COMMONWEALTH OF MASSACHUSETTS

SUFFOLK, ss.

CIVIL SERVICE COMMISSION
One Ashburton Place – Room 503
Boston, MA 02108
(617) 727-2293

JEAN QUINTIN,
Appellant
v.
CITY OF NEW BEDFORD,
Respondent

Case No. D1-11-170

Appearance for Appellant:

Maureen R. Medeiros, Esq.
AFSCME Council 93
8 Beacon Street
Boston, MA 02108

Appearance for Respondent:

Jane Medeiros Friedman
First Assistant City Solicitor
City of New Bedford Law Department
133William Street
New Bedford, MA 02740

Commissioner:

Paul M. Stein[1]

DECISION

Procedural History

Pursuant to G.L. c. 31, § 43, the Appellant, Ms. Jean Quintin (hereinafter "Appellant" or "Ms. Quintin") filed a timely appeal with the Civil Service Commission (hereinafter "Commission") on May 17, 2011, contesting the decision of the City of New Bedford (hereinafter "City") to terminate her employment as an Emergency Medical Technician (hereinafter "EMT") Intermediate on May 9, 2011. A pre-hearing conference was held on June 24, 2011, at the University of Massachusetts School of Law in Dartmouth, Massachusetts and a full hearing was held on November 18, 2011, at the same location. Neither party requested a

[1] The Commission acknowledges the assistance of Law Clerk Beverly J. Baker, Esq., in the drafting of this decision.

public hearing, so the hearing was deemed private. The witnesses were sequestered. The hearing was digitally recorded and the parties were provided with copies of the recording. The parties submitted post-hearing briefs.

Summary

By a preponderance of evidence, the City has shown that it had just cause to terminate Ms. Quintin from her position as an EMT Intermediate for her serious lack of judgment that demonstrated an inability to understand her core responsibility to act within the scope of her training by stating that she administered epinephrine to a patient in violation of 105 CMR 700.800.000 et seq and the Statewide Treatment Protocols.

FINDINGS OF FACT

Based on the nine exhibits entered into evidence, the stipulations of the parties, the testimony of:

Called by the City:

- Mr. Richard Torrey, Captain of Training, New Bedford Department of Emergency Medical Services (hereinafter "EMS");
- Mr. Steven Arruda, Deputy Director, New Bedford EMS;
- Mr. Mark McGraw, Director, New Bedford EMS;

Called by Ms.Quintin:

- Ms. Jean Quintin, Appellant;

and taking administrative notice of all matters filed in the case and pertinent statutes, regulations, and policies, and reasonable inferences therefrom, a preponderance of the evidence establishes the following findings of fact:

1. Ms. Quintin's employment with the City began when she was appointed to the position of provisional EMT. On September 23, 1991, Ms. Quintin was appointed to the position of permanent full-time EMT. Ex. A.A.-1

2. Ms. Quintin attained the rank of EMT Intermediate on March 28, 2007. Ex. A.A.-1
3. Prior to being licensed as a basic EMT, and also as an EMT Intermediate, Ms. Quintin was trained to follow the CMRs and State Treatment Protocols. In addition, Ms. Quintin received instruction on roles and responsibilities. Testimony of Ms. Quintin
4. Pursuant to 105 CMR 170.800(B), EMTs are prohibited from performing functions for which they have not been properly trained and certified. Ex. A.A.-25
5. The Commonwealth of Massachusetts Department of Public Health, Office of Emergency Medical Services (hereinafter "OEMS") Required Policy 6 states, in pertinent part, that all EMS providers with the City shall provide care at the level for which they are certified in accordance with G.L. c. 111C, 105 CMR 170.800 et seq., and the standards set forth in the Massachusetts Statewide Treatment Protocols. Ex. A.A.21 & A.A.26
6. On or about May 28, 2009, Ms. Quintin received a Letter of Clinical Deficiency from OEMS for violating statewide treatment protocol. OEMS determined that Ms. Quintin "failed to provide care at the Intermediate level to four patients that were experiencing signs of poisoning." In addition, OEMS found that "by transporting four patients exhibiting signs of illness without reasonable assistance of another ambulance and additional EMTs, [Ms. Quintin] failed to demonstrate reasonable clinical decision making in the treatment of those patients." Ex. A.A.-4
7. Ms. Quintin was the only EMT Intermediate in the entire department. All other employees were paramedics. Testimony of Capt. Torrey
8. Ms. Quintin became partners with Ms. Debra Norcross in or about June 2010. Testimony of Ms. Quintin

9. Prior to June 2010, Ms. Quintin was familiar with Ms. Norcross, but the two women did not know each other well. Testimony of Ms. Quintin.

10. In April 2011, Ms. Quintin worked three shifts per week with Ms. Norcross. Testimony of Ms. Quintin

11. At all relevant times, Ms. Norcross was a paramedic with the City's EMS Department. The paramedic is higher in the chain of command than an EMT Intermediate and is the ultimate decision maker with respect to patient care. Testimony of Dep. Arruda, Dir. McGraw

12. After becoming partners, the relationship between Ms. Quintin and Ms. Norcross began to deteriorate. In November 2010, Ms. Quintin complained to Director McGraw about Ms. Norcross, stating that Ms. Norcross was not letting Ms. Quintin "do her skills." Testimony of Dir. McGraw, Ms. Quintin

13. Ms. Quintin also complained that Ms. Norcross would "do stupid things," such as hiding the remote control to the television. Testimony of Ms. Quintin

14. In approximately February 2011, Ms. Quintin and Ms. Norcross had a disagreement regarding having paramedic students ride with them. Ex. A.A.-7; Testimony of Dep. Arruda

15. On or about March 29, 2011, both Ms. Quintin and Ms. Norcross made allegations of a hostile work environment. Testimony of Dir. McGraw, Ms. Quintin; Ex. A.A.-8

16. On April 6, 2011, Ms. Angela Natho, Director of the City's Department of Labor Relations and Personnel issued a memorandum to both Ms. Quintin and Ms. Norcross in which Ms. Natho concluded that while the complaints did not rise to the level of harassment or hostile environment, "there have been instances of unprofessional conduct and miscommunication." Ms. Quintin and Ms. Norcross were ordered to "immediately conduct themselves with the highest degree of professionalism at all times . . . . Director McGraw

has indicated that you are both valued, capable employees . . . . Although past tensions have existed, I am confident that professional, productive work behaviors will be exhibited by all involved." Ex. A.A.-8

17. In her April 6, 2011 memorandum, Ms. Natho specifically directed both employees that: "*If there are further concerns regarding patient care or interactions with the public they will be documented and brought to your Supervisor immediately*. Likewise, if concerns regarding inappropriate work behaviors arise in the future, they will be documented and brought to your Supervisor." Ex.A.A.8 (*emphasis added*)
18. Director McGraw offered both Ms. Quintin and Ms. Norcross the opportunity to switch shifts; however, both employees refused the offer. Director McGraw also considered an involuntary move of one of the employees but ultimately did not pursue this route. Testimony of Dir. McGraw, Ms. Quintin
19. Ms. Quintin was reluctant to change her shift, despite her issues with Ms. Norcross, because it would be inconvenient for her and she would lose $40 per week. Testimony of Ms. Quintin
20. On or about April 12, 2011, Ms. Quintin and Ms. Norcross were working together when they responded to a call at approximately 5:00 AM involving a patient in cardiac arrest. Testimony of Ms. Quintin; Ex. A.A.-9
21. Upon arrival at the scene, Ms. Quintin and Ms. Norcross found a woman lying on the floor, not breathing, and without a pulse. Police officers and firefighters were attempting to administer CPR. Testimony of Ms. Quintin; Ex. A.A.-9
22. Ms. Quintin intubated the patient while Ms. Norcross was applying the defibrillator pads on the patient. Ms. Norcross attempted to start an IV in the patient's hand unsuccessfully. Ms.

Quintin then prepared to move the patient and the patient was transported to the ambulance. Testimony of Ms. Quintin

23. In the ambulance, Ms. Quintin watched the patient's breathing monitor while Ms. Norcross attempted a second IV. Testimony of Ms. Quintin

24. When Ms. Norcross was unable to gain access to the patient's vein, she performed an intraosseous infusion[2] (IO) on the patient. Testimony of Ms. Quintin; Ex. A.A.-9

25. On April 14, 2011, at approximately 5:00 AM, Captain Torrey arrived at the Hillman Street station pursuant to orders from Director McGraw. Mr. Torrey was assigned to provide Ms. Norcross and Ms. Quintin CPR training. However, based on conversations with Ms. Quintin and Ms. Norcross, Director McGraw decided to change the purpose of the training and directed Capt. Torrey to train Ms. Quintin and Ms. Norcross on roles and responsibilities of a paramedic and EMT Intermediate. Testimony of Capt. Torrey, Dir. McGraw; Exs. A.A.-11 & A.A.-14

26. During the training session, the interaction between Ms. Quintin and Ms. Norcross was "strained" and they would speak to each other through Captain Torrey, making him feel like a "counselor between a couple." Testimony of Capt. Torrey; Ex. A.A.-11

27. During the training session, Ms. Quintin stated she would "get a lawyer and sue for harassment." Ms. Quintin also stated that she had a learning disability and "there is such a thing as Americans with Disabilities Act and she is going to get a lawyer." Ex. A.A.-11

28. At some point during the training session, Ms. Quintin became very upset and stated "I can't take it anymore" and left the class. Testimony of Capt. Torrey

[2] This procedure involves drilling into a patient's tibia to gain access to veins.

29. At approximately 5:15 AM, Ms. Quintin called Director McGraw to inform him that she was upset and needed to go home. Director McGraw told Ms. Quintin that if she was indeed upset and could not work, to go home. Testimony of Ms. Quintin, Ex. A.A.-14
30. Captain Torrey eventually continued the training session with both Ms. Quintin and Ms. Norcross separately, as the atmosphere had deteriorated and was not conducive to training. While Captain Torrey was going over the roles and responsibilities with Ms. Quintin, individually, she asked Captain Torrey "if the new protocols stated, so I can clarify in my mind, that we were not supposed to put anything down any tube." When Captain Torrey replied that this was accurate and asked her why she was inquiring about it, Ms. Quintin then stated that Ms. Norcross made her put epinephrine down the endotracheal tube. Ex. A.A.-11; Testimony of Ms. Quintin
31. After asking Ms. Quintin to explain what happened in greater detail, Captain Torrey instructed Ms. Quintin not to do that anymore and she stated that she would not. Ex. A.A.-11; Testimony of Capt. Torrey
32. Later that day, at approximately 8:30 AM, Director McGraw met with Deputy Arruda and Captain Torrey to discuss the events that had transpired during the training session earlier. Ex. A.A.-14; Testimony of Dir. McGraw
33. After their discussion, Director McGraw, Deputy Arruda, and Captain Torrey met with Ms. Norcross and Ms. Quintin in the training room. They were also joined by the union steward, Ms. Rosemary Nunes. Ex. A.A.-14
34. At this time, Director McGraw expressed his "dismay with the situation" and that it has "totally gone out of control." Director McGraw further informed them that he might take the matter to personnel again and discuss possible termination of employment for both of

them. Director McGraw noted that Ms. Quintin and Ms. Norcross are required to work in a professional manner at all times. Ex. A.A.-14

35. At some point during the meeting, Ms. Quintin, Ms. Norcross, and Ms. Nunes went into another room to speak privately. When Ms. Quintin returned to the training room, approximately two or three minutes later, she was visibly upset, crying, and stated that she "can't take it anymore." Ms. Quintin also stated that the situation was causing her stress and chest pain and that she would "make it easy on them" by going out on leave due to stress. Ms. Quintin then told Director McGraw and Deputy Arruda that she had administered epinephrine to a patient through an endotracheal tube at the direction of Ms. Norcross. Testimony of Dir. McGraw, Deputy Arruda; Ex. A.A.-14
36. Ms. Quintin then informed Director McGraw that during the cardiac arrest call that had occurred earlier in the week, Ms. Norcross ordered her to give epinephrine down the patient's endotracheal tube. Ms. Quintin said that while she initially told Ms. Norcross that it was wrong to put medication down the endotracheal tube, Ms. Norcross insisted and Ms. Quintin complied out of fear that Ms. Norcross would "write her up" for something else. Ms. Quintin then left, crying. Ex. A.A.-14
37. Ms. Nunes and Ms. Norcross then returned to the training room and asked where Ms. Quintin had gone. Director McGraw informed them that Ms. Quintin had left upset. At this time, Director McGraw asked Ms. Norcross about the allegations that had just been raised by Ms. Quintin. Ex. A.A.-14
38. Ms. Norcross denied the allegation and stated that it never happened. Director McGraw requested a written incident report from Ms. Norcross and the meeting concluded. Testimony of Dir. McGraw; Ex. A.A.-14

39. Ms. Quintin was also asked to submit a written report of the April 12, 2011 incident. Testimony of Dir. McGraw

40. On April 15, 2011, at approximately 9:00 AM, Ms. Quintin spoke to Director McGraw to apologize for what had transpired over the past few weeks. At this time, Ms. Quintin also questioned Director McGraw about the possible ramifications of her alleged actions, including what might happen if the state were to be notified. Director McGraw stated that he was unsure of the potential consequences and until he knew all the facts, "it was unclear if this was a serious reportable incident mandating that we call the state [referring to OEMS]." Ex. A.A.-14

41. Shortly after this conversation took place, at approximately 10:25 AM, Ms. Quintin called Director McGraw again. During this conversation, Ms. Quintin informed him that she had called OEMS on her own initiative and reported what had transpired on the cardiac arrest call. Ms. Quintin called OEMS anonymously, initially, and was informed that if the allegations were true, both medics could lose their licenses. Ms. Quintin was eventually convinced to give her name and where she worked. She told Director McGraw that she was calling him to give him a "heads up" that the state is aware of the incident and apologized for any trouble she had caused. Ex. A.A.-14

42. Ms. Quintin knew that giving a patient medication "down the tube" would be "wrong". Testimony of Ms. Quintin

43. Director McGraw was "unsure of the validity of the allegation" and placed Deputy Arruda in charge of investigating Ms. Quintin's accusation. Testimony of Dir. McGraw, Deputy Arruda; Ex. A.A.-14

44. The run sheet for the cardiac arrest call, which took place on April 12, 2011, shows that Ms. Norcross administered three doses of epinephrine via "O/S" after Ms. Norcross attached the O/S line. The run sheet does not indicate that epinephrine was administered to the patient through the endotracheal tube at any time. Ex. A.A.-9

45. Neither the audio recording nor the hospital nurses' notes make any mention about epinephrine being administered via the patient's endotracheal tube. A.A.-15

46. As part of his investigation, Deputy Arruda interviewed the two firefighters who were present during the April 12, 2011 incident and summarized the interviews in a memorandum dated April 21, 2011. Ex. A.A.-12

47. Neither firefighter could recall observing Ms. Quintin administer epinephrine down the patient's endotracheal tube. Firefighter Horn stated that he did not hear any sort of disagreement or argument between Ms. Norcross and Ms. Quintin. Lieutenant Barriteau did not see Ms. Quintin give a drug down the endotracheal tube. Ex. A.A.-12

48. Following his investigation, Deputy Arruda was unable to make a definitive conclusion as to whether Ms. Norcross ordered Ms. Quintin to administer epinephrine to a patient through the endotracheal tube. Deputy Arruda took Ms. Quintin "at her word" and believed that she had administered the medication to the patient through the endotracheal tube. Testimony of Dep. Arruda

49. Deputy Arruda lost confidence in Ms. Quintin as a provider as a result of the incident that occurred on April 12, 2011, because, whether ordered or not, she said she gave medicine to a patient, which exceeded the scope of her training. Deputy Arruda recommended to Director McGraw that both Ms. Quintin and Ms. Norcross be terminated. Testimony of Deputy Arruda; Ex. A.A.-16

50. In a letter dated April 26, 2011, Director McGraw informed Ms. Natho that he had decided to move forward with a disciplinary hearing for both Ms. Quintin and Ms. Norcross, citing the "poor behaviors of both." Ex. A.A.-17

51. By letter dated April 28, 2011, Director McGraw notified Ms. Quintin that he was contemplating her termination and suspending her immediately because she advised him that she had acted beyond her scope of training by administering a medication via the endotracheal tube on April 12, 2011. Copies of G.L. c. 31, §§ 41-45 were also enclosed. Ex. A.A. 18

52. Director McGraw conducted a hearing to consider Ms. Quintin's termination on May 5, 2011. Ex. A.A.-19

53. In a letter dated May 9, 2011, Director McGraw informed Ms. Quintin that her employment with the City's EMS Department was terminated. This letter provided the following reason for her termination:

> "Following a training class on April 14, 2011, you reported tht on April 12, 2011, you gave Epinephrie 1:100000 via Endotracheal Tube to a patient in Cardiac Arrest. You stated that you were aware this practice was prohibited at you level of training . . .yet, despite knowing it was prohibited, you gave the medication to a patient. This incident occurred after a Letter of Clinical Deficiency was issued to you in 2008. . . . I find just cause for your suspension and termination for knowingly violating 105 CMR 170.810 and 105 CMR 170.820 and the Statewide Treatment Protocols."

(Ex. AA.19)

54. OEMS conducted an investigation following Ms. Quintin's allegations. The conclusion of the investigation report was "unable to be determined" and the investigation was closed on October 19, 2011. OEMS found the evidence did not establish that Ms. Quintin was ordered to give a patient Epinephrine or that she actually did so. OEMS noted the acrimony that

existed between Ms. Quintin and Ms. Norcross. OEMS closed its investigation without taking any disciplinary action against either one of them. Ex. A.A.-24

55. As part of the changes to the Statewide Treatment Protocols, the endotracheal tube was removed as a medication delivery route effective March 1, 2011. Ex. A.A.-22

56. An EMT Intermediate is not authorized to administer epinephrine to a patient, however administered, because that is outside the scope of the training for an EMT Intermediate. Testimony of Dep. Arruda

57. During her testimony, Ms. Quintin presented as a very nervous witness. At times, her voice became unsteady and she would stumble over her words. Occasionally, she seemed uncooperative with her own attorney. Ms. Quintin also contradicted herself during her testimony. For instance, Ms. Quintin admitted that she knew giving a patient medication was wrong, but she did it anyways, then later testified that she did not do anything "intentionally." Ms. Quintin testified that she was never told, either in formal training or on-the-job, what she should do if she was ordered to take an action outside the scope of her training. In addition, Ms. Quintin stated that she never "demeaned" Ms. Norcross in any way and never "called her stupid" when Ms. Quintin had testified earlier that Ms. Norcross would "do stupid things" to her. Testimony of Ms. Quintin.

58. When asked specifically about what happened in the ambulance during the incident that allegedly occurred on April 12, 2011, and again when asked what she told Director McGraw on April 14, 2011, regarding the cardiac arrest call, Ms. Quintin became even more nervous and had difficulty responding clearly. She couldn't provide a coherent and consistent account of the alleged administration of epinephrine, either by her or Ms. Norcross. Both times, she made statements such as "I can't even think" and that she could not think straight

at work or at home. I find Ms. Quintin's testimony, particularly her testimony regarding the core events of April 12, 2011, not to be credible.

CONCLUSION

a. Legal Standard

Pursuant to G.L. c. 31, § 43, a "person aggrieved by a decision of an appointing authority made pursuant to section forty-one shall, within ten days after receiving written notice of such decision, appeal in writing to the commission . . . ." The statute provides, in pertinent part:

> If the commission by a preponderance of the evidence determines that there was just cause for an action taken against such person it shall affirm the action of the appointing authority, otherwise it shall reverse such action and the person concerned shall be returned to his position without loss of compensation or other rights; provided, however, if the employee, by a preponderance of the evidence, establishes that said action was based upon harmful error in the application of the appointing authority's procedure, an error of law, or upon any factor or conduct on the part of the employee not reasonably related to the fitness of the employee to perform his position, said action shall not be sustained and the person shall be returned to his position without loss of compensation or other rights. The commission may also modify any penalty imposed by the appointing authority.

G.L. c. 31, § 43.

An action is "justified" if it is "done upon adequate reasons sufficiently supported by credible evidence, when weighed by an unprejudiced mind; guided by common sense and by correct rules of law." Cambridge v. Civil Serv. Comm'n, 43 Mass. App. Ct. 300, 304 (1997); Comm'rs of Civil Serv. v. Mun. Ct. of Bos., 359 Mass. 211, 214 (1971); Selectmen of Wakefield v. Judge of First Dist. Ct., 262 Mass. 477, 482 (1928). The Commission determines justification for discipline by inquiring "whether the employee has been guilty of substantial misconduct which adversely affects the public interest by impairing the efficiency of public

service." School Comm. of Brockton v. Civil Serv. Comm'n, 43 Mass. App. Ct. 486, 488 (citing Murray v. Second Dist. Ct., 389 Mass. 508, 514 (1983).

The Appointing Authority's burden of proof by a preponderance of the evidence is satisfied "if it is made to appear more likely or probable in the sense that actual belief in its truth, derived from the evidence, exists in the mind or minds of the tribunal notwithstanding any doubts that may still linger there." Tucker v. Pearlstein, 334 Mass. 33, 35-36 (1956).

While the Commission makes *de novo* findings of fact, "the Commission's task, however, is not to be accomplished on a wholly blank slate." Town of Falmouth v. Civil Serv. Comm'n, 447 Mass. 814, 823 (2006). "Here, the Commission does not act without regard to the previous decision of the town, but rather decides whether 'there was reasonable justification for the action taken by the appointing authority in the circumstances found by the commission to have existed when the appointing authority made its decision.'" Id. (citing Watertown v. Arria, 16 Mass. App. Ct. 331, 334 (1983)).

B. Analysis

Following the April 12, 2011 incident in which Ms. Quintin said that Ms. Norcross ordered her to administer epinephrine through a patient's endotracheal tube, two investigations were conducted: one was performed by Deputy Arruda of the City's EMS Department; the other was carried out by OEMS. The results of these investigations were both inconclusive as to whether Ms. Norcross ordered Ms. Quintin to administer a medication down the endotracheal tube. Furthermore, other than Ms. Quintin's testimony, there is no evidence to indicate that the patient received any medication via endotracheal tube at all. Therefore, I have concluded, by preponderance of the evidence that the medication was never administered by Ms. Quintin.

As did OEMS, I am unable to credit the truthfulness of Ms. Quintin's allegations. I conclude that the incident did not take place as Ms. Quintin claimed. During Ms. Quintin's testimony before the Commission, she appeared especially nervous and flustered when asked directly about the events that occurred during the cardiac arrest call on April 12, 2011 and when asked about what she told Director McGraw about the incident on the morning of April 14, 2011. In addition to her demeanor during her testimony, Ms. Quintin's statements to the effect that she could not think straight prevents me from crediting her testimony, particularly regarding these two events, with significant weight. I also find relevant the timing of Ms. Quintin's accusations, which occurred after an emotional and confrontational exchange between her and Ms. Norcross. Although she had been instructed by Personnel Director Natho a few days earlier to report all such incidents *immediately*, her allegation was not made until approximately two days after the incident allegedly occurred, and only in passing to Captain Torrey. Had Ms. Quintin been forced to administer the medication to the patient, as she claims, it was her responsibility to notify Director McGraw *immediately*.

Additionally, there are inconsistencies in Ms. Quintin's account of the events and the credible testimony of both Director McGraw and Captain Torrey; for instance, Ms. Quintin's report indicates that she told Director McGraw on April 13, 2011 that she was forced to administer a medication down the endotracheal tube. Captain Torrey claims that he first heard Ms. Quintin's allegations after the training session on April 14, 2011. Director McGraw testified that he learned of these allegations when Ms. Quintin informed him following a meeting later that same day. It is also concerning that Ms. Quintin reported herself to OEMS, before the City was able to conduct an investigation, and only provided her name after inquiring about the possible repercussions of her alleged actions. When asked why she self-reported to

OEMS, Ms. Quintin was quick to place fault on others, including her superiors for failing to notice how much stress she was under working with Ms. Norcross and doing nothing to stop her "abuse."

The Statewide Treatment Protocols set forth the "acceptable standard of care for managing patient injury and illness" and the scope of practice by certified EMTs. Commonwealth of Massachusetts Department of Public Health/OEMS Emergency Medical Services Pre-Hospital Treatment Protocols, 9th ed., version #9.02, April 2011. These protocols are in place to ensure that patients receive the highest degree of medical care possible and, as a result, it is vitally important that such protocols be adhered to. Ms. Quintin does not claim that she accidentally or unknowingly administer epinephrine to a patient via the endotracheal tube. Rather, she asserts that she knowingly administered the medication to a patient, which is clearly something she was not permitted to do. Not only do the new protocols prohibit the administration of epinephrine down the endotracheal tube by paramedics, but, as an EMT Intermediate, Ms. Quintin is not permitted to give epinephrine to a patient *at all*. Ms. Quintin is responsible for acting within her scope of training as an EMT Intermediate at all times. By making statements that showed she could not be trusted to act within the scope of her training, Ms. Quintin caused her superiors to lose faith in her as a provider, as they did not believe this behavior could be corrected through remedial training. In Ms. Quintin's version of the incident that took place, she emphasizes the method by which the epinephrine was administered, via the endotracheal tube in violation of the new protocol, rather than the fact that as an EMT Intermediate, she was not authorized to administer the medication at all. The fact that Ms. Quintin's allegations against Ms. Norcross were false, as I believe is the case, only this serves to exacerbate Ms. Quintin's serious lack of judgment. She breached the City's trust in her as an

EMT Intermediate and, therefore, I find that the City had just cause to terminate Ms. Quintin's employment.

For all of the above reasons, Ms. Quintin's appeal under Docket Number D1-11-170 is hereby ***dismissed.***

Civil Service Commission

_____
Paul M. Stein
Commissioner

By 4-1 vote of the Civil Service Commission (Bowman, Chairman[AYE]; Ittleman [AYE], Marquis [AYE], McDowell [NO], and Stein [AYE], Commissioners) on June 13, 2013.

A True Record. Attest:

_____
Commissioner

Either party may file a motion for reconsideration within ten days of the receipt of this Commission order or decision. Under the pertinent provisions of the Code of Mass. Regulations, 801 CMR 1.01(7)(l), the motion must identify a clerical or mechanical error in this order or decision or a significant factor the Agency or the Presiding Officer may have overlooked in deciding the case. A motion for reconsideration does not toll the statutorily prescribed thirty-day time limit for seeking judicial review of this Commission order or decision.

Under the provisions of G.L c. 31, § 44, any party aggrieved by this Commission order or decision may initiate proceedings for judicial review under G.L. c. 30A, § 14 in the superior court within thirty (30) days after receipt of this order or decision. Commencement of such proceeding shall not, unless specifically ordered by the court, operate as a stay of this Commission order or decision.

Notice:
Maureen R. Medeiros, Esq. (for the Appellant)
Jane Medeiros Friedman, Esq. (for the Respondent)

DISSENTING OPINION OF COMMISSIONER MCDOWELL

I respectfully dissent. Although I respect the majority conclusion that Ms. Quintin has not acted appropriately, I do not believe that, since she was not found guilty of the misconduct for which she was terminated – i.e. giving medication to patient in violation of her duty of care – the City of New Bedford has not proved just cause for her termination. I would uphold the discipline but modify it to a short term suspension, as the Commission has done in the related case decided today involving Ms. Norcross.

_____

Ellaina M. McDowell
Commissioner