

BEFORE THE
EMERGENCY MEDICAL SERVICES AUTHORITY
STATE OF CALIFORNIA

In the Matter of the Emergency Medical
Technician – Paramedic License Held by:

RICHARD HOULE,
License Number P09946,

Respondent.

Case No.: 07-0317

OAH No.: 2009090699

DECISION

The attached Proposed Decision of the Administrative Law Judge is hereby adopted
by the Emergency Medical Services Authority as its Decision in the above-entitled matter.

This Decision shall become effective

5/1/10

IT IS SO ORDERED

4/29/10

EMERGENCY MEDICAL SERVICES AUTHORITY
STATE OF CALIFORNIA

By



rfm

**BEFORE THE
EMERGENCY MEDICAL SERVICES AUTHORITY
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In the Matter of the Emergency Medical
Technician-Paramedic License Held by:

RICHARD HOULE,
License No. P03946

Respondent.

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PROPOSED DECISION

Presiding Administrative Law Judge Michael A. Scarlett, Office of Administrative Hearings, State of California, heard this matter in Los Angeles, California on January 25, 2010.

Cynthia L. Curry, Senior Staff Counsel, Emergency Medical Services Authority, represented Complainant.

Robert R. Rico, Attorney at Law, represented Richard Houle (Respondent) who was present at the hearing.

Evidence was received, the case was argued, and the matter submitted for decision on January 25, 2010. The Administrative Law Judge hereby makes his factual findings, legal conclusions, and order.

FACTUAL FINDINGS

1. On July 22, 2009, Complainant Nancy Steiner issued the Accusation in the above-captioned matter while acting in her official capacity as Chief of the EMS Personnel Division of the Emergency Medical Services Authority (the Authority), State of California. On August 3, 2009, Respondent submitted his Notice of Defense and this hearing ensued. All jurisdictional requirements have been met.

2. On July 1, 1990, the Authority issued Emergency Medical Technician-Paramedic (EMT-P), license number P03946 to Respondent. His license was in full force and effect at all times relevant to the allegations brought in this case and will expire on June 30, 2010, unless renewed.

3. Respondent has been a firefighter with the Los Angeles Fire Department (LAFD) for over 40 years. He also worked as a paramedic with the City of Los Angeles since 1973, almost 27 years. At all times relevant to the allegations in the Authority's Accusation, Respondent was assigned to Fire station No.3 and Rescue Ambulance No.3 as the "lead paramedic."

4. On December 11, 2006, Respondent and his partner, paramedic Jason Braff, were dispatched to the Los Angeles Police Department (LAPD) Parker Center Jail in response to a medical emergency related to Robert Jones (Jones), an inmate at the jail. Prior to Respondent's arrival Jones had been forcibly extracted from his jail cell by LAPD officers and taken to the jail infirmary. Jones had been arrested for suspicion of being under the influence of a controlled substance/drug and was reacting violently and erratically in his jail cell. Upon arrival at the LAPD city jail, Respondent and Braff were directed to the jail infirmary. Jones was strapped to a LAPD gurney restrained in handcuffs, feet tied with a hobble restraint device, and were wearing a "spit sock." At least four LAPD officers were required to restrain him on the gurney even though he was handcuffed, feet tied, and cuffed to the rail of the gurney. Jones, who was very large and muscular, was exhibiting violent behavior and struggling with officers to free himself from the restraints.

5. Respondent spoke with the physician on duty when he and Braff arrived. The physician advised Respondent that he suspected Jones had overdosed on an "unknown" substance. The physician and nurse on duty were unable to check Jones's vital signs, i.e. blood pressure and pulse rate, due to his combative behavior while restrained on the gurney. Jones was given two milligrams of "Atavin" by the jail physician in an attempt to "calm" him down, but it did not appear to have any immediate impact. In Respondent's opinion, the inmate posed a significant threat of danger to himself or others if he had not been restrained on the gurney by the police officers.

6. Respondent instructed the LAPD officers to transfer Jones from the infirmary gurney to the EMT gurney for transport to the rescue ambulance. Respondent testified that he instructed LAPD officers to transfer the patient onto the EMT gurney in a lateral position on the patient's side. LAPD officers placed Jones onto the EMT gurney with his hands cuffed behind his back, attached to one of the guard rails on the gurney, his feet still tied with the hobble device employed by LAPD, and the "spit sock" over his head. In addition, straps were used to secure the patient to the gurney in an attempt to restrict his movement. Thereafter, Jones was transported by LAPD officers and paramedic Braff from the jail infirmary to the rescue ambulance in the parking lot of the jail. Jones continued to struggle on the EMT gurney during transport to the rescue ambulance. During transport from the jail infirmary to the rescue ambulance, he turned over onto his face in a prone position with his hands cuffed behind his back. It took less than two minutes to transport the patient from the jail infirmary to the rescue ambulance.

7. Respondent testified that he remained in the LAPD infirmary to obtain information about the patient needed to complete the Emergency Medical Service Report (EMT Report), which is filled out by paramedics after every emergency call, and to gather the EMT

equipment taken into the jail by the paramedics. Respondent did not arrive at the rescue ambulance until after the patient was placed in the back of the vehicle by Braff and the LAPD officers. After Respondent entered the rescue ambulance, he and paramedic Braff instructed the LAPD officers accompanying the patient to release the rail restraint and reposition him in a lateral position to allow the paramedics to check his vital signs. Within minutes of being placed into the rescue ambulance Jones went into cardiac arrest and required advance life support (ALS) procedures, including cardio pulmonary resuscitation (CPR). The paramedics were successful in resuscitating Jones but he later died after arriving at the hospital.

8. The Authority alleges Respondent's EMT-P license is subject to discipline under Health and Safety Code section 1798.200, subdivision (c) in that while performing his duties as a paramedic, Respondent committed gross negligence when he "functioned outside the supervision of medical control" and violated the regulations applying to the conduct of paramedics. The Authority asserts that Respondent failed to properly transport the restrained patient in conformity with Los Angeles County Emergency Medical Services guidelines and protocols and failed to take the appropriate equipment with him into the jail infirmary to treat the patient during transport. The Authority does not allege that Respondent is responsible for Jones's death due to improper transport. There was no evidence offered to establish cause of death or that Respondent's conduct was a contributory factor in the death of the patient.

9. Respondent contends that he did not violate the Emergency Medical Service guidelines or protocols. He asserts he complied with the guidelines and protocols in transporting the patient, and furthermore that he was not attending the patient during the brief period when he was transported from the jail infirmary to the rescue ambulance. Respondents argues that he did not become aware the patient had been transported in the prone position until he re-entered the rescue ambulance, at which time he instructed LAPD officers to reposition the patient in a lateral position on his side.

10. Los Angeles County Emergency Medical Services (EMS) Agency Medical Control Guidelines (Guidelines), Principle No. 1 states that "EMS personnel must always act as the restrained patient's advocate. The application of restraints is a high risk procedure, due to the inability of the restrained patient to protect his/her basic needs and rights. Improperly applied restraints could possibly lead to permanent nerve damage, kidney failure from circulatory compromise, aspiration, and death from respiratory compromise." EMS Guideline No. 1 states in pertinent part that "[p]atients shall **not** be transported in the prone position, regardless who has applied the restraint." Guideline No. 2 states that "[r]estraints applied by law enforcement require the officer to remain available at the scene and during transportation to remove or adjust the restraints for patient safety."

11. Los Angeles County, Department of Health Services, EMS Agency Protocol No. 838, referring to the "Application of Patient Restraints," Principle No. 5 states that:

The method of restraint used shall allow for adequate monitoring of vital signs and shall not restrict the ability to protect the patient's airway or compromise neurological or vascular status.

12. EMS Agency Protocol No. 838, Policy No. II(C) "Application and Monitoring of Restraints by EMS Personnel" and Policy No. III(B) "Application of Restraints by Law Enforcement" state that:

Patients shall not be transported in a prone position. Prehospital personnel must ensure that the patient's position does not compromise the patient's respiratory/circulatory systems, and does not preclude any necessary medical intervention to protect or manage the airway should vomiting occur.

13. The Authority relies on interviews of Respondent and paramedic Braff conducted by the LAPD in the investigation of the in-custody death of inmate Jones, and an eight minute video tape. The first six minutes of the video tape primarily shows an irate Jones being forcibly extracted from his cell by LAPD officers and taken to the jail infirmary. Of particular note for this hearing is the last one and one-half minutes of the video tape showing Jones being taken on an EMT gurney from the back door of the jail facility to the LAFD rescue ambulance. The video tape shows the patient in a prone, face-down position in restraints, his hands cuffed and feet tied, and strapped to the gurney. He is being taken to the rescue ambulance by LAPD officers and paramedic Jason Braff. Respondent does not appear in the video tape in the infirmary or during transport of the patient to the rescue ambulance.

14. Patient Jones was in the custody and control of the LAPD at all times during transport from the infirmary to the hospital. LAPD required that the patient be handcuffed, feet restrained with the huddle device, and that he be cuffed to the guardrail of the gurney during transport. Although these restraints were required by law enforcement, the EMT paramedics were required to comply with EMS protocols and guidelines that provide a patient shall not be transported in a prone position where restraints are used. Respondent credibly testified that he instructed the LAPD officers to position patient Jones on his side in a lateral position when the patient was initially placed on the EMT gurney in the jail infirmary. He stated that LAPD complied with this request and the patient was placed in a lateral position on the EMT gurney. Respondent's testimony is corroborated by statements made by paramedic Braff in an interview taken on December 13, 2006, by the LAPD in conjunction with an investigation of the in-custody death of Jones. Braff stated that Jones was placed in "basically a left - or right lateral" position on the EMT gurney by LAPD officers in the infirmary.

15. The video tape does not provide conclusive evidence of the position in which Jones was initially placed on the EMT gurney. It merely shows the patient in a prone position for approximately one and one-half minutes during transport from the back door of the jail to the rear of the rescue ambulance. However, patient Jones exhibited noncompliant, combative behavior inside the infirmary and he continued to struggle with his restraints

during transport to the rescue ambulance. It was believed that Jones had overdosed on an unknown drug. The paramedics were called because the LAPD physician was unable to examine or control Jones due to his aggressive behavior, even with four LAPD officers attempting to restrain him on the infirmary gurney. It is not inconceivable that Jones inadvertently altered his position on the gurney during the short distance from the infirmary to the rear of the rescue ambulance. Jones's struggles to free himself from the restraints applied by LAPD undoubtedly caused, or significantly contributed to, his being repositioned into a prone position on the EMT gurney.

16. The evidence also showed that Respondent was not present with patient Jones during transport from the jail infirmary to the rescue ambulance. Respondent credibly testified that he remained in the infirmary to obtain information about the patient to complete the Emergency Medical Services Report filled out whenever the paramedics respond to an emergency call. His testimony is corroborated by his absence from the video tape of the patient's transport. Respondent does not appear in the video tape and paramedic Braff is the paramedic attending to Jones during this brief period.

17. There is insufficient evidence to conclude Respondent was grossly negligent or functioned outside the supervision of medical control in the field care system when Jones was transported from the jail infirmary to the rescue ambulance on December 11, 2006. The Authority relied solely on evidence other than the video tape to support its assertion of misconduct by the Respondent. The one and one-half minute portion of the video tape showing patient Jones in a prone position on the EMT gurney does not constitute a violation of the EMS guidelines and protocols prohibiting transporting a restrained patient in a prone position, particularly where the patient was as combative and aggressive as patient Jones was in this emergency response call. Respondent acted reasonably and gave proper instruction to the LAPD officers responsible for securing patient Jones during the transport of the patient by Respondent.

18. Respondent also credibly testified that once patient Jones was placed in the rear of the rescue ambulance, the LAPD officers were instructed to release some of the restraints and to reposition the patient into a lateral position so that his vital signs could be checked and he could be properly monitored by the paramedics. This testimony was again corroborated by statements made by paramedic Braff in his December 13, 2006, interview for the LADP in-custody death investigation. Consequently, Respondent gave proper instruction to the LAPD officers regarding the proper positioning of the patient on the occasions in which he was in the presence of and physically responsible for the patient's care. But for the brief period the patient was being taken to the rescue ambulance from the jail infirmary, Respondent attempted to insure that the restrained patient was properly positioned in a lateral position on the EMT gurney.

19. There was also insufficient evidence to conclude that Respondent failed to take the appropriate equipment with him into the jail infirmary to treat the patient. Respondent credibly testified that he did in fact take his equipment into the infirmary and returned to the rescue ambulance with the equipment after the patient was placed in the vehicle.

Complainant relies solely on the video tape in asserting that the paramedics did not have the appropriate equipment because the equipment did not appear in the video tape. However, Respondent explained that he followed paramedic Braff to the rescue ambulance after obtaining additional information from the LAPD physician regarding patient Jones. Neither Respondent nor the equipment he was carrying appeared in the video tape relied upon by Respondent. Respondent's credible testimony afforded more weight than the video tape relied upon by Complainant.

LEGAL CONCLUSIONS

Jurisdiction

1. The Authority has jurisdiction to proceed in this matter pursuant to Health and Safety Code section 1798.200,¹ based on Factual Findings 1 through 3. Administrative proceedings to revoke, suspend, or impose discipline on a professional license are nonpenal; they are not intended to punish the licensee, but rather to protect the public. (*Griffiths v. Superior Court* (2002) 96 Cal.App.4th 757, 768.)

2. The standard of proof in an administrative proceeding seeking to suspend or revoke a certificate that requires substantial education, training, and testing is "clear and convincing evidence." (*Eittinger v. Bd. of Med. Quality Assurance* (1982) 135 Cal.App.3d 853.) Clear and convincing evidence requires a finding of high probability, or evidence so clear as to leave no substantial doubt; sufficiently strong to command the unhesitating assent of every reasonable mind. (*Katie V. v. Superior Court* (2005) 130 Cal.App.4th 586, 594.)

Applicable Law

3. Health and Safety Code section 1798.200 provides in part:

"(b) The authority may . . . suspend, or revoke any EMT-P license issued under this division, or may place any EMT-P license issued under this division, or may place any EMT-P licenseholder on probation upon the finding by the director of the occurrence of any of the actions listed in subdivision (c) . . .

(c) Any of the following actions shall be considered evidence of a threat to the public health and safety and may result in the . . . suspension, or revocation of a certificate or license issued under this division, or in the placement on probation of a certificate or licenseholder under this division:

[¶]...[¶]

¹ All statutory references are to the Health and Safety Code unless otherwise specifically noted.

(2) Gross negligence.

[¶]...[¶]

(7) Violating or attempting to violate directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this division or the regulations adopted by the authority pertaining to prehospital personnel.

[¶]...[¶]

(10) Functioning outside the supervision of medical control in the field care system operating at the local level, except as authorized by any other license or certification. . . .”

4. “For the purposes of denial, placement on probation, suspension, or revocation, of a license, pursuant to Section 1798.200 of the Health and Safety Code . . . , a crime or act shall be substantially related to the qualifications, functions and/or duties of a person holding a paramedic license under Division 2.5 of the Health and Safety Code. A crime or act shall be considered to be substantially related to the qualifications, functions, or duties of a paramedic if to a substantial degree it evidences present or potential unfitness of a paramedic to perform the functions authorized by her/his license in a manner consistent with the public health and safety.” (Cal. Code Regs. tit. 22 § 100174, subd. (a).)

Determination of Issues

5. Cause does not exist to suspend or revoke Respondent’s EMT-P license pursuant to Health and Safety Code section 1798.200, subdivisions (c)(2), (c)(7), or (c)(10) in that there was insufficient evidence to conclude that Respondent was grossly negligent, violated or attempted any law enforced by the Authority, or functioned outside the supervision of medical control in transporting patient Jones on December 11, 2006, by reason of Factual Findings 4 through 19.

Discussion

The Authority must show by clear and convincing evidence that Respondent functioned outside the supervision of medical control or that his conduct constituted gross negligence. Gross negligence has been defined as: “the want of even scant care or an extreme departure from the ordinary standard of conduct.” (*Kearl v. Board of Medical Quality Assurance*, (1986) 189 Cal.App.3d 1040, at p.p. 1052-53; quoting *Cooper v. Board of Medical Examiners* (1975) 49 Cal.App.3d 931, 941; *Van Meter v. Bent Construction Co.* (1956) 46 Cal.2d 588, 594.) Although the evidence showed that inmate/patient Jones was transported restrained and in the prone position for less than two minutes, this brief period of transport did not violate the EMS guidelines and protocols regulating the transport of restrained patients by a paramedic.

Given the circumstances accompanying the EMT response by Respondent and his partner on December 11, 2006, it can not be concluded that Respondent acted outside the supervision of medical control in the field care at the local level, violated any laws of the Authority, or committed gross negligence in transporting patient Jones. The EMS guidelines and protocols specifically prohibit transporting a restrained patient in the prone position. However, evidence showed that Respondent instructed the LAPD officers to position patient Jones on the EMT gurney in a lateral position, not prone position, in conformance with EMS Guidelines Principal No. 1 and EMS Protocol No. 838.

Evidence showed that patient Jones was restrained in the prone position on the EMT gurney for approximately one and one-half minutes while being transported from the jail infirmary to the rear of the EMT rescue ambulance. This brief period in a prone position was a result of the patient's own aggressive and violent behavior in attempting free himself of the restraints required by LAPD. The patient was restrained in this manner because he posed a significant threat to himself and others.

Respondent could not have adjusted the patient's position on the EMT gurney during this short window of time given the patient's combative disposition. No less than four LAPD officers were required to keep patient Jones on the gurney in the infirmary, and the physician could not examine Jones because he could not be controlled. The EMS guidelines and protocols do not prohibit Jones being in a prone position for this short period under the circumstances of this case. Respondent acted reasonably and in accordance with EMS guidelines and protocols when he gave instructions to LAPD officers, who were in charge of the inmate/patient at all relevant time periods, to position the patient in the lateral position on the gurney, first in the infirmary, and then a few minutes later in the rear of the rescue ambulance.

Moreover, the evidence showed Respondent was not present during the approximately two minutes the patient was in the prone position because Respondent remained in the infirmary obtaining information to complete the EMT report and to gather the EMT equipment used for the emergency call.²

Although the Authority alleged Respondent was also subject to discipline because he failed to take the appropriate equipment into jail infirmary when responding to the emergency call, the evidence did not support this allegation. Respondent credibly testified

² At hearing, the Authority asserted that even if Respondent was not present during the time Jones was transferred from the jail to the rescue ambulance, as the "lead paramedic" he was responsible for the patient's care regardless. The Authority offered no legal authority for this position, either regulatory or case law. However, courts have held that a professional licensee may not be held vicariously liable for the alleged negligent conduct of another professional licensee in the absence of evidence that the Respondent actually ratified, approved of, or had control over the work of the other licensee. (*James v. Board of Dental Examiners* (1985) 172 Cal.App.3d 1096.)

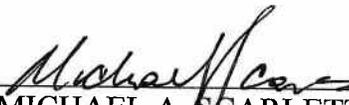
that he and his partner took the necessary equipment into the jail infirmary. The Authority's only evidence supporting its allegation is the absence of the EMT equipment in the eight minute video tape of patient Jones being taken from the jail infirmary. This does not constitute clear and convincing evidence that Respondent did not have the appropriate equipment to respond to the emergency call.

There is insufficient evidence to conclude Respondent acted in a grossly negligent manner. Respondent's conduct was not an extreme departure from the ordinary standard of care as specified in the EMS guidelines and protocols. (*Kearl v. Board of Medical Quality Assurance, supra*, 189 Cal.App.3d 1040, at p.p. 1052-53.) Consequently, no laws or regulations enforced by the Authority violated by Respondent's conduct on December 11, 2006. Based upon the totality of the evidence, Respondent acted in conformity with the EMS guidelines and protocols.

ORDER

The Authority's Accusation against Respondent Richard Houle, EMT-P license number P03946 is hereby Dismissed.

April 23, 2010


MICHAEL A. SCARLETT
Presiding Administrative Law Judge
Office of Administrative Hearings