COMMONWEALTH OF MASSACHUSETTS

BARNSTABLE, SS.

SUPERIOR COURT DEPARTMENT
CIVIL ACTION NO: 2172CV171

JAMES E. MEAD, as EXECUTOR and PERSONAL REPRESENTATIVE OF THE ESTATE OF DUANE E. MEAD,
Plaintiff,

v.

TOWN OF ORLEANS,
Defendant.

COMPLAINT AND JURY DEMAND

James E. Mead, as Executor and Personal Representative of the Estate of Duane E. Mead, brings this lawsuit for wrongful death against the Town of Orleans, for the negligence and gross misconduct of its emergency medical services (EMS) personnel. The EMS personnel prematurely terminated resuscitative efforts on Plaintiff's decedent, Duane Mead, in clear violation of standard emergency protocols, a derogation of duty which led to his premature death. In an attempt to conceal their misconduct, the EMS personnel then falsely documented the emergency call. Under regulations issued by the Department of Public Health and guidelines issued by Cape & Islands Emergency Medical Services System, Inc. (CIEMSS), of which the Town is a member, Defendant was required to conduct a review of the Priority One call, but for unknown reasons, it failed to do so. The Town also failed to discipline the personnel responsible for Duane's death. Therefore, in addition to money damages for the negligence of the Town and its EMS personnel, Plaintiff seeks the issuance of an injunctive relief, requiring and mandating that the Town: (i) conduct a review of the emergency call that led to Duane Mead's death in accordance with DPH regulations and CIEMSS guidelines and make the results of that review public; (ii) discipline and/or remove the

responsible EMS personnel and/or management from active duty; and (iii) implement such other measures and procedures that the review determines are appropriate and necessary for public safety and the future protection of the Town's residents.

PARTIES, JURISDICTION AND VENUE

1. Plaintiff James E. Mead is the Executor and Personal Representative of the Estate of Duane Mead ("Plaintiff" or "the Estate") and is a resident of South Dennis, in Barnstable County, Massachusetts.

2. Defendant Town of Orleans ("Orleans" or "the Town"), is a body corporate and politic established by law that conducts its municipal functions and business at the Orleans Town Hall, Barnstable County, Massachusetts.

3. This Court has jurisdiction pursuant to G.L. c. 258, § 2, which provides that public employers shall be liable for injury or loss of property or person injury or death caused by the negligent or wrongful act or omission of any public employee while acting within the scope of their employment. Pursuant to Section 4 of G.L. ch. 258, a civil action may be instituted against a public employer on a claim for damages after the executive office of the public employer denies the presentation of such a claim. As further described below, the Town has denied the claim presented by Plaintiff pursuant to the Statute.

4. The Town is situated in Barnstable County. Therefore, venue lies in this Court pursuant to G.L. c. 258 § 3.

FACTS

5. In or around September of 2016, Duane Mead ("Duane") was a 52-year-old resident of the Town in generally good health.

6. On September 12, 2016, Duane visited his primary care physician complaining of a cough and fever which had manifested approximately five (5) days prior.

7. At no time had Duane experienced any shortness of breath or chest pain.

8. The primary care physician determined that Duane had contracted pneumonia. This diagnosis was confirmed by X-ray. Duane was prescribed medication (Zithromax Z-pak) and sent home.

9. Early the next morning, on September 13, 2016 at or approximately 4:20 a.m., Duane went to the bathroom and collapsed face down. When he fell, he became lodged between the toilet and the vanity.

10. Duane's significant other, Inger, heard Duane fall and went to investigate. Inger found Duane mumbling incoherently but conscious. But because of the difference in their size and weight, she was unable to extricate Duane from where he had fallen.

11. Inger immediately called the Town's emergency services by dialing 9-1-1. At 4:22 a.m., Inger was connected with an emergency dispatcher who informed her that an emergency response team was on its way.

12. The Orleans police were the first to arrive on the scene at 4:27 a.m. Upon arrival, the responding police officer dislodged Duane from where he had fallen in the bathroom and turned him on his back. As confirmed by the police report of the emergency call, the police found Duane "warm to touch" but no pulse was detected.

13. The police immediately began administering cardiopulmonary resuscitation ("CPR") on Duane. The police continued to administer CPR until the Orleans Fire and Rescue Department arrived on the scene at or about 4:28 a.m.

14. Two minutes later, at approximately 4:30 a.m., the Fire and Rescue Department's emergency medical services personnel (the "EMS personnel") took over from the Orleans Police in administering resuscitative efforts on Duane.

15. The EMS personnel took Duane's vital signs, placed defibrillation pads (which indicated "asystole – do not shock") and administered oxygen.

16. By 4:44 a.m., the EMS personnel had made the determination to abandon further resuscitative efforts on Duane. The EMS personnel made this determination prematurely after administering resuscitative efforts for less than the twenty (20) minutes called for under the Pre-Hospital Statewide Treatment Protocols established by the Massachusetts Office of Emergency Medical Services, Department of Public Health (the "Emergency Protocols"). The Emergency Protocols constitute the standard of care for Emergency Medical Service providers in Massachusetts and govern the conduct of emergency medical personnel in the Commonwealth.

17. Section 3.4A of the Emergency Protocols sets forth the protocols for responding to adult cardiac arrest. It provides, in relevant part, that emergency responders must:

a. Verify Asystole in 2 leads, if possible;

b. Consider and treat underlying causes for Asystole/PEA;

c. If cause is unknown and Asystole/PEA persists: Administer Epinephrine 1: 10,000 1mg IV/IO every 3-5 minutes; may substitute Vasopressin 40 units IV/IO in place of first or second dose of Epinephrine 1: 10,000.

18. At 4:32 a.m., the Town's EMS personnel administered a single 2 milligram dose of Narcan. However, in violation of Section 3.4A of the Emergency Protocols, the Town's EMS personnel never administered either Epinephrine or Vasopressin. Upon information and belief, the EMS personnel also violated Section 3.4A of the Emergency Protocols by failing to verify

asystole in 2 leads; and by failing to consider and treat any underlying causes for Duane's asystole/PEA condition.

19. Section 7.7 of the Emergency Protocols sets forth strict procedures for when emergency resuscitative efforts may be terminated. According to Section 7.7, only a paramedic can make the determination to cease resuscitative efforts "regardless of who initiated the resuscitative efforts," without a finding of "obvious death" and only if the EMS system's Affiliate Hospital Medical Director has approved the request to discontinue such efforts.

20. Under Section 7.7 of the Emergency Protocols, paramedics must undertake and/or verify each of the following before discontinuing resuscitation:

a. There is no evidence of or suspicion of hypothermia;

b. Indicated standard Advanced Life Support measures have been successfully undertaken (including for example effective airway support, intravenous access, medications, transcutaneous pacing, and rhythm monitoring);

c. The patient is asystole or pulseless electrical activate (PEA), and remains so persistently, unresponsive to resuscitative efforts, for ***at least twenty (20) minutes while resuscitative efforts continue***;

d. No reversible cause of arrest is evident;

e. The patient is not visibly pregnant; ***and***

f. An on-line medical control physician gives an order to terminate resuscitative efforts.

21. At 4:44 a.m., less than 20 minutes after emergency personnel had arrived on the scene, the EMS personnel requested a radio patch to Cape Cod Hospital in order to obtain permission from a physician to terminate resuscitation efforts on Duane.

22. The request to terminate resuscitative efforts violated the Emergency Protocols because the Town's EMS personnel had failed to undertake Advanced Life Support measures, including the administration of Epinephrine or Vasopressin.

23. The request to terminate resuscitative efforts violated the Emergency Protocols because the EMS personnel had failed to administer resuscitative efforts continuously for at least twenty (20) minutes.

24. Upon information and belief, the request to terminate resuscitative efforts on Duane also violated the Emergency Protocols because the EMS personnel never determined whether there was an evident, reversible cause of Duane's cardiac arrest.

25. The acts and omissions of the Town's EMS personnel, as described above, were negligent and/or grossly negligent.

26. The acts and omissions of the Town's EMS personnel, as described above, constitute a clear violation of the applicable standard of care.

27. The acts and omissions of the Town's EMS personnel, as described above, are inconsistent with, and deviate from, the Emergency Protocols governing the provision of emergency medical services to Town residents, including Duane Mead.

28. At 4:45 a.m., the EMS personnel were connected with Dr. Peter Bosco, the emergency room physician at Cape Cod Hospital who was on duty at the time.

29. In their rush to terminate resuscitative efforts, the Town's EMS personnel made numerous misstatements to Dr. Bosco that they knew, or reasonably should have known, were false.

30. The EMS personnel falsely reported to Dr. Bosco that Duane was last seen responsive by his significant other "around midnight" and that she "came upon him in the

bathroom unresponsive this morning." In fact, Duane's significant other, Inger, heard Duane fall, found him breathing (and mumbling) at 4:20 a.m. and immediately called 9-1-1.

31. The EMS personnel falsely reported to Dr. Bosco that Duane was found "around" 4:15 a.m. and they had arrived on the scene "around" 4:20 a.m. This statement greatly exaggerated the actual amount of time that the emergency responders, including the police, had been on the scene administering CPR to Duane.

32. The EMS personnel falsely reported to Dr. Bosco that Duane was "cyanotic and mottled with dependent lividity" when the EMS personnel arrived, despite the fact that lividity does not typically occur until several hours after death, and Inger had found Duane mumbling and unconscious merely 30 minutes before the EMS personnel requested permission to terminate resuscitative efforts.

33. The Town's EMS personnel falsely reported to Dr. Bosco that there was a "prolonged" extrication process. In fact, before the EMS arrived the police had already extracted Duane from where he was wedged in the bathroom, turned him on his back, and begun CPR. Upon information and belief, the EMS personnel had no difficulty in moving Duane from the bathroom to the emergency transport vehicle.

34. Upon information and belief, the Town's EMS personnel falsely reported to Dr. Bosco that Duane was emitting no lung sounds.

35. The Town's EMS personnel falsely reported to Dr. Bosco that they had been working "the code" for approximately 25 minutes.

36. Based on these false and misleading statements, Dr. Bosco authorized the EMS personnel to discontinue further life-saving efforts on Duane.

37. Upon information and belief, Duane was pronounced dead at 5:40 a.m. upon arrival at Cape Cod Hospital.

38. According to Section 7.7, Special Considerations and Procedures, sub-section 3 of the Emergency Protocols, "EMS trip record documentation must reflect the criteria used to determine obvious death or allow cessation of resuscitative efforts."

39. The report prepared by the EMS personnel (the "OFD Report") not only failed to document the criteria used for stopping resuscitative efforts, but it also contained numerous demonstrably false and misleading statements.

40. Specifically, the EMS personnel knowingly and falsely recorded the following in the OFD Report:

a. Duane's vital signs, 4-lead EKG, Oxygen via Bag-Valve-Mask, LUCAS machine and defibrillation pads were all administered to the patient at 4:30 a.m. This statement is not true: at 4:31 a.m., the senior paramedic can be heard on the radio dispatch giving directions to the paramedics to "use [the] door out back."

b. The EMS personnel had a "difficult time accessing due to multiple houses on the property." This statement is obviously false, given that the Town police had arrived on scene without difficulty ***prior to*** the EMS personnel, and upon information and belief, had activated the flashing lights on the police cruiser, which was parked in front of the house.

c. There was an "unknown down time" and "patient last seen at bedtime." Both of these statements are demonstrably false based on the fact that Inger heard Duane fall at approximately 4:20 a.m., found him conscious and mumbling in the bathroom and immediately called 9-1-1.

d. Duane had pneumonia for three (3) weeks. In fact, Duane had been ill for only five (5) days and had been diagnosed with pneumonia less than 24 hours before the emergency call.

e. There was no bystander CPR administered. This statement is patently false, given that the Town police had begun administering CPR before the EMS personnel arrived on scene.

f. There was a "prolonged extraction." As described above, this statement is false, given that the Town police had already extracted Duane from where he had fallen, placed him on his back, and started CPR; and, upon information and belief, the EMS personnel had no difficulty in removing Duane from the bathroom and placing him in the emergency transport vehicle.

41. In the OFD Report, the EMS personnel also failed to record that the Orleans police had started CPR within five (5) minutes from the time of the initial emergency call, and that resuscitative efforts were administered for a total of only sixteen (16) minutes.

42. Plaintiff was appointed Personal Representative of the Estate of Duane E. Mead on January 15, 2019.

43. On or about March 4, 2019, through counsel, the Estate requested all records concerning the emergency call of September 13, 2016 concerning Duane Mead from the Orleans Fire and Rescue Department.

44. In or about March 2019, through counsel, the Estate also requested all records concerning Duane Mead and the emergency call of September 13, 2016 from Cape Cod Hospital; the Orleans Police Department; the Barnstable County Sheriff's Office; and from the Massachusetts Office of Emergency Medical Services.

45. Plaintiff first received documents responsive to the requests for records in or about April 2019. Prior to that time, Plaintiff did not learn and had no reasonable opportunity to learn that the EMS personnel had: (1) failed to administer emergency treatment to Duane in accordance with the Emergency Protocols and the applicable standard of care; (2) falsely reported the circumstances of the emergency call to Cape Cod Hospital in order to obtain permission from its Emergency Room physician to prematurely terminate resuscitative efforts on Duane; and (3) falsely recorded the circumstances and events surrounding the emergency call in the Town's official documentation.

46. The Estate first became aware of the suspicious circumstances surrounding Duane's death as more fully described above, in or about Spring 2019.

47. Pursuant to Section 4 of G.L. ch. 258, on February 19, 2020, Plaintiff presented a written claim to the Board of Selectman for the Town of Orleans and the Town Administrator for the wrongful death of Duane Mead.

48. The Town denied the claim in writing by a letter dated August 12, 2020.

COUNT I
(Wrongful Death – Negligence)

49. Plaintiff realleges and incorporates Paragraphs 1 – 48 above by reference.

50. The Town and its EMS personnel owed a duty of care to Plaintiff's decedent to perform their services in a competent and professional manner, in accordance with the applicable laws and regulations and in accordance with the applicable standard of care.

51. As described above, on September 13, 2016, the Town's EMS personnel breached their duty of care through a series of acts and omissions committed in the course of their employment as employees of the Town.

52. As a direct and proximate result of the Defendant's breach of duty, Duane Mead died on September 13, 2016.

53. The Estate is entitled to an award of money damages, in an amount to be determined at trial, resulting from the negligence of the Town and its EMS personnel.

COUNT II
(Wrongful Death – Willful, Wanton, Reckless Conduct)

54. Plaintiff realleges and incorporates Paragraphs 1 - 53 above by reference.

55. The conduct of the Town's EMS personnel, as described above, constitutes willful, wanton, and reckless conduct as a direct and proximate cause of which Duane Mead died on September 13, 2016.

56. If it were not for the willful, wanton, and reckless behavior of the Town's EMS personnel that caused his death, Duane would have been able to recover damages for personal injuries.

57. The Estate is entitled to recover said damages pursuant to G.L. c. 229 § 2.

COUNT III
(Preliminary and Permanent Injunctive Relief)

58. Plaintiff realleges and incorporates Paragraphs 1 – 57 above by reference.

59. The Orleans Fire and Rescue Department and its EMS personnel are subject to the regulation and oversight of the Department of Public Health (DPH) of the Massachusetts Office of Emergency Medical Services.

60. The DPH has issued regulations appearing at 105 CMR 170, the purpose of which is to: "establish[] a statewide, community-based Emergency Medical Services (EMS) system, in order to reduce death and disability from illness and injury through the coordination of local and regional emergency medical services resources. It is designed to ensure that properly trained and

certified EMS personnel, operating under medical oversight, provide emergency medical care to patients at the scene of their illness or injury, and during transport to appropriate health care facilities. It establishes standards for EMS vehicles and equipment, and standards to ensure safe, adequate transport to an appropriate health care facility in the shortest practicable time." (105 CMR 170.001)

61. The DPH's regulations further provide, at 170.350(B)(1), that: "Each licensed service shall file a written report with the Department within seven business days of other serious incidents involving its service, personnel or property. Serious incidents are incidents that result in injury to a patient not ordinarily expected as a result of the patient's condition. An injury is harm that results in exacerbation, complication or other deterioration of a patient's condition. Such reportable incidents include, but are not limited to... (b) Failure to provide treatment in accordance with the Statewide Treatment Protocols resulting in injury."

62. Under CMR 170.350(B)(2): "Within 30 calendar days of filing a serious incident report, the service shall file with the Department the following: (a) an investigation report of the incident, including the service's findings about the causes of the incident; and (b) a plan of correction and preventability, reflecting participation of, and review by, the affiliate hospital medical director, addressing the corrective measures the service took upon discovery and investigation of the incident, both with respect to the specific personnel and equipment involved in the incident, as well as to policies, procedures, training, orientation, and other such changes to prevent such incident from recurring in the future, if the incident is preventable."

63. Upon information and belief, the Town is a member of the Cape & Islands Emergency Medical Services System, Inc. (CIEMSS) and as such, is required to adhere to its guidelines, training and supervisory procedures. Those guidelines provide, in relevant part, that

an investigation of serious incidents, which include the failure to provide treatment in accordance with the Emergency Protocols, be investigated within twenty-four (24) hours of notification of the incident.

64. On or about November 6, 2020, pursuant to G.L. ch. 66, Section 10, the Estate served a public records request on the Town seeking all records concerning the response of the Town to the emergency call of September 13, 2016 concerning Duane Mead. The Estate also requested all records concerning the Town's review of the response (if any); all communications between the Town and the Massachusetts Office of Emergency Medical Services; and all documents concerning any investigation or review of the emergency call conducted by the Town (if any).

65. On or about December 4, 2020, the Town responded to the public records request and produced certain records. In its response, the Town admitted that it had no records concerning any investigation or review of the emergency call for Duane Mead (other than privileged communications that took place ***after*** the Town received the Estate's Notice of Claim in February 2020).

66. Nevertheless, one of the records produced by the Town, for the first time – despite Plaintiff's previous requests for records that was served in March 2019 – included a Memorandum dated 10/6/16 to the Orleans Fire Rescue Department, from CIEMSS, concerning the OFR's emergency response on September 13, 2016 for Duane Mead. In that Memorandum, CIEMSS concluded that "[t]here was a critical treatment and procedural error."

67. In the Memorandum, CIEMSS also concluded that "the patient [Duane Mead] did not meet the criteria for withholding resuscitative efforts" but that the emergency crew nevertheless requested an order to cease resuscitative efforts. CIEMSS further concluded that the

EMS personnel failed to conduct "full ALS resuscitation... for 20 minutes with persistent asystole prior to the request to cease resuscitation." Finally, CIEMSS concluded: "Based on the documentation this patient did not receive any Epinephrine prior to the request to cease resuscitative efforts."

68. Upon information and belief, the Town was aware of the failure of its EMS personnel to comply with the requirements of the Emergency Protocols on, or immediately after September 13, 2016. Based, *inter alia*, on the CIEMSS Memorandum of 10/6/2016, which was produced by the Town for the first time on December 4, 2020, the Town was also aware of the seriousness of the incident leading to the death of Duane Mead. Nevertheless, at no time has the Town conducted a review of the circumstances surrounding the emergency response on September 13, 2016.

69. The Town also failed to formulate a plan of correction and preventability that includes the participation of, and review by, the affiliate hospital medical director, to address appropriate corrective measures with respect to both the specific personnel involved in the incident, as well as the policies, procedures, training, orientation, and other such changes to prevent such incident(s) from recurring in the future, as required by the governing regulations issued by DPH.

70. As illustrated by its denial of Plaintiff's claim, the Town has repeatedly denied any responsibility for the actions of its EMS personnel and the numerous failures of oversight and supervision evidenced by the failure of the Town, and its Fire and Rescue Department, to conduct a review of the emergency response on September 13, 2016.

71. In order to ensure that the Town complies with its legal obligation to protect residents from future incidents like those that led to the premature death of Duane Mead, the Town

should be required to conduct a review of the circumstances surrounding the emergency response on September 13, 2016 in accordance with the regulations of DPH and the CIEMSS guidelines.

72. Additionally, the Town should be required to formulate a plan of correction and preventability that includes the participation of, and review by, the affiliate hospital medical director, in order to address appropriate corrective measures with respect to both the specific personnel involved in the incident, as well as the policies, procedures, training, orientation, and other such changes to prevent such incident from recurring in the future.

WHEREFORE, Plaintiff respectfully requests that this Court:

(a) Award Plaintiff monetary damages, in an amount to be determined at trial, for the wrongful death of his decedent, Duane E. Mead, together with costs and fees, including but not limited to attorney's fees;

(b) Award Plaintiff monetary damages, in an amount to be determined at trial, for the willful, wanton and reckless conduct of the Defendant's EMS personnel that resulted in the wrongful death of Duane E. Mead, together with costs and fees, including but not limited to attorney's fees;

(c) Preliminarily and permanently enjoin and order that the Town of Orleans comply with its obligation to undertake an investigation of the emergency call for Duane Mead on September 13, 2016; to identify all errors and omissions that occurred; to discipline, suspend and/or terminate personnel and/or management; and to implement such policies and procedures that said investigation determines are necessary and appropriate to prevent such wrongdoing from recurring in the future; and to make the results of the investigation public; and

(d) Enter such other and further relief as the Court may deem proper.

JURY DEMAND

Plaintiff demands a trial by jury on each and every claim and issue so triable.

Respectfully submitted,

JAMES E. MEAD, AS EXECUTOR OF THE ESTATE OF DUANE MEAD,
By his attorneys,

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