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Over 15 Years Litigating Premises and Labor Claims

2011 May 16 via Personal Delivery

District Attorney Nancy E. O'Malley
ALAMEDA COUNTY DISTRICT ATTORNEY'S OFFICE
1225 Fallon Street, Room 900
Oakland, CA 94612

RE: OAKLAND FIRE DEPARTMENT PARAMEDIC [REDACTED], EMT-P

District Attorney O'Malley:

I represent Sheehan (Sean) Gillis, EMT-P. Mr. Gillis is a paramedics trainer and supervisor with the Emergency Medical Services (EMS hereinafter) Division of the Fire Department of the City of Oakland.

As you know, on January 1st, 2009, BART Passenger Oscar Grant was shot in the back from point-blank range by BART Police Officer Johannes Mehserle. Mehserle's bullet passed through Grant's body in the upper torso proximate to his heart and critical cardiovascular region.

Oakland Fire was the first responder. Oakland Fire Paramedic [REDACTED] treated Grant. [REDACTED] failed to provide appropriate treatment. [REDACTED] treated[1] only the entrance wound. Basic emergency medical standards and Oakland Fire emergency medical guidelines require paramedics to treat each penetrating chest injury. All EMS personnel know that the failure to treat any penetrating chest injury is likely to be lethal.

[REDACTED] failure is so egregious that it may indicate intentional misconduct.

At the time of [REDACTED]'s failure, the Fire Department's highest medical authority was Oakland Fire Medical Director Dr. Howard Michaels, MD. Dr. Michaels was very concerned about [REDACTED]'s misconduct. At the time, Dr. Michaels ordered a call review.

It is the express policy and actual practice of the Fire Department to conduct a call review in all cases in which: 1) Mistake or misconduct occurred, and 2) Said mistake or misconduct *may* have resulted in morbidity or mortality.

In spite this policy and practice and the order of the Medical Director, the call review was suppressed by Acting Oakland Fire EMS Division Manager Nina Morris.

[1] By applying semi-occlusive dressing.

Over the months after the death of Oscar Grant, the paper records—the Fire Department Oscar Grant file—and the computer archive of part of the paper file—the Patient Care Report—were destroyed by the Fire Department (most likely at the orders of Morris).

My client, Sheehan (Sean) Gillis, EMT-P was responsible for supervising [REDACTED]. My client supported the order for a call review and expressed concern about the destruction of the records.

From the point in time when Dr. Michaels ordered a review, Oakland Fire withheld Dr. Michaels' pay. Dr. Michaels continued working and finally left after six (6) months without pay.

When Dr. Michaels left, he turned to my client and said, "You are next."

Sure enough and shortly after, Oakland Fire EMS Division Manager William Sugiyama told Gillis that Gillis was "on the firing list."

Gillis complained—to Interim Fire Chief Mark Hoffmann, Equal Opportunity Programs Department Investigator Judy Jackson, and Deputy City Attorney Vicki Larsen of the City of Oakland—about the failure to perform a call review, destruction of documents and archives, and harassment and retaliation against Dr. Michaels and Gillis.

Gillis complained to Interim Chief Mark Hoffman that the Grant case may be an single incident in a pattern of collusion between Oakland Fire and law enforcement in "excessive use of force" cases and that such misconduct which is un-detected because Oakland Fire fails and refuses to provide field oversight of paramedics (required by Alameda county Emergency Medical Service Authority Administrative Manual Policy #2270 [attached]).

Mr. [REDACTED] may pose a danger to other victims of police "excessive use of force." It is imperative that someone investigate his actions on January 1st, 2009. He should be placed on administrative leave immediately.

Because the City fails and refuses to respond to our complaints, we turn to the County.

I am happy to provide Mr. Gillis to you at any time to pursue this matter.

Thank you for your attention to this matter.

Sincerely,

/s/Philip Horne, Esq.
PHILIP HORNE, ESQ.
ATTORNEY FOR OFD EMPLOYEE
SHEEHAN (SEAN) GILLIS, EMT-P
Attached: Policy #2270

QUALITY IMPROVEMENT RESPONSIBILITIES - ALS PROVIDER AGENCIES

1. Prospective

   1.1 Participation on committees as specified by the EMS Agency.

   1.2 Education

      1.2.1 Orientation to EMS system
      1.2.2 Continuing Education
      1.2.3 Participate in certification courses and the training of prehospital care providers.
      1.2.4 Offer educational programs based on problem identification and trend analysis.
      1.2.5 Establish procedure for informing all field personnel of system changes

   1.3 Evaluation - Develop criteria for evaluation of individual paramedics to include, but not limited to:

      1.3.1 PCR review/Tape review or other documentation as available
      1.3.2 Ride-along
      1.3.3 Evaluation of new employees
      1.3.4 Routine
      1.3.5 Problem-oriented
      1.3.6 Design standardized corrective action plans for individual paramedic deficiencies

   1.4 Certification/Accreditation - establish procedures, Based on Alameda County policies, regarding:

      1.4.1 Initial certification/accreditation
      1.4.2 Recertification/Continuing Accreditation
      1.4.3 BTLS or PHTLS certification
      1.4.4 ACLS certification
      1.4.5 PALS or PEPP
      1.4.6 Preceptor authorization
      1.4.7 Other training as specified by the EMS Agency.

2. Concurrent Activities

   2.1 Ride-along - Establish a procedure for evaluation of paramedics utilizing performance standards through direct observation
   2.2 Provide availability of Field Supervisors and/or Quality Improvement Liaison personnel for consultation/assistance.
   2.3 Provide patient information to the base hospital to facilitate obtaining patient follow-up information from receiving hospitals.

QUALITY IMPROVEMENT RESPONSIBILITIES - ALS PROVIDER AGENCIES

3. Retrospective Analysis

3.1 Develop a process for retrospective analysis of field care, utilizing PCRs and audio tape (if applicable), to include but not limited to:

3.1.1 High-risk
3.1.2 High-volume
3.1.3 Problem-oriented calls
3.1.4 Any call requested to be reviewed by EMS or other appropriate agency.
3.1.5 Specific audit topics established through the Quality Council.

3.2 Develop performance standards for evaluating the quality of care delivered by field personnel through retrospective analysis.
3.3 Participate in the Incident Review Process according to policy #2300.
3.4 Comply with reporting and other quality improvement requirements as specified by the EMS Agency.
3.5 Participate in prehospital research and efficacy studies requested by the EMS Agency and/or the Quality Improvement Committee.

4. Reporting/Feedback

4.1 Develop a process for identifying trends in the quality of field care.

4.1.1 report as specified by the EMS Agency.
4.1.2 Design and participate in educational offering based on problem identification and trend analysis.
4.1.3 make approved changes in internal policies and procedures based on trend analysis.