associated with the requirements of the conditions required for termination of the revocation period.

E. The Department will notify the Respondent of its decision on any request(s) to terminate the temporary revocation period. The Department reserves the right to impose probationary conditions on the Respondent's EMT certification that are reasonably necessary to protect the public health and safety.

Date: 4/23/2024

By: _____
Robert Goldstein, MD, PhD
Commissioner
Department of Public Health