INVESTIGATION REPORT

TO: Andy Glenn, Trustee/Board Chairman
Tom Anderson, Jr., Trustee
Rachael Geiger, Trustee

FROM: R. Kent Murphree, Esq.

DATE: April 2, 2024

RE: Investigation Report
Springfield Township Fire Department
Emergency Medical Services Call (January 2, 2024)

I. Introduction

This communication constitutes my investigation report into an emergency services call to Springfield Township Fire Department (hereafter "STFD") that occurred in the morning of January 2, 2024, as it relates to STFD Paramedics Aiden Yoon and William Fordyce. Below is a summary of the relevant facts revealed in the investigation, as well as my findings, conclusions, and recommendations as to the actions of Messrs. Yoon and Fordyce.

II. Relevant Evidence Considered in Investigation

(A) Witnesses Interviewed:

(i) Aiden Yoon (Firefighter/Paramedic - Lead Paramedic on Run - STFD);

(ii) William Fordyce (Paramedic/Driver - STFD);

(iii) Jonathon Ziehr (Battalion Chief - STFD);

(iv) Barry Cousino (Chief – STFD);

(v) David Moore (Assistant Chief – STFD);

(vi) Michael Hampton (Administrator – Springfield Township);

(vii) Shelbie Flegal (Firefighter/Paramedic – Vice President Union Local 3544 - STFD);

(viii) Barry Porter (Lucas County Coroner's Office);

(ix) Jessica Clay (Lucas County Dog Warden's Office); and

(x) Jeff Young (Director of Franklin County Emergency Management & Homeland Security – Former Fire Chief – Former Firefighter/Paramedic).

(B) **Relevant Documents Reviewed**:

(i) Lucas County Emergency Medical Services Report Dated January 2, 2024 (hereafter "Run Report");

(ii) Police Report Dated January 2, 2024, of Officer M. Johnson of the Toledo Police Department (hereafter "TPD");

(iii) Springfield Township Fire Department Unusual Incident Report of Aiden Yoon Dated January 2, 2024;

(iv) Springfield Township Fire Department Unusual Incident Report of William Fordyce Dated January 2, 2024;

(v) Investigator's Report of Barry Porter Dated January 2, 2024;

(vi) Memorandum of Battalion Chief D. Williams of the Toledo Fire & Rescue Department (hereafter "TFRD") Dated January 2, 2024;

(vii) Memorandum of Private E. Letso of the TFRD Dated January 2, 2024;

(viii) Memorandum of Lt. Scouten of the TFRD Dated January 2, 2024;

(ix) Memorandum of Private Gyetvai of the TFRD Dated January 2, 2024 (mistakenly dated 1-2-23);

(x) Memorandum of Private Dusseau of the TFRD Dated January 2, 2024;

(xi) Handwritten Note of David Moore Dated January 3, 2024 re: Conversation with Barry Porter;

(xii) Handwritten Notes of David Moore (Not Dated) re: Incident

(xiii) Document Titled "Internal Investigation" of Asst. Chief David Moore dated January 11, 2024;

(xiv) E-mail from Shelbie Flegal to BC Jonathon Ziehr Dated January 14, 2024;

(xv) Correspondence Addressed to Aiden Yoon Dated January 16, 2024 and Signed by Asst. Chief David Moore;

(xvi) Correspondence Addressed to William Fordyce Dated January 16, 2024 and Signed by Asst. Chief David Moore;

(xvii) Correspondence Addressed to William Fordyce Dated January 17, 2024 and Signed by David Moore;

(xviii) Correspondence Addressed to Aiden Yoon Dated January 17, 2024 and signed by David Moore;

(xix) Correspondence Addressed to Asst. Chief Moore Dated January 22, 2024, from David Lindstrom, M.D. (Medical Director);

(xx) Remedial Training Packet Compiled by BC Jonathon Ziehr;

(xxi) Springfield Township Organizational Chart;

(xxii) Applicable Collective Bargaining Agreement between the International Association of Fire Fighters Local 3544 and Springfield Township Board of Trustees (hereafter "the CBA").

(C) <u>Relevant Video and Audio</u>:

(i) 911 Call Placed by Purported Owner of Residence (hereafter "the 911 Call);

(ii) Body Camera Video of TPD Officers On Scene (hereafter "Video"); and

(iii) Audio of "Med Line" Call Between Aiden Yoon and "Dr. Scott" at Sylvania Mercy (hereafter "Audio").

III. Relevant Evidence Disclosed from Relevant Evidence Considered

(i) <u>Evidence Not in Question Revealed by Investigation</u>

On January 2, 2024, Life Squad 10 (hereafter "LS10") was dispatched to the scene for a woman who had possibly overdosed (hereafter "the Patient") at 6123 W. Bancroft Street in Toledo.[1] According to the Run Report, Mr. Yoon, and Mr. Fordyce, Mr. Yoon was "Lead" and Mr. Fordyce was the "Driver" on the call. However, both Mr. Yoon and Mr.

[1] Lucas County does not provide its own Fire and EMS service. By agreement with various surrounding jurisdictions within the County, those various jurisdictions respond to calls for such services and depending on the location, one of the surrounding jurisdictions is responsible to dispatch to the scene. Based on the location of this scene, Springfield Township was the lead responding agency.

Fordyce acknowledged that they were both responsible for the Patient's assessment and care on scene. Also, TFRD was a supporting agency on scene.

The call was received by Lucas County Dispatch at 7:39 a.m. and LS10 arrived on scene at 7:43 a.m., almost simultaneously with a TPD Officer. LS10's ambulance was parked near the driveway entrance just off of Bancroft Street. LS10 and the TPD Officer entered the house together from the back door entrance as requested by the individual who made the 911 call (who claimed to also own the house) (hereafter "the Caller"). LS10 was notified prior to arriving on scene that there was a potentially dangerous dog in the room with the Patient. Messrs. Yoon and Fordyce, along with a TPD Officer, were directed through the kitchen and were told by the Caller that the person at issue was upstairs. Mr. Yoon and Mr. Fordyce took resuscitative equipment and supplies with them into the residence upon entry. There were two TPD Officers who went upstairs followed by Mr. Yoon. The emergency equipment and supplies remained downstairs on the couch in the living room. The Video shows a large dog laying very close to a person laying on the bed. One of the TPD Officers attempted to coax the dog away from the Patient. Mr. Yoon can be seen in the Video [from a door cracked open what appears on Video to be between six (6) to twelve (12) inches] a person laying on a bed in an upstairs bedroom with the dog laying very close to her. She appeared motionless to Mr. Yoon, which is confirmed by the Video. The distance from the doorway to the patient was approximately ten (10) to fifteen (15) feet. In the audio from the Video, Mr. Yoon can be heard stating that he is unable to make a determination on the Patient's status without entering the room or getting closer to the Patient.

After a TPD Officer attempted unsuccessfully to get the dog to move away from the Patient, a TPD Sergeant arrived on the scene. The decision was made by TPD to contact the Lucas County Dog Warden's Office to have someone remove the dog from the premises. At approximately 8:09 a.m. LS10's equipment and supplies were removed from the house and taken to LS10's vehicle according to Mr. Fordyce. Prior to the dog being removed from the residence, there were multiple references to the Patient showing signs of being deceased.

The Dog Warden employee, Jessica Clay, arrived on the scene at approximately 8:21 a.m. (according to Ms. Clay – which is consistent with the Video). Ms. Clay went upstairs and removed the dog from the residence. By the time the dog was removed from the room, Messrs. Yoon and Fordyce were outside very near the back porch. Although in his interview Mr. Yoon described that he and Mr. Fordyce were "moving with a sense of urgency" once the dog was removed from the house, the Video shows Ms. Clay exit the house with the dog at 8:24:01 a.m., and Messrs. Yoon and Fordyce entered the house twenty-nine (29) seconds later, at 8:24:30 a.m. Neither was carrying any equipment or supplies with them. Mr. Yoon claimed in his interview that once the dog exited was out of the house, he asked the TFRD employees to retrieve the equipment and supplies from LS10's vehicle. However, nothing resembling such a request can be heard in the audio from the Video, notwithstanding that a TPD Officer followed them shortly after they entered the residence. On the Video, one minute after Messrs. Yoon and Fordyce entered the residence, at 8:25:30 a.m., Mr. Yoon is heard stating "Code 18" (meaning the Patient was deceased). A TFRD employee states immediately thereafter "good enough for me" and she turns around to exit the residence.

After exiting the residence, Mr. Yoon made contact with Sylvania Mercy, Dr. Scott, on what is referred to as "the Med. Channel" which is captured by the Audio that was reviewed by this investigator. Part of that conversation between Mr. Yoon and Dr. Scott was also captured on the Video. Messrs. Yoon and Fordyce were standing very close to one another while Mr. Yoon was speaking with Dr. Scott. Mr. Yoon was asked questions by Dr. Scott, and Mr. Yoon indicated that the Patient was pulseless, apneic, and there was dependent levity. He indicated to Dr. Scott that there were no signs of "rigor". Mr. Fordyce was listening to the conversation between Mr. Yoon and Dr. Scott, and undoubtedly heard Mr. Yoon say that there were no signs of rigor, but affirmatively states that there was dependent lividity present. Dr. Scott then stated that the time of death would be noted as 8:28 a.m.

(ii) Written Statement and Interview of Aiden Yoon

When interviewed, in addition to the facts stated above, Mr. Yoon indicated that when he and Mr. Fordyce entered the room where the Patient was located, he checked her right radial pulse, and stated that there was no pulse felt. At first, he also stated that he did not see any "dependent lividity", but that Mr. Fordyce did verbalize that there was lividity present. He also identified in his interview that the Patient's left leg was stiff. However, when he spoke with Dr. Scott he unequivocally stated that there was lividity present, that the Patient was pulseless, and that there were no signs of rigor. He stated in his interview that he "trusted his partner". Mr. Yoon also stated that he did not observe that the patient was cold to the touch. In Mr. Yoon's very brief written statement provided to Asst. Chief Moore he states that only Mr. Fordyce noticed dependent lividity, again, notwithstanding that he reported dependent lividity being present to Dr. Scott. Putting the Audio, the Video, and the written statements together, in summary, Mr. Yoon conveyed that he only checked for a pulse, and relied on Mr. Fordyce otherwise for confirmed signs of death.

(iii) Written Statement and Interview of William Fordyce

In Mr. Fordyce's written statement he states that the patient was cool and that her "left leg that was on the stool was stiff with the leg that was hanging able to move at the knee". He also states in his written statement that the Patient "was cool" and that he "thought there was bruising on the hands and arm possible dependent levity". In the Video, however, Mr. Fordyce states very affirmatively to Mr. Yoon while on the Med Channel, "dependent lividity". He stated in his interview that he *thought* there was dependent lividity present, but that it was not extreme. He also stated in his interview that the Patient's "right thigh was stiff" to the touch. He did not mention in the interview anything about a left leg being stiff, or even touching the left leg. He also expressed in the interview that he visualized the chest and body for movement. Also during his interview Mr. Fordyce was asked approximately how long it should take to make an assessment for death in a situation of that nature and he stated ten (10) to fifteen (15) minutes, but that he did not know how long he and Mr. Yoon were in the room (and they did exit together). Mr. Fordyce stated in his interview that he did not see Mr. Yoon take a pulse. When asked if he would have seen Mr. Yoon do so if one was taken, he stated again, that he did not see Mr. Yoon take a pulse, and that he could not say whether he did, or did not check for a pulse. In a follow-up telephone interview, this investigator pressed Mr. Fordyce again on this issue, and he stated that he would have seen it if Mr. Yoon took a pulse, but that he did not.

(iv) Written Report and Interview Barry Porter

Given that a death had been reported, an investigator from the Lucas County Coroner's Office, Barry Porter, was dispatched to the scene. Mr. Porter was a flight nurse in the United States Air Force, and a long time practicing nurse after leaving the military. He was also an Advanced EMT. In all, Mr. Porter explained that he has about forty (40) years of working in healthcare as either a nurse or EMT.

Mr. Porter identified in his report and confirmed in his interview that he arrived on scene at 9:45 a.m. [one (1) hour and seventeen (17) minutes after the then documented time of death]. He explained that the process in a situation of this nature is to treat the scene as a "crime scene". He identified that when he enters a room, he takes photographs from the entry to the decedent, which he did in this instance. I viewed some of those photos which were on a phone in his possession. In the photos (and in the Video) upon entry, the Patient was supine on a bed located in the corner of a room. Her right arm and hand were above her head a slightly to the right with arm in a flexed position. Mr. Porter explained in the interview and in his written report that he raised her shirt to take a photo of her chest and abdomen, and when he touched her, she felt *warm* to the touch. He also wrote in his report that there were no signs of post mortem lividity or rigor. At approximately 9:57 a.m. as he turned the Patient's face to take a better photo for identification purposes, he heard a gasp from her mouth. He first believed that it may have been just trapped air in her abdomen or lungs. He then noticed "shallow respirations" and a "slight rise in the abdomen". He confirmed that she was having spontaneous respirations. He alerted TPD personnel on scene and asked if they had oxygen or a face mask, and asked them to call the fire department personnel back to the scene. A TPD Vice Sergeant on scene stated to Mr. Porter that he too saw the Patient breathing. Mr. Porter opened the Patient's mouth and moved her jaw to further clear an airway. He noticed no signs of rigor or stiffness. Three doses of Narcan were administered, as well as assisted breathing. Around that time TFRD personnel arrived and took over the scene - - at which time he then exited the home and premises.

During my interview with Mr. Porter, he showed this investigator pictures that he had taken at the scene, and in those pictures, there is no apparent bruising, or what would appear to be any other potential signs of lividity.

(v) Interview of Shelbie Flegal

Ms. Flegal was interviewed and identified that the same day of the incident that Messrs. Yoon and Fordyce came back to the station and were joking about the fact that they had caused a person to be declared deceased, but who was not. She stated that the very next shift, Mr. Yoon stated to her regarding another run, "what, you don't trust me to take a pulse".

IV. Discussion Regarding STFD Paramedics - Findings

(i) *Aiden Yoon*

Simply put, Mr. Yoon's version of the facts are not credible. He stated in his interview that he and Mr. Fordyce were acting with a "sense of urgency" once the dog was removed from the premises. That is betrayed entirely by the Video. It took the two (2) of

them twenty-nine (29) seconds to walk approximately twenty (20) feet to get into the house. The Video shows them very slowly and nonchalantly walking into the house once the dog was out of the house. Also, Mr. Yoon stated that he called for the TFRD employees to get the equipment and supplies from his vehicle, which did not happen. That is confirmed by both the Video, and Mr. Fordyce's statement and interview. The equipment and supplies remained in the STFD vehicle from approximately 8:09 a.m. until Messrs. Yoon and Fordyce exited the scene. It is clear they had no intention of attempting to resuscitate the Patient once they gained access to her. Additionally, Mr. Yoon's suggestion that he checked the right radial pulse does not make sense under any circumstance. The Patient's arm was over her head on the right side of her body. He and Mr. Fordyce were on her left side, as she was supine on the bed. Therefore, the right radial would have been the farthest point from where they were in terms of where pulses should be checked. Moreover, the proper protocol, according to Mr. Young (and his decades of experience), as well as B.C. Ziehr, is to check a carotid pulse (the neck), then femoral (groin area), and then radial. The reason for that is the radial pulse is farthest from the heart, and least likely to show a pulse even if someone's heart is still beating. In this instance also, the right radial was across the patient's body, and above the source of a pulse (the heart). For these reasons, checking the right radial pulse area is nonsensical, which suggests a lack of candor in what actually occurred.

Also, only Messrs. Fordyce and Mr. Yoon were present in the room at the time the "Code 18" was called by Mr. Yoon. As Mr. Fordyce indicated, if Mr. Yoon would have checked a pulse, he would have seen him do so - - and yet he did not. Also, it is not credible that a full assessment was completed on the Patient in approximately one (1) minute from the time they entered the house, which was the basis to call a "Code 18" as heard on the Video. In summary, it is more likely than not that Mr. Yoon never checked for a pulse.

(ii) ***William Fordyce***

Mr. Fordyce was not the lead paramedic on the call. However, he acknowledged that he was equally responsible for the Patient's care. He stated in his interview that he thought there was dependent lividity, and he stated the same in his written statement. He also stated in his interview that he did not take a pulse. But, when he was standing next to Mr. Yoon, he appears to prompt Mr. Yoon to express to Dr. Scott on the Med Line that there was dependent lividity, which Mr. Yoon did state to Dr. Scott, and even though he (Mr. Yoon) stated that he did not see such signs. His (Mr. Yoon) explanation was that the "trusted his partner", Mr. Fordyce. Thus, in summary, the notion of "dependent lividity" as a basis for a time of death came from Mr. Fordyce. Additionally, Mr. Fordyce's statement that the Patient was "cool to the touch" is directly contradicted by Mr. Porter's report - - who was not at the scene until one (1) hour and seventeen (17) minutes after the time of death was called, and he noted that the Patient was warm to the touch. Both Mr. Porter and Mr. Young indicated that lividity or even bruising that could be mistaken for lividity does not just disappear within a few hours. It is therefore, more likely than not that there were not actual signs of dependent lividity. It is also clear that notwithstanding that Mr. Fordyce did not see Mr. Yoon take a pulse on the Patient, and yet Mr. Yoon still reported that she was "pulseless", there was no question or attempt to inquire of Mr. Yoon whether he was certain there was no pulse. Likewise, there was no questioning of Mr. Fordyce by Mr. Yoon whether he was certain he saw lividity, even though he claims he did not see any signs thereof. In shorty, both Messrs. Yoon and Mr. Fordyce were derelict of their duty in ensuring that the Patient was actually deceased before they chose

to make the call to Dr. Scott (and report lividity and pulseless), assert that the patient showed obvious signs of death, and to not engage in any resuscitative efforts.

IV. Recommendations

Pursuant to Section 11.3 of the CBA, which applies to Messrs. Yoon and Mr. Fordyce, their actions identified herein constitute "neglect of duty as relates to patient care", "incompetency and/or grossly negligent or willful breach of" Standard Operating Procedures. Additionally, Mr. Yoon was not forthright with his interview or in his written statement. He also seemed less than contrite for his actions as he was reportedly joking about the circumstances one (1) day later. Mr. Fordyce's version of what occurred in both his written statement and his interview was not accurate. That is, he could not have seen signs of lividity, which he reported to Mr. Yoon as identified above. Based upon their failure to follow protocol, lack of candor, Mr. Yoon's lack of remorse for his actions (and inactions), and their neglect of duty owed to the Patient, I recommend termination of their employment with the STFD.