COMMONWEALTH OF MASSACHUSETTS

Middlesex, ss. **Division of Administrative Law Appeals**

Department of Public Health,
Petitioner

v. Docket No. PHET-23-0318

Mariko Weston,
Respondent

Appearance for Petitioner:

Matt A. Murphy, Esq.
Deputy General Counsel
Department of Public Health
250 Washington Street
Boston, MA 02108

Appearance for Respondent:

Pro se

Administrative Magistrate:

Melinda E. Troy

SUMMARY OF TENTATIVE DECISION

The decision of the Department of Public Health to temporarily revoke a Paramedic certification for twenty-four months and until completion of remedial training is affirmed. The Department, through its Office of Emergency Medical Services, has established grounds to discipline the Paramedic for failure to exercise reasonable care and to perform duties in conformance with the Statewide Treatment Protocols in violation of 170 CMR 940(C); failure to meet the requirements of 105 CMR 170.800(C), which requires EMS personnel to provide care in conformance with those Statewide Treatment Protocols; failure to accurately and contemporaneously, or as soon as practicable after, prepare the PCR in accordance with 105 CMR 170.345(B) in violation of 105 CMR 170.940(P); violating 105 CMR 170.940(F) and endangering the health and safety of the public because of a failure to work cooperatively with other EMS personnel; and violating

105 CMR 170.940(O) for knowingly making an omission of a material fact or a false statement in a document filed with or obtained by the Department.

TENTATIVE DECISION

On April 18, 2023, the Department of Public Health ("Department"), through the Office of Emergency Medical Services ("OEMS"), notified Mariko Weston ("Ms. Weston") of its decision to temporarily revoke her certification as an EMT-Paramedic ("Paramedic") at all levels for a minimum of two years with the requirement that she complete extensive remediation in that time frame. On October 4, 2023, the Respondent submitted a pre-hearing memorandum and proposed exhibits, which I marked "B" for identification. By email dated December 21, 2023, counsel for the Petitioner submitted a pre-hearing memorandum and proposed exhibits. I marked the Petitioner's memorandum as "A" for identification.

I held a hearing on December 22, 2023 via the Webex platform, with the parties' consent. A digital recording was made of the proceedings. I admitted the proposed exhibits as marked in the Petitioner's pre-hearing memorandum[1] and added the exhibits offered by the Respondent which are listed at the conclusion of this recommended decision. (Exhibits 1-11.) The Department called the following witnesses: Leonard MacNeil, the Department's OEMS Compliance Investigator; and Jonathan Burstein, M.D., FACEP, the Department's OEMS Medical Director. Ms. Weston testified on her own behalf and called no other witnesses. Neither party submitted post-hearing briefs, so the record closed at the conclusion of the hearing.

[1] The Petitioner's email submission included the same exhibits, but they were listed in a different order. For consistency, I marked them as listed in the Petitioner's pre-hearing memorandum.

FINDINGS OF FACT

Based upon the testimony and documents admitted into evidence, I make the following findings of fact:

1. Mariko Weston is certified as an Emergency Medical Technician ("EMT") at the Paramedic level. Her certification has an expiration date of March 31, 2024. (Exhibit 1.) At the time of the hearing, she had been in the emergency medicine field as an EMT or Paramedic for approximately 21 years. (Testimony, Weston.)

2. A certified Paramedic is qualified by virtue of his or her training to provide the highest level of pre-hospital care. An EMT-Basic is certified to provide basic life support after 150 hours of classroom instruction; an advanced EMT undergoes an additional 200 hours of instruction; a Paramedic undergoes 1500 hours of additional instruction. (Testimony, MacNeil.)

3. EMTs and paramedics are subject to the rules and regulations of the Department, specifically 105 CMR 170. (Testimony, MacNeil; Testimony, Burstein.)

4. Standard Treatment Protocols ("STPs") are standards of pre-hospital care in Massachusetts, and licensed Paramedics are bound to follow them. (Testimony, MacNeil.) They are updated annually. (Testimony, Burstein.)

5. One requirement of the STPs is that Paramedics are required to complete a Patient Care Report ("PCR"), which documents the care that they provided. It is generated by the Paramedic/ EMT crew while the emergency response is provided and should be completed contemporaneously with the call or as soon as possible thereafter. It

is left in the hospital after the crew departs and is intended to assist hospital staff to provide continuity of care. (Testimony, MacNeil).

6. In this case, Ms. Weston completed the PCR eight days after the ambulance run that it documented. Ms. Weston testified that she completed the PCR then because the other Paramedic on the call, Shawn Miles, had taken the cardiac monitor that she had used that day.[2] (Testimony, Weston.)

7. Dr. Burstein testified that when an EMT or Paramedic does not have his or her monitor they could ask for it to be returned to them, or involve a supervisor to help them retrieve it so that they could complete a PCR. (Testimony, Burstein.)

8. During the period of alleged misconduct, Ms. Weston was employed by Atlantic Ambulance Service ("Atlantic"), which is a subsidiary of Cataldo Ambulance Service. (Exhibit 1.)

9. On November 28, 2022, Atlantic dispatched two units to respond to a call in Salem, MA regarding a patient reported to be in cardiac arrest. One ambulance was an SUV-like vehicle staffed by Ms. Weston, known as Advanced Life Support 3 ("ALS 3"). The second unit, which was the transport unit ("PB-5") was staffed by Paramedic Shawn Miles ("Mr. Miles"), EMT-Basic Nathan Desrosiers ("Mr. Desrosiers") and a student Paramedic named Alexandra Torres-Chambers ("Ms. Chambers"). (Exhibit 1.)

10. Ms. Weston responded to the call. When she arrived at the residence, fire department first responders were already on site and providing cardiopulmonary resuscitation ("CPR"). (Exhibit 1.)

[2] Any allegations made against that other Paramedic, Mr. Miles, are not before me and I make no findings related to his actions or behavior during this emergency call.

11. Because she was the first EMT/Paramedic to the scene, Ms. Weston was primarily responsible for the call. (Testimony, MacNeil; Testimony, Burstein.)

12. Ms. Weston reported that when she arrived, the first responders stated that their automated external defibrillator ("AED") device was informing them that there was "no shock advised" and her cardiac monitor was showing that the patient's cardiac rhythm was asystole. (Exhibit 1.)

13. "Asystole" means that the patient had flatlined and there was no electrical activity in the patient's heart. (Testimony, Burstein.)

14. Shortly after Ms. Weston arrived, PB-5 and its staff arrived on the scene. Mr. DesRosiers entered first and placed a Lucas device on the patient, which is a device that provides chest compressions. (Exhibit 1.)

15. When CPR is provided to a patient, the responding crew should stop the intervention every two minutes to check if the patient's cardiac rhythm has been restored. Cardiac monitor data will show the interruption of CPR when and if those rhythm checks are conducted. (Testimony, MacNeil.)

16. A few minutes later, Mr. Miles and Ms. Chambers entered the patient's residence. (Exhibit 1.)

17. When they arrived, Mr. Miles admitted that he "sat on the couch". He stated that he did so because the home was crowded. Ms. Weston believed that he did so as part of an effort not to help her. (Exhibit 2.)

18. During the evaluation of the patient, Ms. Weston determined that an intravenous line needed to be placed. She asked Ms. Chambers to do so and eventually took over that medical intervention from Ms. Chambers. (Exhibit 1.)

19. The jugular vein is an external vein on the neck. During her treatment of the patient, Ms. Weston was unable to establish external jugular ("EJ") intravenous access. She admitted this to Mr. MacNeil during the investigation of this incident. Id.

20. In the PCR, Ms. Weston incorrectly stated that the EJ line had been established, that it had been done on the left side when it was actually attempted on the right side, and that a saline lock had been used, none of which was true. (Exhibit 3.)

21. Ms. Chambers was able to obtain intra-osseus intravenous access for the patient, which means that the IV was inserted into a bone. (Exhibit 1; Testimony. Burstein.)

22. Ms. Weston administered 1 mg. of epinephrine to the patient. (Exhibit 1; Testimony, MacNeil). The PCR stated that the student Paramedic administered this medication. (Exhibit 3.)

23. After that, the intra-osseus ("IO") line became dislodged. Ms. Weston admitted that the IO line was not secured after it had been placed. The EMS staff decided not to attempt any other IV access. (Exhibit 1.)

24. In addition to attempting to establish an IV line, the responders, including Ms. Weston, determined that the patient needed assistance to breathe and that an endotracheal tube ("ET tube") needed to be utilized in the patient's treatment. They moved the patient to the ambulance for this intervention. Ms. Weston intubated the patient. Id.

25. An ET tube is a flexible tube that is placed in the trachea to allow air exchange and get air to a patient's lungs to allow for effective ventilation of them. It is used when a patient is not breathing on his or her own. (Testimony, Burstein.)

26. It is important for a medical professional to confirm that an ET tube is properly placed and be cognizant of signs that an ET tube may have been misplaced because if it is not properly placed, it means that air is not properly getting into a patient's lungs. (Testimony, MacNeil; Testimony Burstein.)

27. The fact that an ET tube might be improperly placed is not necessarily uncommon; the issue which more commonly leads to problems and discipline is the failure to check to confirm that the ET tube is properly placed and to take corrective action when necessary. (Testimony, Burstein.)

28. There are several methods to verify that an ET tube is properly placed. The standard of care requires that capnography and at least 2 of the following other methods are used to confirm the proper placement of an ET tube: auscultation of each lung and over the patient's stomach, colorimetric readings, visualization of the patient's vocal chords with a laryngoscope, checking for condensation or misting in the tube, checking for a distended stomach, and checking (after the first few breaths) for vomit in the tube. (Testimony, MacNeil; Testimony, Burstein; Exhibit 5.)

29. A capnography machine is a machine which measures carbon dioxide output when a patient exhales. It is the preferred method that is used after an ET tube is placed to confirm that the tube has been properly placed and it is the best method for doing so. Its readings can be viewed on the cardiac monitor in an ambulance. Normal readings indicative of a properly placed ET tube are between 12 and 24 mm/hg. The readings are called "end-title CO_2" or "$ETCO_2$" readings. (Testimony, MacNeil; Testimony, Burstein; Exhibit 7.)

30. The cardiac monitor data indicates that the highest capnography reading for this patient was 8 mm/hg. It reached that value once and then returned to a zero reading, which is indicative of an improperly placed ET tube because a zero reading shows that there is no carbon dioxide being exhaled by the patient. The reading remained at zero for the remainder of this ambulance run. (Testimony MacNeil; Testimony, Burstein.)

31. Other signs that indicate a misplaced ET tube are that the patient does not have lung sounds, the patient's abdomen becomes distended because air is going to his or her abdomen and not the lungs, the patient's chest is not rising and falling, and there is vomit in the ET tube itself. (Testimony, MacNeil; Testimony, Burstein).

32. The placement of an ET tube should be verified at least three different times during an emergency call- on site, in the ambulance, and upon arrival at the hospital. (Testimony, Burstein; Exhibit 5.)

33. The PCR for the ambulance call does not reflect that Ms. Weston conducted three verifications of the ET tube placement. Instead, Ms. Weston wrote in the PCR that the capnography readings were between 12/mm./hg and 24 mm./hg (which were never reflected in the cardiac monitor data). (Exhibit 3.) Ms. Weston stated that the values she wrote in the PCR were reported to her by Mr. Miles, but that she never verified them by looking at the cardiac monitor itself. Mr. Miles reported that he did not, in fact, see those numbers on the monitor. When asked where he had come up with the numbers, Mr. Miles stated, "I honestly don't know." (Exhibit 2.)

34. The PCR documents "Pt intubated with 7.0 tube, visualization of chords, auscultation bilat, lung sound, capnography (12-24)." (Exhibit 3.)

35. During the investigation, none of the other first responders present could verify that Ms. Weston had verified lung sounds to check the placement of the ET tube. I find that Ms. Weston did not perform the auscultation documented in the PCR. (Exhibit 1.)

36. Ms. Weston admitted she did not check for vomit in the ET tube. All other EMTs on the call stated that there was vomit in the patient's ET tube. (Exhibit 2.)

37. As a result of this failed medical intervention, the patient suffered an esophageal intubation.

38. Following the events of November 28, 2022, Cataldo Ambulance Service filed a "Serious Incident Report" ("SIR") on behalf of Atlantic, alleging that on that date, one of Atlantic's crews failed to recognize esophageal intubation, and this failure resulted in patient injury. Id.

39. Atlantic also reported that Salem Hospital's Emergency Department complained to Atlantic that a patient had arrived there with an improperly placed endotracheal tube, which was found to be an undetected esophageal intubation. Id.

40. Ambulance services that submit SIRs are also required to submit an investigation report and a Plan of Correction and Preventability ("POC") to the Petitioner Department. The report and POC that Atlantic submitted reported several issues with the response to this call in November 2022. Id.

41. The Department initiated an investigation regarding this call. Mr. MacNeil and Dr. Burstein had roles in the investigation. (Testimony, MacNeil; Testimony, Burstein.)

42. Mr. MacNeil has worked at OEMS Compliance since October of 2022 and has worked in Emergency Medical Services since 1987. He commenced the investigation in this case on January 24, 2023. He requested the documents related to the case and conducted interviews of Ms. Weston, Messrs. Miles and DesRosiers, and Ms. Chambers. (Testimony, MacNeil.)

43. Dr. Burstein is the Medical Director of OEMS. He graduated from medical school in 1992 and is Board certified in Emergency Medicine and Emergency Medical Services. He is familiar with the statewide protocols related to ET tubes because he drafted them. The protocols are designed to reflect the best available medical science for emergency medical care and they are updated annually. (Testimony, Burstein.)

44. During the investigation, interviews were conducted with the EMS staff who responded to this emergency call. As part of the investigation, they were asked about the interaction between Ms. Weston and Mr. Miles. (Exhibit 2.)

45. Ms. Weston reported that during this call, she felt that Mr. Miles did not communicate with her and did not contribute to the efforts to respond during this call. She regretted the lack of communication during this call. Id.

46. Mr. Miles reported that one prior call he had with Ms. Weston "went fine". However, he also reported that on another prior call, when he had appeared at the ambulance doors she stated, "I don't [expletive] want you, I want your partner." He then stated, "Why would I want to work with her?" He went on to clarify, "I don't care whether she likes me or not, it should not affect patient care." Id.

47. When asked if he sensed tension among the staff responding to this call, Mr. Desrosiers stated, "Absolutely between Weston and Miles and also between Weston

and Alexandra." Id. He also stated in part that Weston and Miles, "don't see eye to eye and they don't respect each other." Id.

48. Ms. Chambers reported, "I thought there was a lack of communication for everyone" and "[t]here was a lot of tension with everyone there." She recalled Mr. Miles stating that he had had some kind of prior conflict with Ms. Weston, but she could not specifically recall what he said. Id.

49. Following investigation, on April 18, 2023, DPH OEMS issued a Notice of Agency Action citing six separate grounds from the temporary revocation of Ms. Weston's EMT-Paramedic certification. They are:

a) Ms. Weston's failure to adhere to the STPs constituted a failure to exercise reasonable care, judgment, knowledge or ability in the performance of her duties and to perform those duties within the scope of her training and certification, in violation of 105 CMR 170.940(C);

b) Ms. Weston's action constituted a failure to meet the requirements of 105 CMR 170.800 or 170.900, in violation of 105 CMR 170.940(B)[3];

c) Ms. Weston's actions failed 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;

[3] 105 CMR 170.800 states general provisions related to EMS Personnel; 105 CMR 170.900 states that a first responder must be appropriately certified in order to use the applicable EMS titles. 105 CMR 170.940(B) lists as one specific grounds for suspension the "[f]ailure to meet the requirements of 105 CMR 170.800 or 170.900." The Department focused its substantive arguments on the other regulatory violations cited in Exhibit 1, so this decision will focus on the arguments that the Department made at hearing.

d) Ms. Weston failed to accurately, contemporaneously or as soon as is practicable after, prepare the PCR in accordance with 105 CMR 170.345(B) in violation of 105 CMR 170.940(P);

e) Ms. Weston failed to work cooperatively with other EMS personnel on the ambulances dispatched with providing patient care, which endangered the health or safety of the public in violation of 105 CMR 170.940(F); and

f) Ms. Weston knowingly made omissions of fact and or false statements in a document filed with or obtained by the Department or any other entity in the EMS system, in violation of 105 CMR 170.940(O)

50. Ms. Weston timely appealed the proposed agency action under 105 CMR 170.740(A). (Exhibit 1.)

CONCLUSION AND ORDER

General Laws c. 112, § 61 grants broad authority to the Department of Public Health, through the OEMS, to suspend, revoke, or cancel an EMT certification at any level. The grounds for such an action are set forth in 105 CMR 170.940.

The Department now acts to temporarily revoke Mariko Weston's EMT-Paramedic Certification for a period of twenty-four months and until successful completion of remedial training. The Department charges Ms. Weston with violating six provisions of its regulations.

Three of the violations alleged in this case relate to Ms. Weston's failure to exercise reasonable care, judgment, knowledge or ability in the performance of her duties

and her failure to conform her behavior to the STPs.[4] Because these contentions are interrelated, I will address them collectively below.

Failure to exercise reasonable care and to perform duties in conformance with the Statewide Treatment Protocols

One of the Department's applicable regulations, 170 CMR 940(C), allows the Department to discipline an EMT for the "failure to exercise reasonable care, judgment, knowledge or ability in the performance of duties or to perform those duties within the scope of...her training and certification, and in accordance with the Statewide Treatment Protocols." A Paramedic's clinical practice is governed by the STPs. 105 CMR 170.020. Another regulation, 105 CMR 170.800(C), states, in relevant part, "EMS personnel working in connection with a licensed service shall provide care in conformance with the Statewide Treatment Protocols."

Ms. Weston admitted to investigators that she placed the patient's ET tube. Placement of the ET tube is a critical intervention for a patient because it ventilates the lungs of a patient who is not able to breathe on his or her own. The applicable STPs require that an EMT or Paramedic treating a patient who is unable to breathe on his or her own and who requires advanced airway management with an ET tube must verify the placement of the ET tube in three ways and this verification must be conducted three

[4] Specifically, the Department alleges a failure to meet the requirements of 105 CMR 170.800 or 170.900, in violation of 105 CMR 170.940(B), and a failure 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 and the failure to exercise reasonable care, judgment, knowledge or ability in the performance of her duties and to perform those duties within the scope of her training and certification in violation of 105 CMR 170.940(C)."

separate times, including upon arrival at the hospital. According to the STPs, specifically Section 1.0 of the 2022 STPs[5], "Routine Patient Care", subheading "Advanced Airway Confirmation",

> The standard of care requires specific methods of verification to be used including capnography, and at least two of the following- auscultation, colorimetric readings, visualization of the chords, the presence of condensation, and other clinical signs that the advanced airway is positioned correctly.

The Department has proven that Ms. Weston did not verify the ET tube placement for this patient in three ways or at three separate times as required by the STPs.[6] Ms. Weston did not verify the patient's ET tube placement using capnography- she relied on the end-title CO_2 values provided to her by Mr. Miles and did not independently verify those values using the monitor data. The Department has established that the cardiac monitor data reflected an end-title CO_2 value of zero with the exception of a single reading of 8 mm/mg. Dr. Burstein credibly testified that the end-title CO_2 numbers Ms. Weston wrote in the PCR (12 to 24) would have been within the normal range, indicative of a properly placed ET tube. However, in this case, the cardiac monitor data reflected only a single entry above zero, which would alert a first responder that the ET tube was not properly placed. In failing to recognize that the data on the cardiac monitor indicated

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[5] These STPs were in effect at the time of the incident.

[6] Dr. Burstein testified that the evidence showed that Ms. Weston verified the ET tube placement "no more than twice" but given the vagueness of the PCR entries related to the ET tube placement (*i.e.*, the PCR states that the confirmation of placement on scene was through "visualization of vocal chords". The "type of person confirming" was "Another Person on the same crew.") and the fact that there are many falsified entries on the PCR, I am not able to find that Ms. Weston verified the ET tube placement in three ways in accordance with the STPs during this call. It is also clear that she did not do so at the three times she was required to verify placement- on scene, in the ambulance and upon arrival at the hospital.

that the ET tube for this patient had not been properly placed and in failing to address that problem, Ms. Weston failed to exercise reasonable care and failed to perform her duties within the scope of her training and certification as a paramedic.

In addition, Ms. Weston admitted that she did not utilize auscultation to confirm the placement of the ET tube; she admitted that she did not listen for epigastric sounds and neither Mr. Desrosiers nor Ms. Chambers saw her listen for lung sounds to verify that the patient's ET tube was properly placed.

Finally, there were other indicia of an improperly placed ET tube that Ms. Weston either ignored or at the very least failed to appreciate. All other EMTs on the call noted the presence of vomit in the patient's ET tube, which is indicative of an improperly placed ET tube.

Ms. Weston failed to address the issue of the improperly placed ET tube during her response on this call and therefore failed to exercise reasonable care, judgment, knowledge or ability in the performance of her duties. She failed to perform her duties as a Paramedic within the scope of her training and experience and she failed to perform her duties in accordance with the applicable STPs. She is subject to discipline on that basis.

Failure to accurately, contemporaneously or as soon as is practicable after, prepare the PCR in accordance with 105 CMR 170.345(B) in violation of 105 CMR 170.940(P)

The Department also alleges that Ms. Weston did not appropriately prepare the PCR in this case. The applicable regulation, 105 CMR 170.345(B) states, in relevant part, "Each patient care report shall be accurate, prepared contemporaneously with or as soon as practicable thereafter, the EMS call that it documents…[a]ll EMS personnel on

the… ambulances dispatched are responsible for the accuracy of the contents of their respective patient care reports, in accordance with their level of certification."

Ms. Weston does not dispute that she completed the PCR in this case eight days after the ambulance call took place. In her argument, she suggested that the completion was timely because the regulation provides that the PCR can be completed "as soon as practicable" after the call. Ms. Weston is correct that the regulations do not solely require that the PCR is completed contemporaneously with the call, although both Mr. MacNeil and Dr. Burstein credibly testified that it is important to do so to ensure the continuity of care for the affected patient when the patient is left at the hospital. (In fact, the STPs[7] state that, "[p]ertinent data must be left at the receiving hospital at the time of transport.") Ms. Weston attempted to explain that the reason she did not complete the PCR for eight days was because she did not have access to the data required to complete it because Mr. Miles had taken the monitor which contained the data. Ms. Weston's testimony about this fellow Paramedic revealed that she still has some animosity toward him. In fact, she stated and primarily argued that he was also responsible for the shortcomings in care that occurred on this call. DPH recognized this interpersonal dynamic in its report and does not dispute that Mr. Miles was subject to discipline as the result of his own conduct. I find that Ms. Weston, an experienced Paramedic, did not complete the PCR "as soon as is practicable" after this ambulance run as the DPH regulations require when she completed it eight days later. She allowed her animosity toward her fellow Paramedic to influence her actions and made no effort to obtain the

[7] 2022 STPs, Section One, "Routine Patient Care", subsection "Patient Care Reports and Data Collection."

monitor data for the call so that she could complete the PCR more timely. She is subject to discipline on this basis.

Knowingly making an omission of a material fact or a false statement orally or in any document filed with or obtained by the Department in violation of 105 CMR 940(O).

The same regulation cited above, 105 CMR 170.345(B), requires that "…[a]ll EMS personnel on the… ambulances dispatched are responsible for the accuracy of the contents of their respective patient care reports, in accordance with their level of certification." The Department alleges that Ms. Weston knowingly made a number of false statements on the PCR she filed and in the conduct of this investigation. The Department primarily bases its charge on Ms. Weston's conflicting answers regarding the placement of the patient's ET tube during the investigation, the data reported by the capnography, the documentation of the establishment of intravenous access for the patient and the statements made related to obtaining IV access for this patient.

With respect to the placement of the ET tube and the medical documentation of that intervention, Ms. Weston did not dispute that the PCR and the available data from the cardiac monitor conflicted. I find that she knowingly omitted a material fact from her PCR and that she knowingly falsified it. First, the PCR that Ms. Weston completed documented that the end-title CO_2 readings related to the ET tube placement read 12 at their highest levels in one section and then later states that the "numeric value" reflected on the end-title CO_2 Digital Capnography was "24". Dr. Burstein testified that CO_2 values ranging from 12-24 would be in the normal range and would be indicative that the ET tube had been properly placed. However, the actual monitor data submitted by the Department shows that the highest CO_2 reading only briefly read 8, and that it never

reached a reading of 12 or 24, or any value ranging between those two. I find that a Paramedic with 21 years' experience such as Ms. Weston would know that the PCR she filed did not accurately reflect the end-title CO_2 values that were on the cardiac monitor. I find that as the result of her experience she also would have known that the falsified end-title CO_2 values that she stated in the PCR would have been in the normal range. I find that she falsified the data about the ET tube in the PCR in an attempt to conceal the fact that the ET tube had neither been properly placed nor its placement thereafter verified in accordance with the STPs.

Second, Ms. Weston wrote in the PCR that an EJ IV was placed for the patient yet under the portion of the PCR inquiring about "Complications", it lists "none". The PCR states that the placement of the EJ IV was "successful". In the interviews conducted in connection with the investigation of this incident, all of the EMTs who were interviewed stated that the placement of the EJ IV was not successful, that eventually an IO IV was placed in the patient's shoulder and the responding EMTs had not been able to re-establish IV access once the IO IV was dislodged during the treatment of the patient. I find that the reference in the PCR to the "successful" placement of the EJ IV was false. Again, given Ms. Weston's experience as an EMT and Paramedic, I find that she knowingly falsified the information on the PCR to minimize the seriousness of her infractions in this case and in an attempt to conceal the fact that they had occurred.

Failure to work cooperatively with other EMS personnel on the ambulances dispatched with providing patient care, which endangered the health or safety of the public in violation of 105 CMR 170.940(F).

The Department has proven that Ms. Weston failed to work cooperatively with the other EMS personnel when she responded to this call and that she endangered the health or safety of the public as a result. In presenting her case, Ms. Weston primarily focused her argument on the fact that Paramedic Miles was not performing his duties and was not working cooperatively with her to assist this patient. She seemingly did so in an effort to excuse her own conduct- she never disputed that she had done or failed to do any actions that the Department alleged. The questions that she asked and her demeanor during cross-examination of the witnesses revealed that Ms. Weston was angry with Mr. Miles at the time of this incident, and she remains so today. As noted above, the Department recognized this interpersonal dynamic in its investigation and report and does not dispute that Mr. Miles was subject to discipline as the result of his own conduct. However, the Department is also correct that this does not relieve Ms. Weston of her obligation to provide appropriate care to patients in need. Ms. Weston's attempts to excuse her own conduct by pointing out alleged shortcomings in Mr. Miles's behavior are unavailing. Ms. Weston allowed her personal feelings for Mr. Miles to influence her behavior during and after this ambulance run and she did not provide the level of care that the applicable regulations required of her as a result. The Department has proven this allegation against her.

For the above-stated reasons, I recommend that the Department of Public Health's temporary revocation of Mariko Weston's EMT-Paramedic certification and requirement of remedial training be affirmed.

SO ORDERED,

DIVISION OF ADMINISTRATIVE LAW APPEALS,

Melinda E. Troy

Melinda E. Troy
Administrative Magistrate

DATED: August 2, 2024

Exhibits

1. Notice of Agency Action dated April 18, 2023.
2. Investigative Report #22-1217.
3. Patient Care Report dated December 6, 2022.
4. Copy of 105 CMR 170, applicable OEMS regulations.
5. 2022 Statewide Treatment Protocols.
6. Certified Mail "Read" receipt pertaining to the Notice of Agency Action.
7. Patient Monitor Data.
8. Certificates Related to trainings completed by the Respondent.
   8a) Certificate of Completion of Capnography training.
   8b) Certificate of Completion of "Endocrine Emergencies" training.
   8c) Certificate of Completion of "Infectious Diseases" training.
   8d) Certificate of Completion of "Toxicological Emergencies-Opiods" training.
   8e) Certificate of Completion of "12 Lead Competency Class" training.
   8f) Certificate of Completion of "Cardiac Arrest 1" training.
   8g) Certificate of Completion of "Hazard Communication Standard" training.
   8h) Certificate of Completion of "MA Protocol Update 2023- ALS & BLS".
   8i) Certificate of Completion of "Understanding Shock" training.
   8j) Certificate of Completion of "Acute Abdomen" training.
   8k) Certificate of Completion of "Cardiac Arrest 2" training.

8l) Certificate of Completion of "Immunological Diseases" training.
8m) Certificate of Completion of "Neurological Emergencies & Seizures" training.

9) Statement of Todd Labrie, undated

10) Clinical Review Letter

11) Statement of Brent Batchelder, undated.