COMMONWEALTH OF MASSACHUSETTS

DIVISION OF ADMINISTRATIVE LAW APPEALS

Middlesex, ss.

Department of Public Health,
Petitioner, Docket No.: PHET-24-0314

v.

Thomas McLean,
Respondent.

Appearances:

For Petitioner: Widmaier Charles, Esq; Paul Cirel, Esq
For Respondent: Matt Murphy, Esq.

Administrative Magistrate:

Eric Tennen

SUMMARY OF DECISION

The Department of Public Health has proven that some of the Petitioner's conduct during an EMS call was sanctionable, but not all. Specifically, he did not fail to begin care at the patient's original site, did not submit an inaccurate patient care report, and did not commit conduct that generally endangers the public health. However, the Department did prove that he failed to exercise reasonable care and violated several statewide treatment protocols and regulations. The Department may sanction him for these violations.

DECISION

The Respondent, Thomas McLean, timely appeals a Notice of Agency Action issued by the Department of Public Health (DPH) proposing to revoke his paramedic license. I held a live hearing on October 6 and 7, 2025. DPH called two witnesses: Kenneth Long, compliance investigator, and Dr. Jonathan Burstein, medical director for the office of emergency medical services (OEMS). The Respondent testified on his own behalf and also called an expert, John

Everlove. The parties also stipulated to some facts. I entered exhibits 1-18 at the hearing and 19-20 after the hearing through the parties' post-hearing submissions. The parties submitted closing briefs on January 9, 2026, at which point I closed the administrative record.

FINDINGS OF FACT

1. Mr. McLean has been certified in Massachusetts as an emergency medical technician (EMT) for seven years. He has been a certified paramedic since 2021.[1] (McLean; Ex. 10.)
2. At the time of this incident, Mr. McLean worked out of Lawrence General Hospital. (McLean.)

Introduction: October 29, 2023 incident

3. This case arises out of a call on October 29, 2023. That night, Mr. McLean was working with a partner, Shaun Dean. (McLean; Exs. 9 & 10.)
4. They were dispatched for a call of an "unknown problem/person down." While on the way, they were told it might be a cardiac arrest. (Stipulated facts; McLean.)
5. Mr. Dean was the more experienced paramedic. Typically, that means he would run the call and designate each person's task. Here, he suggested he would "monitor," which meant he would be in charge of looking at the heart monitor readings, instructing others, and generally managing the call; he suggested Mr. McLean do the "skills," which meant Mr. McLean would be in charge of tasks such as inserting an IV and airway management. (McLean.)

[1] There are different levels of certification: EMT basic, EMT advanced, and paramedic. Mr. McLean held all these certifications at some point and presently holds the highest certification, paramedic.

6. When they got there, the fire department and police were on scene, but no one was tending to the patient. They were told the family had last seen her the night before around 9:00pm. They were also informed that, when first responders arrived on scene, the patient was hanging from a cord tied around a doorknob. Someone cut her down, removed the cord from her neck, and moved her body to a flat surface. She had ligature marks and was blue in the face. (Stipulated facts; McLean; Ex. 2.)
7. The patient was in a "mud room" just off the driveway. It was extremely narrow and messy. The patient's body was in a very narrow space where no one could stand beside her. (McLean.)
8. Mr. McLean and his partner were able to tell that she was not breathing and did not have a pulse. However, there were no other obvious signs of death, such as rigor mortis. That meant they were going to provide aid but, because of the small space, could not do it where she was located. The decision was made to move her to the driveway. (McLean.)
9. Mr. McLean started setting up his equipment in the driveway while Mr. Dean and others moved the patient outside. Once outside, they immediately began treating her. (McLean.)

<u>DPH Regulations and Statewide Treatment Protocols</u>

10. DPH regulations govern emergency medical services (EMS).[2] 105 Code of Mass. Regs. § 170.000 *et seq*.

[2] EMS refers to "pre-hospital assessment, treatment and other services utilized in responding to an emergency or provided during the emergency or interfacility transport of patients to appropriate health care facilities." 105 Code of Mass. Regs. § 170.020.

11. The regulations require, among other things, that EMS providers comply with the statewide treatment protocols (STP). Failure to follow them may be grounds for discipline. (Ex. 1; Long; Burstein.)

12. The STPs typically give a step-by-step guide to handling a particular situation. Deviation is not allowed except in very narrow circumstances. Even then, under STP 1.0, an EMS provider must first speak to their medical director before deviating from protocol:

> On occasion, good medical practice and the needs of patient care may require deviations from these protocols, as no protocol can anticipate every clinical situation. In those circumstances, EMS personnel deviating from the protocols should only take such actions as allowed by their training **and** only in conjunction with their on-line medical control physician.

(Ex. 1 (emphasis in original); Burstein.)

Specific allegations of misconduct

13. DPH alleges that Mr. McLean committed misconduct in several ways that warrant discipline. I lay out the facts of each alleged act of misconduct in the sections that follow.

Initial treatment of the patient at the original point of contact.[3]

14. As noted, when Mr. McLean and his partner arrived on the scene, the patient had already been moved once by the first responders. She was originally found in the mud room by the interior door up a few steps; the first responders moved her down the steps and laid her on the floor. She was in a narrow hallway where it was difficult to even stand by her side. (McLean.)

[3] DPH does not appear to press this point in its closing brief, but it was part of the allegations and an issue at the hearing. Therefore, I will address it in my findings.

15. While in that hallway, Mr. McLean and his partner were able to do enough to determine there were no signs of death, e.g. rigor mortis. That meant the patient required treatment, but there was no space to do what they needed to do. It is not clear if Mr. Dean made the decision to move her himself or in conjunction with Mr. McLean. Nevertheless, with the help of some other first responders, Mr. Dean moved the Patient to the driveway just outside the door; there they had space to treat her. (McLean.)

16. They then immediately began performing the standard treatments. For example, Mr. McLean hooked the patient up to an IV drip. She was then connected to a cardiac monitor. After, they intubated her so they could begin CPR. (McLean.)

Compliance with STP 4.8 regarding spinal column/cord injuries

17. There is no dispute the patient had been found with a cord wrapped around her neck and hanging from a doorknob. There is also no dispute that when the patient was cut down, she had ligature marks around her neck. (Stipulated facts.)

18. This situation triggered STP 4.8 related to possible or known spinal column/cord injuries. (Ex. 1; Burstein; Long.)

19. The protocol requires spine restriction by applying a cervical collar. First, the providers must manually stabilize the patient's neck in the position they were found. That just means they need to hold the patient's head and neck still. Then, they must "assess for correct size and properly apply a cervical collar." (Ex. 1; Burstein.)

20. Mr. McLean agrees they never put a cervical collar on the patient. He explained that when she was first found in the narrow hallway, it was extremely difficult to do anything at that location. Once she was moved, it was not their priority. It was a difficult call, and

they were focused on other things, like troubleshooting failures in their attempts to resuscitate the patient.[4] (McLean.)

21. Mr. Everlove backed up Mr. McLean's decision. He was hesitant to say this was a situation calling for a cervical collar since it was not clear there was an injury to the neck requiring immobilization. (Everlove.)

22. Since no one was present when the patient hung herself, and Mr. McLean did not see how the first responders interacted with her, there was no question she *could* have spinal cord injury. Again, she was found hanging and had ligature marks around her neck. While it may be that the patient here did not experience enough of an injury to require immobilization, the STPs do not make room for clinical judgment in this scenario. The STPs require a cervical collar in every situation where there might be a spinal cord injury. (Burstein.)

23. It is not clear whether there was enough space to put the collar on while the patient was in the narrow hallway. I do not fault Mr. McLean or his partner for failing to put it on there. But once she was in a space where they could treat her, part of that treatment needed to include the cervical collar. (Ex. 1; Burstein; Long.)

24. And while Mr. McLean and his partner were dealing with a difficult situation in trying to manage several different treatment aspects, that does not excuse the failure to follow this specific STP at any point. (Burstein.)

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[4] Mr. McLean added that when they got to the hospital, the hospital also did not place a cervical collar on the patient. That does not help him because the hospital is not required to follow the STP. Moreover, it may be that the hospital should have placed a collar on the patient.

Was the patient in ventricular fibrillation at any point requiring defibrillation?

25. Whenever there is a cardiac event, a patient is immediately connected to a cardiac monitor. This is initially done with two pads. The pads allow EMS personnel to see if there is any aortic activity. (Burstein.)

26. The heart is divided into upper and lower chambers that beat in unison. Fibrillation occurs when the chambers are firing individually instead of in conjunction with each other. If the upper chambers are misfiring, that is known as atrial fibrillation; if the lower chambers are misfiring, that is known as ventricular fibrillation (Vfib). Sometimes the heart is not beating at all. That is called asystole. (Burstein.)

27. There are different treatment responses depending on the noted rhythm. Vfib calls for electrical defibrillation (more colloquially known as "shocking the heart"). However, if the heart remains in asystole, no shock is called for. Instead, cardiopulmonary resuscitation (CPR) is administered in an attempt to get the heart pumping. (Burstein.)

28. Paramedics are trained to read a heart monitor. It shows lines fluctuating, or not moving at all, that reflect the activity of the heart. In the middle of CPR, when the heart is being artificially pumped, the lines are aggressively fluctuating. (Ex. 4; Burstein.)

29. However, CPR requires an occasional pause to see if the heart might have some activity on its own. If, during the pause, the heart remains in asystole, there will be no, or minimal, fluctuation. If there is Vfib, the lines will fluctuate. But, also, the monitor may produce what is called an "artifact." This is when the body is moved in such a way to make the lines fluctuate, but it is clear the movement is not on account of natural heart activity. (Burstein.)

30. Paramedics are supposed to be able to accurately read a cardiac monitor to identify the different patterns and respond accordingly. The cardiac monitor stores the information from an incident so that the same lines appearing during a call can be printed out and evaluated after the fact. (Ex. 4.)

31. In this case, neither Mr. Dean nor Mr. McLean ever saw rhythms that they believed were Vfib. In their assessment, the patient remained in asystole. Thus, they continued performing CPR but never administered electrical defibrillation. (McLean; Exs. 4, 6, & 9.)

32. Mr. McLean said that he reviewed the printouts after the incident and saw what he would characterize as artifacts, but not Vfib. He said the patient was being moved around a lot. He also worked many cases where he identified Vfib and provided electrical defibrillation; this was not one of them. (McLean.)

33. Mr. Everlove agreed that, on balance, the printouts more likely reflected artifacts and not Vfib. (Everlove.)

34. On the other hand, Mr. Long and Dr. Burstein both identified multiple instances of Vfib in their review of the printouts. In fact, at the hearing, I had Dr. Burstein specifically point to some parts of the printout where he interpreted it as Vfib. He did so and credibly explained his conclusions, showing which parts were Vfib, which were not, and what artifact might look like. (Ex. 4; Long; Burstein.)

35. The medical director for emergency medical services at Lawrence general hospital, Johannah Merrill, also investigated this incident and wrote a report. She too concluded that the printouts showed Vfib throughout the case. (Ex. 5.)

36. I find that the patient did experience Vfib which required electrical defibrillation.[5]

37. That said, almost everyone agreed that it is common for partners to divide tasks during a call and that one paramedic should be able to rely on the other paramedic's assessment of a situation. (McLean; Burstein; Everlove.)

38. In this case, Mr. Dean was in charge of "monitoring," which includes looking for signs of Vfib, and Mr. McLean was tasked with other things, such as maintaining the patient's airway. Thus, Mr. McLean relied on Mr. Dean's assessment of the cardiac monitor.

Intubation of the patient

39. When a patient is in cardiac arrest, and requires CPR, they must be intubated. This is done with an endotracheal tube (ET tube). (Ex. 1; General testimony.[6])

40. An ET tube is inserted into the trachea through an opening just past the vocal cords. Next to that is an opening to the esophagus. Because the openings are next to each other, the treater must be careful not to accidentally insert the tube into the wrong opening. (General testimony.)

41. Once the tube is properly placed, it is connected to a mask and pump that allows air to be artificially pushed into the patient's lungs. (General testimony.)

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[5] On balance, I credit Dr. Burstein's testimony, corroborated by Mr. Long and Dr. Merrill's similar opinions. Among other things, his explanation of why the fluctuations were more likely Vfib than an artifact made more sense. Mr. McLean was unable to see the monitor during the call and, in fact, it was Mr. Dean's job to look at the monitor anyway. Mr. Everlove's opinion that it was artifact depends on accepting a version of facts I do not necessarily adopt—that every instance which he identified as artifact was when the patient was being moved.

[6] There is some evidence which is not in dispute, and multiple witnesses explained. Instead of referring to each specific witness, I refer to this as "general testimony."

42. The esophagus leads to the stomach, and pumping air into a tube placed in the esophagus would pump air into the wrong place. (General testimony.)

43. Once placed, a paramedic is supposed to confirm correct placement in a few ways. In every case, a paramedic must consult the capnography meter. When air is pumped into a patient's lungs, even artificially, the patient expels CO2, just like we all do when we breathe. The capnography meter measures the amount of CO2 the patient is expelling. When the pump is working correctly, the capnography meter should measure CO2 levels at least over 10 millimeters of mercury (MM). If CO2 levels are consistently below that, it indicates there is a problem with the tube or its placement. (General testimony.)

44. In addition to checking the CO2 readings, a paramedic must use at least two other methods of verification. Possible methods include visualization (looking to see if it is in the right place), auscultation (listening for air in the lungs with a stethoscope), looking for condensation in the mask, or consulting a colorimetric strip.[7] (Ex. 1; General testimony.)

45. The capnography reading is the most accurate way of determining if air is properly flowing. If the measurements are low, it indicates there is a problem, even if the secondary methods of confirmation suggest air is flowing. In fact, the secondary methods are secondary for a reason; sometimes they can "fool" a paramedic. (Burstein.)

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[7] A colorimetric strip is an older, less reliable technology. It is a strip attached to the pump that is supposed to change colors from purple to gold when exposed to CO2. Thus, if enough CO2 is being expelled, the strip changes color; if not, it remains purple. (General testimony.) The STPs used to specifically list it as a method of confirmation but, because it is not entirely reliable, they no longer do. (Burstein.) In fact, Mr. McLean was not really familiar with it; Mr. Dean was, and Mr. McLean relied on Mr. Dean's experience in using and reading it. (McLean.)

46. If a tube is incorrectly placed, the CO2 readings may appear correct at first, because there may be some residual CO2 in the stomach that is expelled. But even then, the levels would drop off quickly indicating a problem. (General testimony.)

47. At other times, a tube may be properly placed but, for a variety of reasons, later become dislodged. This can happen through human error or even just by accident if the body is moved in such a way as to affect the tube's placement. In those situations, the tube might be resting just outside the trachea or even enter the esophagus. A paramedic should notice this if there are initially good CO2 readings but then they suddenly drop off. (General testimony.)

48. If there are low CO2 readings, paramedics are trained to troubleshoot by using the various methods of verification described above. That normally confirms proper or improper placement so the paramedics can respond accordingly. (General testimony.)

49. In this case, Mr. McLean was in charge of intubating the patient. He explained he had a good view of the patient's vocal cords and visualized the tube going in. The capnography immediately gave a reading over 10mm. (Exs. 4 & 6; McLean.)

50. However, it almost immediately dropped off. It began giving low readings around 2mm and 4mm. (Exs. 4 & 6; McLean.)

51. Mr. McLean did use some secondary methods of verification. He listened for air in the lungs and said he heard it. He also saw condensation in the mask. Mr. Dean attached a colorimetric device and said that the color was approaching or almost to yellow. (Exs. 7-9; McLean.)

52. The only thing Mr. McLean did not do was revisualize the tube; essentially, he did not look to see if it was in the right place. In retrospect, he wishes he had. (McLean.)

53. Given the low readings, but secondary confirmation, Mr. McLean says they continued to troubleshoot the issue. However, he did not explain what he meant by "troubleshoot." Rather, he apparently meant that they kept checking to see if air was flowing into the lungs, but did not do anything else. For example, he could have revisualized—looked to see if the tube was properly placed. (McLean.)

54. Mr. McLean also suggests the tube could have been malfunctioning. Equipment can malfunction. Mr. McLean says he heard of other times when that occurred. Mr. Everlove even described a recent call he was on in which he ultimately placed three tubes because it appeared the others were malfunctioning. Ambulances typically have multiple tubes for this very scenario. (McLean; Everlove.)

55. If Mr. McLean really believed the tube was malfunctioning, he should have replaced it. He did not do that here. The fact that he did not means he either really did not believe it was malfunctioning or he failed to take a necessary step.

56. There was some testimony that a tube might be properly inserted in the trachea but still produce low CO2 readings. In addition to equipment malfunction, Mr. Everlove testified that if a patient had been without a pulse for too long, their body may have lost the ability to produce CO2 so that even if air is being pumped into the lungs, no CO2 will be expelled. (Everlove.)

57. However, Dr. Burstein and Mr. Long disagreed. They explained that is simply not the case. Even a non-viable patient will expel at least 10mm of CO2. (Burstein; Long.)

58. There is corroboration for this. Here, the patient was probably non-viable when she arrived at the hospital. For a variety of reasons, hospital staff inserted a new tube. When they did that, they instantly registered CO2 levels of over 10mm. (Ex. 7; Burstein; Long.)

59. I find it is more likely than not that Mr. McLean did not properly place the tube in the first instance.[8] Alternatively, if it was somehow properly placed, it must then have been dislodged for some reason; indeed, Mr. McLean explained they moved the patient around a lot.

60. This was a case in which the secondary confirmation methods appear to have "fooled" Mr. McLean into thinking the tube was properly placed.[9]

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[8] One plausible theory is that the tube could not advance much past the trachea's opening because the hanging damaged the trachea in some way. Thus, Mr. McLean could have placed the tube into the opening of the vocal cords, making it look like it was properly placed, but the tube could not advance down far enough to be properly placed. (Ex. 7.)

[9] Mr. McLean argues he properly placed the tube. He says he knows this because Lawrence General Hospital has a practice that the ER doctor must verify proper tube placement when the patient is transferred into their care. Here, Dr. Benjamin Bautz purportedly checked proper placement and "signed off" on it. (Ex. 11; McLean.) Mr. McLean submitted a post-hearing letter from Meaghan Jones, a nurse at Lawrence General. She stated this is the hospital's practice. (Ex. 19.). However, DPH submitted a counter letter from Paul Brennan, the hospital's system director, that explained there is no such written policy and that a physician's signature on the form does not constitute evidence of proper (or improper) placement. (Ex. 20.)

I do not credit Mr. McLean's version of events. For one, I credit Dr. Burstein and Mr. Long that the low CO2 readings at the time show improper placement. Also, I have no way of knowing what Dr. Bautz saw and what his signature meant. It is possible it looked like the tube was properly placed if it was through the vocal cords but limited from going further because of throat trauma. Thus, Dr. Bautz may have mistakenly thought the tube was properly placed when it was not. Finally, Mr. Brennan's letter raises enough doubt that I cannot credit Ms. Jones' letter.

61. I do not believe the tube was malfunctioning. But even if that were the explanation for the low CO2 levels, that would have required placing a new tube, which Mr. McLean also failed to do.

62. A paramedic must be able to properly place an ET tube; they must also be able to properly fix it if the tube is not working. Mr. McLean did not take steps to fix the problem such as revisualizing, reintubating or using a different tube.

Providing high quality CPR

63. One consequence of not properly intubating the patient is that air is not flowing to the lungs. That makes it impossible to provide proper CPR. (Burstein; Long.)

64. In addition to that, the STPs and the standard of care require CPR to be performed in a certain way. For example, paramedics should not discontinue CPR for at least 20 minutes. (Long.)

65. Moreover, CPR must be continuous, without interruptions. Per STP 1.1, It is expected that at least 8 minutes of uninterrupted CPR will be performed on scene. (Ex. 1.)

66. Here, there was a two-minute pause in CPR. This occurred almost immediately at the beginning of the process. It was verified through the monitor printout that shows the CPR pauses to the second. (Ex. 4; Long.)

67. Mr. McLean admitted there was some pause in the CPR but said it was likely when the patient was being transferred into the ambulance and that it was for less than two minutes. However, the data belies that explanation, and Mr. McLean could not explain the discrepancy. (McLean.)

Patient Care Report

68. Every paramedic, or paramedic team, is responsible for writing a patient care report (PCR) as soon as possible after a call. There are certain things that every PCR requires per regulation. 105 Code of Mass. Regs. § 170.345(B).

69. The reports are generally filled out electronically and the software allows the author to fill in the appropriate sections in an organized way. There is also a narrative section where the author can provide the details of the call. (Ex. 6; Long; McLean.)

70. One thing that must be reported is a patient's vital signs, which must be measured every few minutes. Here, Mr. McLean did take the patient's vitals, but at some point, there were no readings (e.g. no pulse, no blood pressure, etc.). He reported the first measurements; the second time he reported some of them; the third time he simply put her CO2 level (2mm), which was the only thing to report because nothing had changed. (McLean.)

71. In the narrative, Mr. McLean wrote that a "colorimetric device used to confirm placement as well." (Ex. 6.). That statement was true—Mr. Dean did use it to confirm placement.

72. The narrative also stated that "manual c-spine precautions are taken." (Ex. 6.) That statement was also true—Mr. McLean explained that while they never placed a cervical collar on the patient, they instead steadied her neck throughout manually.

73. The narrative noted that the "patient remains asystolic throughout the arrest." (Ex. 6.) This appears to be Mr. McLean documenting what Mr. Dean had represented to him.

Mitigation

74. Mr. McLean offered significant mitigation evidence.

75. By all accounts, he has never had any prior discipline nor any reports that discipline was warranted. (McLean.)

76. Some of Mr. McLean's failings can be attributed to his reliance on Mr. Dean, who was the senior paramedic running the call. Mr. McLean trusted him to watch the cardiac monitor for signs of Vfib. He also relied on Mr. Dean's confirmation of the colorimetric strip for ET tube placement verification since he was unfamiliar with it. And, it appears it was likely Mr. Dean's decision to move the body from the narrow hallway in which it was found.

77. He also submitted several strong letters of support from colleagues. (Ex. 19.)

78. Finally, Mr. Everlove is an extremely experienced paramedic with years of hands-on work in addition to providing high-level instruction. In his experience, he believes revoking Mr. McLean's license in this situation is unusually harsh. Rather, this seems to be the kind of case that warrants instruction, supervision, and oversight. (Everlove.)

DISCUSSION

DPH has the burden of proof by a preponderance of the evidence that it has grounds to revoke Mr. McLean's certification. *Dept. of Public Health, Office of Emergency Med. Services v. Walsh*, PHET-23-0269, 2023 WL 5170541 (Div. of Admin. Law Apps. Aug. 1, 2023). Moreover, the Presiding Officer need only find a single ground for discipline to affirm DPH's actions. 105 Code of Mass. Regs. § 170.770(B). I find that DPH has proven some of the allegations against Mr. Mclean, but not all. Still, that is enough to warrant a sanction.

1. Mr. McLean did not fail to begin care at the Patient's original site nor fail to promptly apply the cardiac monitor leads.

DPH alleged this failure in its notice of agency action, though it did not press it in its closing brief. Nevertheless, I find that it did not prove this point. I credit Mr. McLean that it would have been impossible to render any aid at the site where the patient was located or attach the cardiac monitor leads. There was no space for anyone to even stand beside her, let alone bring in equipment to intubate her and perform CPR. If they left the patient there, she would not have received any treatment. The STPs require EMTs to begin care at the patient's original site. To the extent they require the EMTs to properly assess the situation and identify how they can care for the patients, that was done here. I do not interpret them to mean EMTs must care for patients wherever they are, even if they cannot properly care for them in that location. Moving the patient to an open area was part of her care.

2. Mr. McLean did not fail to properly monitor the patient's heart rate.

DPH also alleges that Mr. McLean was equally responsible for monitoring the Patient's heart rate. Had he done that, he would have seen the Patient experienced Vfib which warranted electrical defibrillation. While I find the Patient did experience Vfib, and should have received electrical defibrillation, I do not find Mr. McLean at fault for that. If EMTs are allowed to divide up tasks, which was done here, then Mr. McLean should not be punished for a task Mr. Dean, the senior EMT, oversaw. Here, Mr. Dean was supposed to read the heart monitor. This call was chaotic and Mr. McLean was focused on the ET tube. It was reasonable for him to rely on Mr. Dean in this instance.

3. Mr. McLean complied with the regulation concerning the patient care report.

EMTs are required to submit patient care reports that are accurate and "at a minimum, include the data elements pertaining to the call as specified in administrative requirements of the Department." 105 Code of Mass. Regs. § 170.345(B). I do not interpret certain statements in Mr. McLean's report to be inaccurate or misleading. First, the narrative reported the vital signs that Mr. McLean was able to measure. If he did not detect a pulse, for example, then there was no pulse to report. Second, the narrative accurately states that he and his partner took certain steps, e.g. manual c-spine precautions were taken. That much is true and accurate; he did take c-spine precautions. For purposes of the report, that is sufficient. Whether or not he appropriately carried out these steps is a different issue, which I discuss below.

The report also wrongly stated that the patient was in asystole the entire time. DPH argues that Mr. McLean should have noted that this was what Mr. Dean told him and if that was not the case, he "negligently" relied on what he believed to be true. However, I do not find this statement means Mr. McLean submitted an inaccurate report. I see nothing in the regulations that require an EMT to contextualize their narratives so that it explains who observed what, as opposed to trying to summarize the collective actions of the call. And because I find Mr. McLean did rely on Mr. Dean for this part of the report, I do not find that he was negligent because he relied on what he reasonably believed to be true.

4. DPH has failed to prove Mr. McLean's multiple critical failures represents a "condition or action that endangers the health or safety of the public."

DPH may discipline an EMT for any ""condition or action that endangers the health or safety of the public." 105 Code of Mass. Regs. § 170.940(F). DPH alleges Mr. McLean's actions fall under this regulation. As I explain below, DPH has proven that Mr. McLean failed to follow

many STPs and did not provide reasonable care in this specific case. But "[w]hile the regulations do not define public health, at the very least the phrase refers to a broader concept than only the health of one person. Thus, an EMT's failure to adequately perform his duties with respect to a particular patient . . . may place him in violation of one or [more regulations], but does not necessarily mean he is a threat to public health generally." *Dept. of Public Health, Office of Emergency Med. Services v. Ruiz*, PHET-20-0298 (Div. of Admin. Law Apps. Jan. 14, 2021). Here, DPH did not provide evidence that Mr. McLean's deficiencies in this one call were part of a pattern or on account of general professional inadequacies. *Contrast Dept. of Public Health, Office of Emergency Med. Services v. Cameron*, PHET-13-256 (Div. of Admin. Law Apps. Feb. 13, 2014) (EMT posed threat to public health based on misconduct over repeated calls). His actions on this one call are sanctionable, but I cannot conclude on this record that they present a general pattern that endangers the health and safety of the public. According to Mr. Everlove, this is the kind of case that should warrant training and oversight. While I take no position on what type of sanction DPH should impose, I credit Mr. Everlove's testimony that Mr. McLean is a generally competent EMT who can be retrained.

5. Mr. McLean failed to exercise reasonable care and did not comply with the STPs.

There is no dispute that Mr. McLean is required to follow the STPs and, relatedly, exercise reasonable care, judgement, knowledge and ability in performing his duties. *See* 105 Code of Mass. Regs. §§ 170.940 (B), (C), & (S). There were several points in this call where he did not follow the STPS and did not provide reasonable care.

First, Mr. McLean did not comply with the STPs regarding C-Spine stabilization. He was required to place a cervical spine collar on the patient since he was aware there was a

possibility of a c-spine injury. While he may have been unable to do so right away because of the patient's location, there was no excuse for his failure to do so after she was moved to the driveway. Mr. McLean indicated he was focused on other things. I do not doubt an EMT in this situation is juggling multiple duties. Regardless, he is expected to perform the tasks that are required, no matter what. This situation clearly called for a spine collar.

Second, Mr. McLean failed to perform competent CPR. Putting aside the issue with intubation, CPR is supposed to be continuous for at least 20 minutes. Here, there was a two-minute pause in CPR towards the beginning of the call. I do not credit Mr. McLean's explanation that the pause likely occurred when they were transferring the patient to the ambulance. The pause occurred too early in the call to have occurred during the transfer. Also, even a pause to transfer the patient should not delay CPR for that long. He did not comply with the STPs and failed to exercise reasonable care.[10]

Finally, Mr. McLean failed to competently deal with the patient's intubation. He did not correctly place the ET tube and, when that became apparent, failed to fix it. This task was clearly Mr. McLean's responsibility. Alternatively, there are lots of ways in which a tube might be improperly placed and several more ways in which it might be dislodged. I find it was never correctly placed, but even if it was, something happened during the call that caused it to come out. Mr. McLean failed to revisualize the tube. While not a required method of secondary confirmation, failure to revisualize might not be a problem if there are appropriate CO2 levels. But here, with the levels so consistently low, he failed to exercise reasonable care by not

[10] It is not clear if he otherwise performed CPR for at least 20 minutes but DPH did not advance any allegations about the total length of time CPR was performed.

revisualizing. I disagree with Mr. McLean that a possible explanation for the low CO2 levels is that the tube may have malfunctioned. Yet, even if it did—and Mr. McLean believed that might be why the readings were so low—he absolutely should have taken out the "malfunctioning" tube and placed a new one. Even under his theory, he did not respond correctly.

ET tube placement is a basic EMT function. While I do not doubt Mr. McLean has correctly placed countless ET tubes in the past, he did not do so here. Worse, he did not accept that he may have made a mistake, so he failed to take corrective steps. He did not comply with the STPs and failed to exercise reasonable care.

CONCLUSION AND ORDER

DPH's Notice of Agency Action is **affirmed** for the reasons identified in this decision. It may sanction Mr. McLean. It should consider that he was not found responsible for each allegation and also take into account the mitigating evidence presented in his favor.

SO ORDERED.

DIVISION OF ADMINISTRATIVE LAW APPEALS

Eric Tennen

Date: February 6, 2026 _____

Eric Tennen
Administrative Magistrate