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BEFORE THE
EMERGENCY MEDICAL SERVICES AUTHORITY
STATE OF CALIFORNIA

In the Matter of the Emergency Medical
Technician- Paramedic License of:

MARK FINSTUEN
License No. P0431
Respondent.

)
) Enforcement Matter No.: 15-0194
) OAH No.: 2016080056
)

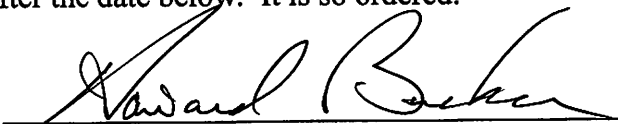
) **DECISION AND ORDER**
)
)
)

The attached Proposed Decision is hereby adopted by the Emergency Medical Services
Authority as its Decision in this matter.

This decision shall become effective 30 days after the date below. It is so ordered.

DATED:

May 4, 2017


Howard Backer MD, MPH
Director
Emergency Medical Services Authority

BEFORE THE
EMERGENCY MEDICAL SERVICES AUTHORITY
STATE OF CALIFORNIA

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

MARK FINSTUEN,
License No. P04311,

Respondent.

Case No. 15-0194

OAH No. 2016080056

PROPOSED DECISION

Debra D. Nye-Perkins, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter in San Diego, California, on March 6 through 8, 2017.

Stephen J. Egan, Staff Counsel III, represented complainant Sean Trask, Chief of the EMS Personnel Division of the Emergency Medical Services Authority (EMSA or Authority).

James Cunningham, Attorney at Law, represented respondent Mark Finstuen.

The matter was consolidated for hearing with Case No. 15-0195, OAH No. 2016080052 (Matthew N. Duhamell); Case No. 15-0281, OAH No. 2016080059 (Gabriel D. Kessler); and Case No. 15-0280, OAH No. 2016080060 (Anthony Valentine). At the hearing the parties requested that separate decisions be issued for each respondent. The matters were submitted for decisions on March 8, 2017.

FACTUAL FINDINGS

License Background

1. On an unknown date in the 1980's,¹ EMSA issued Emergency Medical Technician -Paramedic (EMT-P) license number P24439 to respondent. His license is

¹ The documents received related to respondent's license history were incomplete and provided no information on the date of issuance of respondent's EMT-P license and no

currently valid, unless revoked or suspended. There is no history of discipline against that license.

Jurisdictional Information

2. On June 21, 2016, complainant executed the Accusation in the above - captioned matter in his official capacity. The Accusation alleged four causes for discipline: First, respondent violated Health and Safety Code section 1798.200, subdivision (c)(2), gross negligence, and subdivision (c)(4), incompetence, for failing to provide prehospital care to patient G.M., taking inadequate vital signs of G.M., failing to determine patient G.M.'s mental orientation, fraudulently preparing an electronic Patient Care Report (ePCR) for G.M., falsifying G.M.'s signature on a document indicating that G.M. refused to be transferred by ambulance, failing to contact base hospital for patient G.M., and refusing to transport G.M. in an ambulance to the hospital on May 17, 2015; Second, respondent violated Health and Safety Code section 1798.200, subdivision (c)(5), the commission of a fraudulent, dishonest, or corrupt act that is substantially related to the duties of prehospital personnel, for fraudulently preparing the ePCR for patient G.M.; Third, respondent violated Health and Safety Code section 1798.200, subdivision (c)(7), violating or conspiring to violate any provision of the regulations pertaining to prehospital personnel, for conspiring with respondent Matthew N. Duhamell to fraudulently prepare the PCR for patient G.M. and for falsely reporting that patient G.M. refused to be transported by ambulance; and Fourth, respondent violated Health and Safety Code section 1798.200, subdivision (c)(10), functioning outside the supervision of medical control in the field care system operating at the local level, for his failure to comply with protocols, regulations and statutes, including Policy S-415 and Policy S-412, for failing to provide the minimal level of required care for patient G.M.

3. Respondent timely submitted his Notice of Defense.

The May 17, 2015, Emergency Response For Patient G.M.

4. On May 17, 2015, at 10:36 p.m. Francisca Moon placed a telephone call to 911 requesting assistance for patient G.M. The transcript of the 911 telephone call was received into evidence. The transcript shows that Mrs. Moon told the 911 operator that G.M. was 86 years old, had been "running his bowels loose since this morning," and had become weaker as the day progressed. Mrs. Moon told the operator that G.M. broke out in a cold sweat about two hours prior to her call to 911 and that G.M. was awake and breathing. Mrs. Moon further stated that she was afraid to touch G.M. "because he might pass out on me." In response to the 911 operator's question of, "Is he completely alert?," Mrs. Moon stated:

information regarding the expiration of his license. The documents indicated only that his EMT-P license is currently active. Respondent testified that his EMT-P license is currently active and he has had no history of prior discipline.

No, he's not completely alert, he's, I mean, he's confused at times. But today it's more or less alert, yes.

The 911 operator then asked Mrs. Moon, "Is he alert to what he normally would be?" and Mrs. Moon responded, "Yes. No, no, no, no. He's, he's lethargic." Mrs. Moon told the 911 operator that G.M. was breathing normally with "some kind of excitement because he's got a bad stomach, a stomachache and he's weak, I can tell that he's weak." Mrs. Moon told the 911 operator that G.M.'s heart rate was 104 but had gone down to 102. In response to the 911 operator's question regarding G.M.'s color, Mrs. Moon stated that G.M. was "very pale, very, very pale . . . they said they were giving him transfusion in the nursing home or the hospital, one of the two, but I don't think they did because, I mean, he doesn't look good to me." In response to the 911 operator's question, "Is he clammy?," Mrs. Moon responded "Very clammy, I mean just clammy." Mrs. Moon informed the 911 operator that G.M. had a quadruple bypass about 18 years ago and that he is currently taking medication for Parkinson's Disease. The 911 operator told Mrs. Moon that paramedics were on the way to their home, and she should be prepared to give the paramedics a list of the medications G.M. was taking.

5. At 10:36 p.m. on May 17, 2015, the 911 emergency dispatcher assigned paramedics from the Oceanside Fire Department (OFD) to respond to G.M.'s home. By 10:38 p.m. on May 17, 2015, the paramedics were on route; they arrived at G.M.'s home at 10:43 p.m. One fire engine and one ambulance were dispatched G.M.'s home. The fire engine arrived on the scene first. Respondent Finstuen, Engineer Schrader and respondent² Duhamell arrived in the fire engine, and respondent Kessler and respondent Valentine arrived soon thereafter in the ambulance. Respondent Duhamell was the primary paramedic responsible for evaluating G.M. and providing medical aid as necessary.

Information obtained during the emergency response is documented on an electronic Patient Care Report (ePCR) through the use of an iPad. Some of the information in the ePCR is automatically generated by the 911 dispatcher and from the computer system, such as time and date. Other information in the ePCR, such as vital signs and statistics, is manually entered by the paramedics. For G.M.'s evaluation, respondent Duhamell utilized a Zoll monitor to obtain vital signs. The Zoll monitor will obtain results of an electrocardiogram (EKG), blood pressure, oxygen saturation, and pulse for a patient automatically if properly connected to the patient for each of those functions. The information obtained from the Zoll monitor must be manually entered into the ePCR. Information entered into the ePCR is recorded and, if any changes are made to the information, the date and time of the changes are also recorded in the ePCR. Any information entered into the ePCR for the patient is recorded and if any changes are made to the information, the date and time of any such change is also recorded in the ePCR.

² The paramedics who are the subject of these four consolidated accusations shall be referred to as respondents in this decision.

While Duhamell was assessing G.M., respondent Finstuen was documenting information gathered from G.M. and F.M., such as G.M.'s medical history, on the ePCR. At some point during Duhamell's evaluation of G.M., respondent Finstuen gave the iPad to respondent Duhamell so that he could enter G.M.'s vital signs from the Zoll monitor in the ePCR.

The vital signs entered in the ePCR indicated that G.M.'s vital signs were normal. Specifically, his pulse was 95, his blood pressure was 124/68, his oxygen saturation was 96 percent, his skin color and temperature were normal, his eyes were opening spontaneously, and he was "oriented x3." The "narrative" portion of the ePCR noted that G.M. was found sitting in a chair with a chief complaint of abdominal pain. The ePCR showed that G.M.'s assessment was completed by respondent Duhamell at 10:58 p.m. and that G.M.'s assessment was normal in all areas other than pain and tenderness in his lower left abdomen. The assessment noted that G.M.'s abdominal pain was diffuse, and he had diarrhea, but there was no history of recent illness or trauma. The "Medical History" portion of the ePCR showed that G.M. had hypertension, was allergic to Compazine, had a medication list and had abdominal pain for one day. Under the "Transportation" section, the ePCR stated the patient refused ambulance transportation, and transportation to TriCity hospital was provided by the family. The ePCR also showed that a 12 lead EKG was performed on G.M. at 10:53 p.m. and showed a normal sinus rhythm. The ePCR recorded that paramedic Duhamell provided the information regarding the patient assessment and that the last date and time the document had been changed was May 17, 2015, at 11:01 p.m. There were no changes or alterations made to the ePCR after that entry.

The last page of the ePCR is dedicated to the "Against Medical Advice" (AMA) questions. It provides that G.M. refused ambulance transportation to the hospital and contains G.M.'s signature after the AMA waiver. The document has a series of seven questions related to the patient's ability to make the decision to refuse treatment or transportation against medical advice. The ePCR showed that each of the following questions was answered "yes":

- Patient/DDM oriented to person, place, time & event?
- Patient/DDM Unimpaired by drugs or alcohol?
- Patient/DDM competent to refuse care?
- Patient/DDM was advised 911 can be re-accessed?
- Risks & complications of refusal discussed?
- Patient is 18 years of age or emancipated?
- No medical care OR ONLY BLS care rendered?

Beneath the list of questions, the ePCR had a paragraph stating:

AMA: As the patient or responsible adult, I have been advised of the possible risks (up to and including death) and/or consequences of my refusal advice, care and/or further care.

I acknowledge that I have read and understand the terms of this release and I have signed this voluntarily. I hereby release and hold harmless the City of Oceanside, its representatives, agents, and the designated Base Hospital and its representatives from any and all further responsibility, for medical care, transportation, destination, advice, or any other form of assistance. I agree that this release shall be binding on my relatives, heirs, legal representatives and assigns. Additionally, I hereby acknowledge that I have received from the City of Oceanside, a copy of its Notice of Privacy Practices (NPP).

Beneath this paragraph is a signature line with a handwritten mark indicating G.M. had signed the acknowledgement and release. On the next page of the ePCR respondent Duhamell signed a statement stating, "I acknowledge that the above assessments/treatments were provided for this patient." The ePCR showed the call to G.M.'s home was cleared on May 17, 2015, at 10:57 p.m. Accordingly, the ePCT indicates that the paramedics were at G.M.'s home for a total of 14 minutes.

6. Prior to leaving G.M.'s home, the paramedics assisted G.M. into a car at his residence. The paramedics were still on the scene when Jose Paco drove that car away from the home, with passengers G.M. and Mrs. Moon, to the emergency room (ER) of TriCity Medical Center.

According to emergency room records, G.M. arrived at TriCity Medical Center's ER at 11:21 p.m. on May 17, 2015. Upon his arrival, G.M. was immediately assessed by a triage nurse. The nurse noted that G.M. presented as being very lethargic, conscience but barely responsive. G.M. was gasping for breath and his oxygen saturation measured by a pulse oximeter was critically low at 72 percent. G.M. appeared to be covered in vomit, emitted an odor of diarrhea, and was wet and sweating. During the approximately 10 minutes he was being evaluated by the triage nurse, G.M. was continuously vomiting a reddish-brown liquid. After assessing G.M. the triage nurse "called a code" and moved G.M. to the "code room" after witnessing him become unresponsive. Cardio-pulmonary resuscitation was initiated on G.M. in the code room after his heart rhythm changed from sinus rhythm to asystole. G.M. died in the code room; his time of death was 11:40 p.m.

Prior Emergency Responses To G.M.'s Home

7. During the 11 months before G.M.'s May 17, 2015, death, the OFD responded to 11 emergency calls at his home for various medical emergencies. For six of those emergency calls, G.M. was transported to the emergency room by ambulance. Four of those emergency calls were to request lift assistance because G.M.'s wife was unable to lift him and did not require transportation to the hospital.

One of the previous emergency calls was made at 11:35 p.m. on December 15, 2014, by Francisca Moon after G.M. fell and hit his head. According to the ePCR, engine 2115 of

the OFD was assigned to respond to the call at 11:35 p.m. and arrived at G.M.'s home at 11:44 p.m. Upon arrival, respondent Duhamell evaluated G.M. and obtained his medical history and medications G.M. had taken. G.M.'s primary complaint was nausea, and he exhibited nausea and vomiting, blurred vision and tinnitus, trauma to his head, weakness, and diarrhea. The ePCR noted that G.M. had run out of his anti-hypertension medication about one week prior to December 15, 2014. The ePCR further stated that G.M. and his wife represented they would follow up with G.M.'s normal physician on December 16, 2014, to re-establish his prescription. On that occasion, G.M. refused transportation to the hospital via ambulance. The ePCR contained the same AMA questions to evaluate G.M.'s ability to refuse medical advice and the same AMA paragraph and signature line as that in the ePCR for the May 17, 2015, emergency response. G.M.'s signature on the AMA for the December 15, 2014, appears to be very similar to the signature on the May 17, 2015, ePCR document. Respondent Duhamell signed the paramedic acknowledgement portion of the AMA for the December 15, 2014, emergency call.

COMPLAINANT'S EVIDENCE

Testimony of Francisca Moon

8. Francisca Moon is G.M.'s widow and is of advanced age. Mrs. Moon worked as a Certified Nurse Assistant (CNA) for 23 years. As a CNA, she worked for the city of San Francisco and in a nursing home and a hospital. Mrs. Moon testified that G.M. had been living in his home with her for one week before he died. Prior to that, G.M. spent two weeks in a nursing home after having hip surgery from a broken hip. She described G.M.'s medical history and stated he had Parkinson's Disease, a quadruple by-pass surgery about 22 years prior to his death, and dementia. Mrs. Moon stated that G.M. became confused at times and at other times his mind was clear, and she believed that his medications made him confused. Mrs. Moon stated that for the three years before G.M. died, he would put food out to feed the angels. Mrs. Moon believes that the "blessed mother" had cured G.M. of the shaking symptoms associated with his Parkinson's Disease, but his doctors insisted that G.M. keep taking his medications.

Mrs. Moon stated that when G.M. came home from the nursing facility one week prior to his death, the nursing facility provided her with instructions for his care. She stated G.M. needed "round the clock" care, and she was not able to provide that for him alone. Mrs. Moon stated that the nursing facility told her she needed an assistant at home to help her take care of G.M. and that he needed hospice. Mrs. Moon believes that his caretakers at the nursing facility knew G.M. was dying, but did not want to tell her.

9. Mrs. Moon testified that on May 17, 2015, she called 911 sometime between 5:00 p.m. and 6:00 p.m. She stated that she was feeding G.M. when he complained of pain in his side. When he looked up at her, he "had the face of a dead man." Mrs. Moon stated that G.M. "passed out on her" and she called 911. Early in her testimony, Mrs. Moon stated that when she called 911 on May 17, 2015, G.M. was "not breathing well" and could not communicate with her. She stated G.M. became unconscious prior to her calling 911, and he

never regained consciousness. Mrs. Moon later testified that when she called 911, G.M. was not breathing at all and had no blood pressure. Mrs. Moon also stated that prior to calling 911 she took G.M.'s pulse, but it was not elevated, and she attempted to take his blood pressure, but could not obtain a reading. She stated that he became very pale and was clammy and weak. Mrs. Moon testified that prior to calling 911, G.M. had "already messed his pants," but that she was so accustomed to the smell of feces from caring for him that she did not notice the smell. Mrs. Moon stated she did not tell the 911 operator anything about G.M.'s mental state because "they knew about" G.M., and she did not need to tell them anything. Mrs. Moon testified that after she called 911, she called a friend named Jose Paco, who had been helping her take care of G.M. for the past three years. Mr. Paco had just left their home that night, and she asked him to return. Mrs. Moon testified that Jose Paco returned to the home just prior to the paramedics arriving. Mrs. Moon stated that Mr. Paco was an illegal immigrant who, after G.M.'s death, was involved in a car accident and deported. Mr. Paco no longer lives in the United States and did not testify at the hearing.

Mrs. Moon repeatedly testified that prior to and when the paramedics arrived on May 17, 2015, G.M. was completely unconscious and never regained his consciousness. She testified that when the paramedics arrived, G.M. was sitting in a lounge chair in the family room. She stated the paramedics were "all over" G.M. in the family room and were speaking to each other, but not to G.M. because G.M. was not conscious. She stated G.M. did not speak to the paramedics at all. Mrs. Moon also testified that none of the paramedics asked her any questions or spoke to her during the emergency response. She also testified she provided a bag of medications to the paramedics and observed them talking to each other and taking notes. She recalled that the paramedics shook G.M.'s shoulder and called his name, but she does not recall seeing them put a blood pressure cuff on him, and she does not recall seeing them perform an EKG on G.M. Mrs. Moon recalled seeing the paramedics bring equipment into their home, but did not recall them using the equipment. Mrs. Moon testified she never spoke to respondent Finstuen and did not recall any paramedic asking her questions. Mrs. Moon testified the paramedics told her they were not going to take G.M. to the hospital in the ambulance; they were going to put G.M. in Mrs. Moon's car, and she had to take him to the hospital. Mrs. Moon testified she was stunned by the paramedic's statements and that when they told her this, two paramedics had already picked up G.M. from the lounge chair and carried him to her car in the garage. She does not recall which paramedics carried G.M. to the car. She stated she was shocked and stunned. She expected the paramedics would "revive" G.M. and take him to the hospital. She "did not know what to do with a dead body" at her home. Mrs. Moon testified she believes that when G.M. became unconscious prior to her call to 911, he was "already dead." Mrs. Moon also testified she never specifically asked the paramedics to take G.M. to the hospital in an ambulance.

Mrs. Moon testified that Mr. Paco drove the car to TriCity hospital with G.M. in the passenger seat while she held G.M. Mrs. Moon said Mr. Paco took the fastest route to the hospital, and when they arrived, Mr. Paco got a wheelchair and picked up G.M. from the car and placed him in the wheelchair. Mrs. Moon held G.M. in the wheelchair with her arm around his chest to hold him up and wheeled him into the emergency room herself. She

stated G.M. had feces on him and there was feces in the seat of her car. Mrs. Moon stated that when G.M. was in the emergency room and “they were taking his name” G.M. threw up blood. Mrs. Moon repeatedly stated she called 911 sometime between 5:00 p.m. and 6:00 p.m. on May 17, 2015, and that by 10:00 p.m. she was already in the hospital, and G.M. was already pronounced dead.

10. Mrs. Moon testified she was interviewed by an investigator from the state and spoke with that investigator twice over the telephone. Additionally, Mrs. Moon stated she was interviewed over the telephone by an individual named Cal Kik. She recalled also speaking to a person from the fire department. Mrs. Moon stated she did not understand why the paramedics did not take G.M. to the hospital in an ambulance. She repeatedly asked a clerk from the fire department this question, but never received an answer. Mrs. Moon also stated she had never had a problem with the paramedics when they had come to their home on prior occasions. She also stated G.M. never refused to be transported to the hospital in an ambulance on any occasion, and he always went to the hospital by ambulance when advised to do so.

Prior Statements Given by Francisca Moon

11. Two summaries of telephone interviews of Mrs. Moon taken by Linda Curtis-Smith, investigator for EMSA, were received in evidence. The first summary was the result of a telephone interview of Mrs. Moon taken by Linda Curtis-Smith at 10:00 a.m. on August 12, 2015. In the interview, Mrs. Moon told Ms. Curtis-Smith that on the morning of May 17, 2015, G.M. had diarrhea and was “not feeling too good.” Mrs. Moon stated that after she came home from church that day, she was feeding G.M. soup. Mrs. Moon stated she wanted to know why the paramedics did not take G.M. to the hospital that day. When Ms. Curtis-Smith told Mrs. Moon that the documents showed that G.M. refused to go in the ambulance to the hospital that day, Mrs. Moon stated “How could he have? He was not talking at that point.” Mrs. Moon told Ms. Curtis-Smith that G.M. was completely pale and had been for a while that day, and he was sweating, damp and clammy. Mrs. Moon stated that G.M.’s heart rate started at 104, then dropped to 102. Mrs. Moon stated “At the time we did not know that all his blood was draining into his stomach.” Mrs. Moon told Ms. Curtis-Smith that when the paramedics were at her house, nobody asked her if G.M. had a “Do not resuscitate” order, and nobody asked her about G.M.’s mental capacity. The interview summary contained the following quoted language from Mrs. Moon:

It was the tallest one; the biggest one of them all who told me they were not going to take him. I did not know what to say. I couldn’t say anything. [G.M.] was so sick, all his color was gone, he wasn’t responding to their questions. Why didn’t they take him? Maybe they could smell him because I didn’t have a chance to change him. Maybe they wouldn’t take him because he was dirty?”

In response to Ms. Curtis-Smith's question of whether G.M. had ever refused paramedic care or to go to the hospital before this incident, Mrs. Moon stated "No. He always went with them." When Ms. Curtis-Smith told Mrs. Moon that G.M. purportedly argued with the paramedics and refused to get in the ambulance, Mrs. Moon stated "It is not true because he was not talking anymore."

12. Ms. Curtis-Smith interviewed Mrs. Moon by telephone a second time at 2:30 p.m. on November 25, 2015. The interview summary shows the following quote from Mrs. Moon:

The paramedics were talking to each other, but not to [G.M.]. [G.M.] was not talking. I wouldn't swear to him being conscious. His eyes kept closing; he was pale, sweaty and had this look on his face. I can't describe it. You know I was certified nurse assistant for close to 40 years. I was very good at taking vitals. His blood pressure was okay, but his pulse was really high, first was 104 then 102.

Ms. Curtis-Smith wrote in the interview summary, "When asked, Mrs. Moon said [G.M.] did walk with the paramedic's help to the car. It would have been through the laundry room, down three steps to where the car was parked." Ms. Curtis-Smith further wrote "When told the paramedics said [G.M.] argued and insisted he did not want to go to [sic] hospital, Mrs. Moon responded "What!?" "That is shocking" "He wasn't even talking. And if the paramedics had told me [G.M.] was refusing, I would have told [G.M.], "No honey, you have to go in the ambulance. And he would have said okay." "No one told me [G.M.] said no." Ms. Curtis-Smith also wrote in the interview summary, "Mrs. Moon vacillated between he was clean to wondering if the paramedics did not take him because he smelled."

13. A third statement was given by Mrs. Moon to private investigator Cal Kik on January 16, 2017. In that statement, Mrs. Moon reiterated the same information from her testimony at this hearing with some notable differences. Specifically, in her statement to Cal Kik, Mrs. Moon stated she drove [G.M.] to the hospital on the evening of May 17, 2015, despite the fact that she did not have a driver's license. Mrs. Moon stated that Jose Gamboa was in the car with her and was holding [G.M.] while Mrs. Moon drove them to the hospital. Mrs. Moon told Cal Kik that she drove the car and did not worry about not having a license that day because it was an emergency.

Testimony of Susan Lynn Williamson

14. Susan Williamson is a registered nurse who has worked in the emergency room of TriCity hospital since 2002. She has been a registered nurse licensed in Illinois since 1991, and she received her California license as a registered nurse in 1993. Ms. Williamson was working in the emergency room of TriCity hospital on the evening of May 17, 2015, when patient [G.M.] entered the emergency room. On that evening, Ms.

Williamson was stationed at the triage area of the emergency room about 15 feet from the main doorway entrance. Ms. Williams testified that G.M. came into the emergency room at 11:21 p.m., a time that is also indicated on the documents from the TriCity records. Ms. Williams stated G.M. was wheeled into the emergency room in a wheelchair pushed by his wife while his wife also had her arm around G.M. Ms. Williamson observed that G.M. was lethargic, barely responsive, and he appeared to be rapidly losing consciousness. Ms. Williamson stated G.M. started gasping for breath, and she placed a pulse oximeter on him to obtain a reading of his oxygen saturation, which was critically low at 72 percent. She stated that normal oxygen saturation is 90 percent or more. She observed that he was wet and had been sweating.

After obtaining his oxygen saturation, Ms. Williamson placed an oxygen mask on G.M. because of his critically low oxygen saturation. However, she had to remove the mask because after she placed it on him G.M. began vomiting profusely. Ms. Williamson described the vomit as a red-brown liquid indicative of bleeding in the gastrointestinal tract. Ms. Williamson testified that while she was taking his vital signs, G.M. began vomiting and having diarrhea. Ms. Williamson stated she evaluated G.M. for about 10 minutes and, after that, she and others “called a code” for G.M. Ms. Williamson explained that “calling a code” is the term used to call the full team to respond to a patient who is in full cardiac arrest or is about to go into cardiac arrest. To respiratory therapists and one emergency room physician responded to the code to treat G.M.

Ms. Williamson stated G.M. was moved into the “code room,” which is a room in the emergency room where most cardio-pulmonary resuscitation (CPR) is conducted. Ms. Williamson testified the resuscitation records from the hospital show that G.M. arrived in the code room at 11:30 p.m. Ms. Williamson stated the code team was not able to revive G.M., and he died in the code room.

Testimony of Bruce E. Haynes, M.D.

15. Dr. Bruce E. Haynes retired from his position as Medical Director of the San Diego County Emergency Medical Service (EMS) on November 5, 2016, after 10 years of service. Prior to his position with San Diego County EMS, Dr. Haynes was the Medical Director Emergency Medical Service (EMS) for Orange County for 15 years, and he was the Director of EMS for the State of California for about five years. Dr. Haynes is board certified in Emergency Medicine. Dr. Haynes attended medical school at Creighton University in Nebraska. He was trained in Emergency Medicine at Harbor UCLA Medical Center in Los Angeles and was on the faculty there after his graduation. During his career Dr. Haynes practiced Emergency Medicine at Harbor UCLA Medical Center, Kaiser Hospital in San Diego, and at several hospitals in Los Angeles.

16. Dr. Haynes testified that his duties as the Medical Director of SDCEMS included reviewing and revising guidelines for EMS professionals to ensure consistency with current medical literature, as well as training and utilization of EMS for disaster response and other emergencies. As part of his work as the Medical Director of San Diego County EMS,

Dr. Haynes reviewed and wrote the protocols implemented by EMS professionals for patient care, including protocols numbered S-412 and S-415 at issue in this matter.

17. Dr. Haynes testified he first became aware of the May 17, 2015, emergency response to G.M.'s home when the staff at San Diego County EMS brought it to his attention. He stated he had never met Mrs. Moon and did not recall ever meeting any of the respondents prior to the hearing. Dr. Haynes stated he reviewed the ePCR related to the May 17, 2015, emergency response; the MICN run sheet from TriCity Medical Center, which is a record of the paramedic call for the case; the emergency department record of care for G.M.; and notes from a third party's discussion with the Oceanside nurse coordinator. Dr. Haynes stated that all of the information he obtained on this matter came from these documents, and stated "Our staff talked to people to determine what happened and then that staff talked to me about it."

Dr. Haynes stated he made a decision to make a complaint to EMSA for the state of California for each of the four respondents based solely on the documents he reviewed in this case. Dr. Haynes concluded that the paramedic's treatment of G.M. was a "significant incident." Dr. Haynes stated that the documents led him to the conclusion that it was a "significant incident" because G.M. was an elderly patient with abdominal tenderness and "was at a high risk of severe illness." He further stated that "the story painted by the doctors" in the hospital was that G.M. was severely ill when he presented at the hospital, but the information on the ePCR regarding his vital signs when evaluated by the paramedics was inconsistent with such severe illness. Dr. Haynes stated the ePCR "sets off alarm bells." However, when pressed on cross examination, Dr. Haynes admitted he had no reason to believe that the vital signs and information reported on the ePCR were inaccurate, and the vital signs of a patient could change dramatically in a very short period of time. Dr. Haynes also admitted there was no information on the ePCR to indicate that G.M.'s condition was high risk in any way.

Dr. Haynes also testified he did not believe G.M. was competent to sign the AMA document on the ePCR because he believes that G.M. was incapacitated when the paramedics evaluated him based on "information he received." Dr. Haynes stated that when he reviewed the ePCR he did not recognize or appreciate that there was a signature on the AMA release that purported to be that of G.M., but he still believes that G.M. was not capable of giving a signature at that time. Dr. Haynes further stated the basis for his belief G.M. was not capable of signing the AMA release was the fact that paramedics were only at his home for a total of 14 minutes, which he believes to be an inappropriate amount of time spent at G.M.'s home without transporting him to the hospital. However, Dr. Haynes admitted that there was nothing in the ePCR or other documents to indicate that G.M. was not capable of providing his signature on the AMA release. Dr. Haynes further admitted he had no reason to believe that anyone other than G.M. signed the AMA release on the ePCR. However, Dr. Haynes continued to assert that he did not believe that G.M. was capable of signing the AMA release at that time based on "information he received." Dr. Haynes stated he was also aware that G.M. had dementia, but the dementia may not have rendered G.M. incapable of making decisions regarding his healthcare. Such incapacity would depend on

the level of dementia, which generally can be determined by the paramedics asking questions of the patient. Dr. Haynes stated if G.M. was not capable of answering questions or was non-responsive, then G.M. was incompetent to make a decision regarding his healthcare.

Dr. Haynes testified that another “alarm bell” set off for him on his review of documents was that G.M.’s medical history on the ePCR was lacking and did not provide any information regarding G.M.’s dementia or Parkinson’s Disease diagnoses. However, Dr. Haynes admitted that paramedics do not have access to a patient’s medical history when they answer an emergency call and only have information provided to them by the patient or the patient’s family.

Dr. Haynes said he believed that Mrs. Moon asked the paramedics to take G.M. to the hospital in an ambulance on May 17, 2015, but the paramedics refused to do so. When questioned on the basis of this belief, Dr. Haynes stated, “We were told based on conversations with the base hospital nurse on duty” that Mrs. Moon wanted the paramedics to transport G.M. to the hospital in an ambulance, but the paramedics did not want to do it. Dr. Haynes admitted he “has an understanding from someone else” that Mrs. Moon believed the paramedics would transfer G.M. to the hospital by ambulance, but the paramedics then refused to do so. Dr. Haynes testified he spoke to the hospital nurse at TriCity Medical Center “to confirm what they talked to Mrs. Moon about” but admitted he never spoke to Mrs. Moon or anyone at the OFD directly as part of his investigation.

18. Dr. Haynes testified he believed each of the four respondents in this matter violated the San Diego County EMS protocol S-412 and S-415 in their care for G.M. on May 17, 2015. With regard to protocol S-415, which dictates when paramedics are required to contact base hospital for an emergency call, Dr. Haynes stated S-415, subdivision (IV)(B)(3) required respondents to contact base hospital on May 17, 2015, regarding their treatment of G.M. Specifically, that subdivision states that the base hospital must be contacted for “any emergency patient assessment involving abnormal vital signs, or an altered level of consciousness.” However, as previously noted Dr. Haynes admitted he had no information to conclude that the normal vital signs as recorded on the ePCR were incorrect, and the only information he had regarding G.M.’s level of consciousness was based on indirect information he received from his staff and others. Dr. Haynes stated he believes that the respondents purposely did not contact base hospital for G.M. and “had some reason why they did not contact base hospital,” but “we may never know what that reason was.” Dr. Haynes postulated the reason may have been that G.M. was covered in diarrhea or vomit and had an odor, and respondents did not want to get the ambulance dirty, or that the respondents were busy that day. Dr. Haynes admitted he had no information regarding how busy the respondents were that day and did not have any information regarding whether G.M. was covered in vomit or diarrhea. Dr. Haynes stated, “I am not sure I knew what the reason was that they did not call base hospital, I just knew that it broke protocol with a very ill patient.”

With regard to S-412, which dictates that all emergency patients will be offered treatment and/or transportation following a complete assessment unless they meet the qualifications to refuse such treatment or transport against medical advice (AMA), Dr.

Haynes testified he believes all four of the respondents violated S-412 for refusing to transport G.M. to the hospital on May 17, 2015, and for failing to contact the base hospital regarding G.M. Dr. Haynes testified he does not believe G.M. signed the AMA release because he does not believe that G.M. was sufficiently capable of doing so based on "information he received."

19. Dr. Haynes is a member of the Pre-Hospital Audit Committee (PAC), which is a panel that reviews treatment by pre-hospital personnel and makes recommendations for quality improvement. Dr. Haynes admitted during his testimony that he spoke to Dr. Ryan Smith, an Emergency Medicine physician at TriCity Medical Center and chairman of PAC, about the May 17, 2015, emergency response to G.M.'s home. Dr. Haynes admitted he has had tensions and disagreements with the OFD in the past regarding the use of a helicopter. Dr. Haynes admitted he told Dr. Smith he wanted to get the attention of the OFD.

RESPONDENT'S EVIDENCE

Testimony of Mark Finstuen

20. Mark Finstuen is 51 years old and a Fire Captain at the OFD. Mr. Finstuen was hired by OFD on November 10, 1988, as a firefighter paramedic. Thereafter, he was promoted to first-class firefighter paramedic and was promoted to fire engineer in 1999. In November 2005 he was promoted to the position of Fire Captain and has held that position for the past 10 years. During his 28 year history with OFD Mr. Finstuen has never been disciplined by his employer and has never received any reprimands for his job performance. During his career with OFD, Mr. Finstuen has responded to approximately 15, 000 emergency calls, about 80 percent of which involve medical care to a patient. Mr. Finstuen's responsibilities as a Fire Captain with regard to an emergency response involving medical aid to a patient include taking a supervisory role to ensure safety of personnel, patients, and family members, and to ensure that OFD policies and procedures are followed. Mr. Finstuen works at Fire Station 5 of OFD and has a regular crew with which he works on emergency calls. In 2015, and on May 17, 2015, Mr. Finstuen worked with Fire Engineer Schrader and respondent Duhamell on Fire Engine 2115. On May 17, 2015, Fire Engineer Schrader drove fire engine 2115, while Mr. Finstuen rode in the passenger seat of the fire engine and respondent Duhamell rode in the rear of the vehicle over the cab.

21. Mr. Finstuen testified that on May 17, 2015, the emergency call regarding G.M. came into Fire Station 5 at 10:36 p.m. Mr. Finstuen and his crew on Fire Engine 2115 arrived at G.M.'s home at 10:43 p.m. Mr. Finstuen stated that Fire Engine 2115 was not the only unit to respond to the emergency call, but it was the first unit to arrive. Ambulance unit 2196 from Fire Station 6 arrived at the G.M.'s home at 10:46 p.m. Ambulance unit 2196 comprised respondent Kessler and respondent Valentine. Mr. Finstuen stated that because Fire Engine 2115 arrived on scene first, respondent Duhamell was the primary paramedic responsible for assessing G.M. While respondent Duhamell was assessing G.M., respondent

Finstuen was documenting the information gathered about G.M. on an iPad to populate the ePCR document, which is a typical function Mr. Finstuen performs during emergency calls.

Mr. Finstuen stated that when receiving an emergency call for medical aid from the 911 system, he typically receives some information regarding the patient's condition from the 911 operator, which is displayed on a mobile computer terminal (MCT) in the Fire Engine. In the case of G.M., the only information on the MCT was that G.M. was a "sick person." He stated that while the information on the MCT may be helpful, paramedics prefer to rely on information they gather at the scene through their own observations.

22. Mr. Finstuen, respondent Duhamell, and engineer Schrader were greeted by Mrs. Moon at the front door of her and G.M.'s home. Mrs. Moon brought Mr. Finstuen and his crew to G.M., who was sitting about 15 feet from the front door in an overstuffed, lounge chair. Mr. Finstuen testified that when they entered the home, G.M. was breathing, talking and conscious. From his location inside the home, Mr. Finstuen observed G.M. throughout the entire emergency response. After entering the home, respondent Duhamell was standing adjacent to G.M. within touching distance while evaluating G.M. and obtaining vital signs, and Mr. Finstuen was asking Mrs. Moon questions regarding G.M.'s medical history as was his custom and practice during emergency calls. Engineer Schrader was assisting respondent Duhamell and bringing in equipment for his use. While obtaining information from Mrs. Moon, Mr. Finstuen was also listening to respondent Duhamell as he called out the information he gathered from G.M., which information Mr. Finstuen entered into the iPad for the ePCR document.

Mr. Finstuen stated that the ePCR document is automatically populated with time stamps for the time of day for when they fire engine is assigned to the emergency call, when they arrive etc. Other information such as G.M.'s name and date of birth were entered by Mr. Finstuen manually. Mr. Finstuen entered information regarding G.M.'s "abdominal pain" based on information he received from respondent Duhamell. Mr. Finstuen asked Mrs. Moon why she called 911 and obtained basic identifying information about G.M. and his medical history, allergies and medications he had taken. Mr. Finstuen testified that despite his questions to Mrs. Moon about G.M.'s medical history, Mrs. Moon did not tell him that G.M. had been released from the hospital the previous week, and she did not tell him that G.M. had suffered a broken hip.

Mr. Finstuen observed respondent Duhamell use a Zoll monitor to obtain vital signs on G.M. Mr. Finstuen stated that the Zoll monitor will obtain an EKG, pulse rate, oxygen saturation and blood pressure reading from a patient automatically after being properly placed on the patient. Obtaining an EKG on a patient with the Zoll monitor is an optional function. However, respondent Duhamell did perform an EKG on G.M. in order to rule out specific medical issues. Mr. Finstuen stated that the vital sign results from the Zoll monitor cannot be manipulated or changed by the user. At some point near the end of respondent Duhamell's assessment of G.M., Mr. Finstuen handed the iPad to respondent Duhamell so his assessment information, including the vital signs recorded by the Zoll monitor, could be entered into the ePCR by respondent Duhamell. Mr. Finstuen stated he had no reason to

believe the vital signs and assessment information entered into the ePCR by respondent Duhamell were inaccurate.

23. Mr. Finstuen also testified that, during the time of the emergency response, G.M. was oriented to time, place, person and event, was able to communicate and, in fact, was communicating with the paramedics. Mr. Finstuen stated respondent Duhamell was speaking with G.M. about the need for him to go to the hospital by ambulance. Mr. Finstuen heard G.M. tell respondent Duhamell more than once in a normal tone of voice that he refused to go to the hospital by ambulance. He stated neither G.M. nor Mrs. Moon ever asked for G.M. to be transported to the hospital by ambulance. Mr. Finstuen stated G.M. continued to refuse transportation by ambulance to the hospital and was behaving normally when he verbally communicated this to the paramedics. After his refusal to go to the hospital by ambulance, respondent Duhamell spoke to G.M. about the AMA waiver. Mr. Finstuen did not recall each question on the AMA document being asked of G.M., but he has no reason to believe that those questions were not asked. Mr. Finstuen stated that he was not able to see G.M. sign the iPad for the AMA waiver because respondent Duhamell was immediately adjacent to G.M. to obtain his signature thereby obstructing Mr. Finstuen's view of G.M. Mr. Finstuen stated that if he had observed any person other than G.M. sign the AMA waiver, he would have immediately called attention to that matter as such an act would be fraudulent and against policy and procedure. Mr. Finstuen testified he has worked with respondent Duhamell on many prior occasions and had no reason to question his integrity, truthfulness and abilities as a paramedic.

24. After G.M. refused transportation to the hospital by ambulance, respondent Duhamell spoke with G.M. about getting to the hospital by other means. Mr. Finstuen witnessed G.M. agree with respondent Duhamell that he would go to the hospital in his private car. Mr. Finstuen observed G.M. get out of his chair on his own accord and walk under his own power from the living room down the hallway towards the garage. Mr. Finstuen stated that no paramedic carried G.M. Mr. Finstuen did not observe G.M. after he walked down the hallway to the garage because Mr. Finstuen left the house through a different doorway.

25. Mr. Finstuen stated that G.M. did not have any vomit or feces on him when they were in G.M.'s home, and Mr. Finstuen did not observe any foul-smelling odors. Mr. Finstuen stated that in his experience, paramedics commonly transport patients who are homeless and have not bathed in a long time, as well as patients with vomit and feces on them with no questions asked. He stated that it would be unethical and against policy and procedure to refuse patient transportation based on foul odors. Additionally, Mr. Finstuen stated that on May 17, 2015, the paramedics responding to G.M.'s emergency call were not in any hurry or otherwise busy. Mr. Finstuen stated they remained at G.M.'s home as long as was warranted, and they were thorough and complete in their assessment and treatment of G.M. Mr. Finstuen drafted a letter on August 6, 2015, to Ms. Curtis-Smith summarizing the events of May 17, 2015, during the emergency response to G.M.'s home that was consistent with the testimony he gave during this hearing.

Testimony of Matthew Duhamell

26. Matthew Duhamell is 35 years old and a firefighter paramedic at OFD. Mr. Duhamell was employed by OFD in October 2013 after completing the fire academy. He has worked at various Fire Stations at OFD since October 2013 in the same capacity as a firefighter paramedic. During his career at OFD, Mr. Duhamell has responded to approximately 2500 to 3000 emergency calls as a paramedic and was primary paramedic on about 50 percent of those calls. Prior to working as a paramedic for OFD, Mr. Duhamell worked as an Emergency Medical Technician (EMT) for three years with another fire department. During his career Mr. Duhamell has never been disciplined by his employer.

27. Mr. Duhamell testified that on May 17, 2015, he was working at Fire Station 5 and was assigned to Fire Engine 2115 with Captain Finstuen and Engineer Schrader when they received instructions to respond to an emergency call at G.M.'s home. By that date Mr. Duhamell had been assigned and worked with Mr. Finstuen and Mr. Schrader for about five to six months. Mr. Duhamell was the primary paramedic responsible for the assessment and treatment of G.M. Mr. Schrader is an EMT, and his role was to drive the fire engine, assist Mr. Duhamell with G.M.'s assessment, and carry equipment into G.M.'s home for use by Mr. Duhamell. Mr. Duhamell testified that on every emergency response, including the one to G.M.'s home, three pieces of equipment are always brought to the patient: a cardiac monitor or Zoll monitor, a bag of medications, and an airway bag with oxygen. Mr. Schrader brought that equipment into G.M.'s home. Mr. Duhamell testified that Mr. Scharder was not a paramedic but was an EMT.

When Mr. Duhamell arrived to G.M.'s home, he immediately entered and contacted G.M. Mr. Duhamell stated G.M. was located on a Lazy-boy like chair in the living room. Mr. Duhamell stated when he initially made contact with G.M., G.M. was conscious, breathing and his eyes were open. Upon initial contact, G.M. was vomiting a small amount of clear liquid into a bucket the size of an ice bucket. Mr. Duhamell observed the contents of the bucket to ensure that there was no blood in the vomit. He stated the bucket only contained a small amount of clear, colorless liquid. After G.M. vomited, G.M. began to talk to Mr. Duhamell, who was within arm's reach of G.M. Mr. Duhamell asked G.M. for his name and G.M. responded. Mr. Duhamell then asked G.M. if he knew where he was or in what city he was located and G.M. said "Oceanside." Mr. Duhamell asked G.M. what day of the week it was and G.M. said "Sunday." Mr. Duhamell asked G.M. what was going on, and G.M. responded that he had been having abdominal pain for the past few hours and was vomiting. By this point in the assessment, Mr. Scharder had already brought in the Zoll monitor and other equipment. Mr. Duhamell proceeded to place EKG leads on G.M. while asking G.M. questions about his medical complaints and history. Mr. Duhamell then proceeded to obtain a four lead EKG and vital sign readings from the Zoll monitor. Mr. Duhamell stated that the EKG was normal, but he wanted to rule out a cardiac related event that may be causing G.M.'s vomiting so Mr. Duhamell then performed a 12 lead EKG by placing more EKG leads on G.M.'s chest. Mr. Duhamell stated that performing a 12 lead EKG is not a standard practice for pre-hospital assessment by paramedics, but it goes above and beyond the standard care. After performing the 12 lead EKG, Mr. Duhamell concluded

that the results were normal and inconclusive. After obtaining this information he focused on G.M.'s main complaint of abdominal pain. Mr. Duhamell palpated G.M.'s abdomen while G.M. verbalized what he felt as a result of the palpations. G.M. told Mr. Duhamell that he had tenderness and pain all over his abdomen and especially in the left quadrant.

After completing his assessment of G.M., Mr. Duhamell obtained the iPad from Mr. Finstuen so that he could fill in the assessment information on the ePCR, which he did. With regard to the information in the ePCR for various body parts, Mr. Duhamell stated that if G.M. did not complain of any other region of his body, Mr. Duhamell put the word "normal" next to that area of the ePCR from a drop-down menu. Mr. Duhamell entered the positive findings for G.M. on the ePCR as abdominal pain in the lower left quadrant. After entering information from his assessment, Mr. Duhamell selected his name as the person entering that information and the document then auto-generated a date and time that the information was entered. In addition to that information Mr. Duhamell entered information in the narrative portion of the ePCR that "pt. was found sitting in chair" and in the history portion he entered "pt. has had abd. Pain X 1 day" and that G.M. had had no treatment or "no rx." Mr. Duhamell also entered into the narrative portion of the ePCR under "Transport" the following language "Pt. refused ambulance tx, tx pov to tricity by family."

28. With regard to G.M.'s mental state and condition, Mr. Duhamell stated that G.M. was conscious, alert, breathing and communicating the entire time Mr. Duhamell was with him. Mr. Duhamell stated that, after he assessed G.M., he told G.M. the ambulance had arrived and the gurney was prepared and they needed to transport him to the hospital. Mr. Duhamell made the decision that G.M. needed to be transported to the hospital based on his age, his previous requests for emergency assistance, and his symptoms. Mr. Duhamell testified G.M. told him in a normal tone of voice that he did not want to be transported to the hospital by ambulance. Mr. Duhamell tried to convince G.M. to go in the ambulance to the hospital and G.M. refused to do so multiple times. The second time he refused, G.M.'s voice was a little louder than his first refusal. Mr. Duhamell explained to G.M. that he needed to go to the hospital. He asked G.M. if he would not go by ambulance, would he go by car, and G.M. stated he would go by car. According to Mr. Duhamell, there was another individual in the home other than Mrs. Moon who was a licensed driver and agreed to drive G.M. to the hospital in a car. Mr. Duhamell proceeded to go through the AMA checklist of questions with G.M. and obtain G.M.'s signature on the AMA waiver.

Mr. Duhamell explained to G.M. what the AMA is about, and he went through the checklist of questions with G.M. During this time G.M. was still in the chair in the living room. Mr. Duhamell explained the content of the AMA waiver to G.M. prior to obtaining his signature, and he offered the iPad to G.M. so that G.M. could read the waiver before signing it. G.M. never indicated to Mr. Duhamell he could not read or that he needed reading glasses to read the waiver. Mr. Duhamell stated he saw G.M. sign the AMA waiver on the iPad with his finger and the signature on the ePCR next to the AMA waiver is G.M.'s signature. Mr. Duhamell signed his own signature as the paramedic acknowledgement underneath G.M.'s signature on the AMA waiver.

29. After G.M. signed the AMA waiver, Mr. Duhamell, Mr. Kessler, and Mr. Valentine assisted G.M. as he got out of the chair and used a walker to walk on his own out of the living room, through the kitchen and into the garage. Mr. Duhamell stated G.M. had to walk down a few stairs to get into the garage, which he did on his own. Mr. Duhamell, Mr. Kessler, and Mr. Valentine assisted G.M. into the passenger side of the car and placed the seat belt around him. Mrs. Moon sat in the back seat of the car while the unknown individual with a license drove the car. Mr. Duhamell stated Mrs. Moon had been advised of the plan to take G.M. to the hospital in the car, and she agreed to that plan. According to Mr. Duhamell, Mrs. Moon never objected to taking G.M. to the hospital by car and never told the paramedics that she wanted G.M. to be transported to the hospital by ambulance. Mr. Duhamell stated that he was not aware of any reason why they would not have transported G.M. to the hospital in the ambulance had G.M. not refused to do so.

30. Mr. Duhamell testified he never changed any information on the ePCR after he assessed G.M., and he stands by the truthfulness of the information he provided at that time. Additionally, he stated G.M. was conscious, alert, communicating and oriented to time, place, person and location during the entire time he spent with G.M. on the evening of May 17, 2015. Mr. Duhamell stated the signature on the AMA waiver was G.M.'s and no other person's. Mr. Duhamell saw the car with G.M. in the passenger seat drive away from the residence toward TriCity hospital before the fire engine and ambulance left the scene. Mr. Duhamell stated that May 17, 2015, was not a particularly busy day at the station and that during the time they were at G.M.'s home, they did not receive another emergency call. Mr. Duhamell stated that after completing the emergency call at G.M.'s home, fire engine 2115 returned back to the fire station. Mr. Duhamell drafted a letter on August 7, 2015, to Ms. Curtis-Smith summarizing the events of May 17, 2015, during the emergency response to G.M.'s home that was consistent with his testimony at this hearing.

Testimony of Gabriel Kessler

31. Gabriel Kessler is 35 years old and a firefighter paramedic with OFD. Mr. Kessler was hired by OFD in 2011 after having worked as a firefighter paramedic at a neighboring fire department. Mr. Kessler has almost 10 years of experience working as a firefighter paramedic and has never received any discipline as a firefighter paramedic.

32. On May 17, 2015, Mr. Kessler worked with Mr. Valentine at Fire Station 6, in ambulance unit 2196. Mr. Kessler recalls receiving the emergency call to G.M.'s home, and arriving on the scene after Fire Engine 2115 had already arrived. When Mr. Kessler arrived at G.M.'s home he pushed the button on the on-board computer in the ambulance to notify dispatch that they arrived at the scene, which activates an automatic time stamp for the Incident Detail Report. After arriving, Mr. Kessler and Mr. Valentine retrieved the gurney out of the ambulance and prepared it for transport of a patient by placing it outside of the front door of the residence. Thereafter Mr. Kessler entered G.M.'s home where Mr. Duhamell had already taken G.M.'s vital signs and was in the process of assessing G.M. Mr. Kessler stated Mr. Duhamell was the primary paramedic in charge of assessment and treatment of G.M. on scene, but if G.M. were to be transported to the hospital by ambulance,

Mr. Kessler would take over the primary paramedic duties because he was the primary paramedic on the ambulance.

After Mr. Kessler entered G.M.'s home he observed G.M. sitting in a chair in the living room. Mr. Kessler stated G.M. was conscious and speaking to Mr. Duhamell. Mr. Kessler observed G.M. answering questions asked of him by Mr. Duhamell. Mr. Kessler approached Mr. Duhamell to ask if he needed assistance and to obtain information regarding G.M. According to Mr. Kessler, Mr. Duhamell told Mr. Kessler that G.M. had abdominal pain, had vomited in the bucket and did not want to be transported by ambulance to the hospital. Mr. Kessler then heard G.M. tell Mr. Duhamell that he did not want to go to the hospital. According to Mr. Kessler, G.M. seemed adamant about his refusal to go to the hospital. Mr. Kessler also observed the contents of the bucket next to G.M. and saw a small amount of clear, colorless liquid in the bucket. After G.M. refused to go to the hospital, Mr. Kessler overheard other paramedics have a conversation with G.M. to convince him to use other transportation to the hospital if he refused to go by ambulance. According to Mr. Kessler, the paramedics wanted G.M. to go to the hospital. Mr. Kessler stated he did not observe G.M. sign the AMA waiver, but he has no reason to believe that G.M. did not sign the AMA waiver, and he did not observe anyone other than G.M. sign the AMA waiver. Mr. Kessler stated the entire time he was at the scene, G.M. was conscious, alert, communicating and oriented to time, place, event and location. According to Mr. Kessler, G.M. was competent to sign the AMA waiver. Additionally, based on his observations, Mr. Kessler believes Mr. Duhamell's assessment of G.M. was thorough and complete. Mr. Kessler never had any conversations with the other firefighter paramedics on scene at G.M.'s home regarding an agreement to not transport G.M. in the ambulance to the hospital.

33. Mr. Kessler stated that ultimately, after discussions with the other paramedics, G.M. agreed to go to the hospital by car instead of the ambulance. Thereafter, Mr. Kessler assisted G.M. to the car by walking next to him to ensure that G.M. did not fall. According to Mr. Kessler, G.M. got up from his chair and walked under his own power to the car. During that time, G.M. was conscious, alert and oriented. Mr. Kessler did not observe any vomit, feces or foul odor emanating from G.M. when he assisted him to the car. Mr. Kessler never had any conversation with Mrs. Moon while he was at G.M.'s home and did not overhear any conversation with Mrs. Moon.

34. Mr. Kessler testified he never refused to transport G.M. to the hospital in the ambulance, and never conspired with any other firefighter paramedic to refuse to transport G.M. by ambulance to the hospital. Other than G.M.'s refusal to be transported by ambulance, Mr. Kessler is not aware of any reason why he would not have transported G.M. to the hospital by ambulance that night. Mr. Kessler drafted a letter on August 13, 2015, to Ms. Curtis-Smith summarizing the events of May 17, 2015, during the emergency response to G.M.'s home that was consistent with his testimony at this hearing.

Testimony of Anthony James Valentine

35. Anthony James Valentine is 34 years old and was hired as a firefighter paramedic at OFD on March 25, 2013, where he is currently employed. Prior to his current position, he worked as a paramedic for Los Angeles County Fire Department for about one year. In 2003, before receiving his paramedic license, Mr. Valentine obtained his EMT license and worked as an EMT for American Medical Response and Orange County Fire Department. Mr. Valentine has about 14 years of experience working as either an EMT or paramedic on ambulances. Throughout his career, Mr. Valentine has responded to approximately 10,000 emergency calls for medical aid. During his career he has never been disciplined by an employer.

36. On May 17, 2015, Mr. Valentine was working with Mr. Kessler in Fire Station 6 and assigned to ambulance unit 2196. After receiving the emergency call to respond to G.M.'s home, Mr. Valentine drove the ambulance to the scene with lights and sirens running. After arriving at G.M.'s home, Mr. Valentine parked the ambulance directly behind Fire Engine 2115, which was already there. Mr. Valentine observed Mr. Kessler press the button on the on-board computer in the ambulance which alerted dispatch that they had arrived to the location of the emergency call. After arriving, Mr. Valentine and Mr. Kessler removed the gurney from the back of the ambulance and prepared it for transporting a patient by placing it near the front door of the home. Thereafter, Mr. Valentine entered G.M.'s home and observed G.M. talking to Mr. Duhamell while sitting on a chair in the living room. Mr. Valentine testified that G.M. was conscious, alert, communicating and oriented to time, place, person and location. He stated that G.M. was answering Mr. Duhamell's questions and was tracking Mr. Duhamell with his eyes as an alert person would normally do. According to Mr. Valentine, G.M. was speaking to Mr. Duhamell, and G.M. never lost consciousness.

Mr. Valentine stated that Mr. Duhamell was the primary paramedic responsible for assessment and treatment of G.M. Mr. Valentine's responsibilities were to drive the ambulance safely to G.M.'s home, and assist Mr. Duhamell, as necessary. If G.M. was to be transported to the hospital by ambulance, Mr. Valentine was to help transport G.M. on the gurney into the ambulance and safely drive the ambulance to the hospital.

Mr. Valentine stated that by the time he and Mr. Kessler had entered G.M.'s home, Mr. Duhamell was about half-way done with his assessment of G.M. Mr. Valentine observed that Mr. Duhamell had already performed a 12 lead EKG on G.M. and was reviewing the findings of that EKG. According to Mr. Valentine, Mr. Duhamell had already made the decision that G.M. needed to be transported by ambulance to the hospital. Mr. Valentine heard G.M. repeatedly tell Mr. Duhamell that he did not want to go to the hospital. Mr. Valentine stated he also heard Mr. Duhamell giving alternative options to G.M. for transportation to the hospital. Mr. Valentine also stated that during those discussions, he saw Mr. Duhamell hand the iPad to G.M., and he saw G.M. sign the iPad with his finger.

After G.M. agreed to be transported to the hospital by car instead of ambulance, Mr. Valentine assisted G.M. from his chair in the living room to the car in the garage. Mr. Valentine stated that G.M. walked under his own power through the house to the garage to the car. Mr. Valentine walked behind G.M. to ensure he did not fall. Mr. Valentine stated G.M. walked down the stairs from the home to the garage on his own. After reaching the car, Mr. Valentine assisted G.M. into the car and reached over G.M. to fasten the seat belt around him. According to Mr. Valentine, G.M. did not have vomit or feces on him at that time and did not have a foul odor. Mr. Valentine drafted a letter on August 10, 2015, to Ms. Curtis-Smith summarizing the events of May 17, 2015, during the emergency response to G.M.'s home that was consistent with his testimony at this hearing.

Testimony of Lynne Seabloom

37. Lynne Seabloom is the Assistant Training Officer/Nurse Educator for the OFD and has held that position since 1999. Her responsibilities in that position include managing the OFD emergency medical services, training firefighters and paramedics on policies and procedures, and participating in the protocol task force for San Diego County. The protocol task force conducts bi-annual reviews of policies and protocols for Emergency Medical Services and makes necessary changes after review. Ms. Seabloom has been licensed as a nurse for about 30 years and also holds a paramedic's license. In addition to her work with OFD, Ms. Seabloom works part-time as an Emergency Room nurse and helicopter nurse. In her current position at OFD, Ms. Seabloom trains paramedics on how to complete the ePCR for emergency responses.

38. Ms. Seabloom testified that she first became aware of the May 17, 2015, emergency response to G.M.'s home on May 18, 2015, when she received a phone call from the TriCity Medical Center nurse coordinator, Yana Gardiner. Ms. Gardiner informed Ms. Seabloom that there was an executed AMA waiver for G.M., who was driven to the hospital in a private car and died soon thereafter in the emergency room. After receiving this information, Ms. Seabloom initiated an investigation of the care given to G.M. by pre-hospital personnel. On May 18, 2015, Ms. Seabloom was out of town at a conference, so she informed her supervisor, Mr. Finstuen, that OFD needed to initiate an investigation in the matter. As part of Ms. Seabloom's investigation, she identified the paramedic and EMT crew on the emergency call to G.M.'s home, interviewed each member of that crew individually, worked with an administrative assistant to obtain a record of all emergency responses made to G.M.'s home over the past year or so, obtained a record of all emergency responses on May 17, 2015, for both Fire Engine 2115 and Ambulance Unit 2196, and interviewed Mrs. Moon on two occasions.

Ms. Seabloom testified that during her investigation she learned there had been 12 emergency calls from G.M.'s home from June 2014 to May 17, 2015. Ten of those calls were for medical aid for G.M. Ms. Seabloom stated that G.M. had signed an AMA waiver on two occasions during that time period. Specifically, G.M. signed an AMA waiver refusing transportation to the hospital by ambulance on December 15, 2014, and on May 17, 2015. With regard to her two conversations with Mrs. Moon, Ms. Seabloom stated Mrs.

Moon repeatedly asked her why the paramedics did not take G.M. to the hospital in the ambulance. Ms. Seabloom stated Mrs. Moon told her that she had provided alcohol to G.M. on the morning of May 17, 2015. Ms. Seabloom stated Mrs. Moon never told her that she asked the paramedics to take G.M. to the hospital in the ambulance and they refused. After completing her investigation Ms. Seabloom did not find any evidence that OFD or the four paramedics subject to discipline in this hearing did anything inappropriate or improper during their care for G.M. She found no evidence that the information on the ePCR was incorrect or falsified and she found no violations of any policy or protocols for EMSA.

In addition to her own investigation of the emergency response to G.M.'s home on May 17, 2015, Ms. Seabloom was aware that the matter had been the subject of a review by the Pre-Hospital Audit Committee (PAC) for San Diego County. Ms. Seabloom described the PAC as a closed quality-assurance committee with representatives from all base hospitals and pre-hospital providers in the county. The PAC reviews emergency responses that are unusual or problematic for the purposes of education and policy improvement for pre-hospital care. She stated that the goal of PAC is not to provide discipline of pre-hospital personnel.

39. Ms. Seabloom first learned that the Emergency Medical Services Agency (EMSA) for the State of California was investigating the four paramedics who responded to G.M.'s home for possible discipline in July 2015, well after she had completed her investigation of the matter. Ms. Seabloom learned of the EMSA's investigation by an email she received from Ms. Curtis-Smith requesting information regarding the May 17, 2015, emergency response to G.M.'s home. Ms. Seabloom stated she learned that PAC had reviewed the matter when she called Dr. Haynes and Dr. Ryan Smith after receiving Ms. Curtis-Smith's email to inquire about the source of the complaint to EMSA. Ms. Seabloom stated Dr. Smith told her the matter had been presented and discussed at a PAC meeting and, during the meeting, Dr. Haynes stated he intended to refer the matter to EMSA for investigation. Ms. Seabloom stated Dr. Haynes told her he had referred the matter to EMSA for investigation because he "wanted to get the attention of OFD."

After learning that EMSA was investigating the matter, Ms. Seabloom contacted the Fire Chief, her supervisor and Barbara Hamilton, the Deputy City Attorney for Oceanside. Ms. Seabloom stated she complied with all requests made by Ms. Curtis-Smith and provided her with access to documentation, as well as provided written statements from each of the four paramedics. Ms. Seabloom stated she consulted with Barbara Hamilton regarding the format of the written statements from the four paramedics, and she asked each of the paramedics to fill in the substantive information on the written statements to provide to Ms. Curtis-Smith. Ms. Seabloom stated she did not provide any guidance to the paramedics regarding the substance of the statements other than to tell them to be truthful and provide all requested information. Ms. Seabloom did not make any changes to the statements of the four paramedics before providing the documents to Ms. Curtis-Smith.

Ms. Seabloom testified that in July 2015, Dr. Haynes came to OFD with a quality assurance nurse from San Diego County to meet with the Fire Chief and Ms. Seabloom

regarding the emergency response to G.M.'s home on May 17, 2015. Ms. Seabloom stated Dr. Haynes discussed the matter with them and told them he did not believe that the information on the ePCR was accurate, that G.M. was just as sick at home as he was in the TriCity Medical Center emergency room, and that the paramedics purposely did not contact the base hospital because they were trying to hide something.

40. Ms. Seabloom further testified that she was personally aware of friction between Dr. Haynes and OFD. She stated the friction began a few years prior to 2015, when San Diego County was rewriting the policy regarding the utilization of air medical services or helicopters. Ms. Seabloom was directly involved in rewriting the policy. She stated Dr. Haynes strongly disagreed with the position of OFD and the drafts presented for the policy rewrite with regard to the utilization of air medical services.

Testimony of Cal Kik

41. Cal Kik is a licensed private investigator and has held a California license for private investigation since 1992. Mr. Kik worked as a private investigator for a law firm for 15 years until 2007 when he started his own business as a private investigator where he currently works. Mr. Kik was hired in January 2017 by respondents' attorney to interview Mrs. Moon, each of the four paramedics subject to discipline, and Lynne Seabloom. Mr. Kik testified he went to Mrs. Moon's residence to interview her, but she was not at home. Thereafter, he spoke to her over the telephone on January 16, 2017, and obtained her permission to record the telephone interview. Mr. Kik stated he recorded the interview with a digital recorder connected through the phone line with an adaptor. The transcript and recording show that Mrs. Moon agreed to allow the recording of the telephone interview and that she declared under penalty of perjury under the laws of California that her statements during the telephone interview were true and correct. The digital recording of the telephone interview of Mrs. Moon, as well as the transcription of the recording were received into evidence.

During the interview, Mrs. Moon stated that the person who helped her with G.M. on May 17, 2015, when the paramedics were there, was a man by the name of Jose Gamboa, but not Jose Paco. Additionally, Mrs. Moon told Mr. Kik she drove G.M. to the hospital that night in her car despite the fact that she did not have a valid driver's license. Mrs. Moon told Mr. Kik that Jose rode with her in the car and was holding G.M., but she drove the car. The remainder of the information provided by Mrs. Moon during the telephone interview with Mr. Kik was consistent with her testimony at the hearing. However, the recorded telephone interview and transcript show that Mrs. Moon's statements to Mr. Kik were somewhat rambling and disjointed.

Testimony of Ryan Stuart Smith, M.D.

42. Dr. Ryan Smith is an emergency room physician and base hospital medical director at TriCity Medical Center. He works as an independent contractor at TriCity Medical Center through his employer, Team Health Medical Specialists. Dr. Smith began

working at TriCity Medical Center in July 2007. He has worked at TriCity Medical Center as the base hospital medical director for the past four and a half years. His responsibilities as the base hospital medical director include supervising the monitoring of radio calls from pre-hospital personnel, providing education to pre-hospital agencies such as fire departments and ambulance companies, reviewing “run records” for pre-hospital calls for improvement of quality for pre-hospital care, and reviewing new developments in pre-hospital care to ensure quality. Dr. Smith is the co-chair of the PAC committee responsible for reviewing pre-hospital care for quality assurance purposes for pre-hospital agencies all over San Diego County. Dr. Smith is also a board-certified emergency physician working in TriCity Medical Center’s emergency room providing emergency medical care. He completed his residency in emergency medicine in 2007 and became board certified in 2008.

43. Dr. Smith first became aware of the emergency response at G.M.’s home on May 17, 2015, through his work on the PAC committee. Specifically, he first heard of the matter at a pre-PAC committee meeting, which is a monthly meeting of PAC committee members held prior to the broader monthly PAC meeting. Dr. Smith stated he and Dr. Haynes were present at the pre-PAC meeting in June 2015 when the G.M. matter was presented to them by a nurse coordinator named Yana Gardiner. Dr. Smith learned during the pre-PAC meeting that G.M. presented at TriCity Medical Center’s emergency room for a very short period of time before going into cardiac arrest and dying, and that there had been paramedic contact with G.M. prior to his arrival at the emergency room. Dr. Smith stated that the pre-PAC committee members discussed the case and determined that there may be educational value to bringing the case up for discussion at the broader PAC committee meeting.

Dr. Smith testified that the G.M. matter was presented at the broader PAC committee meeting for review by a nurse coordinator named Susan Smith. Ms. Smith presented the case and told the PAC committee that there had been pre-hospital contact with G.M. before he came to the emergency room. The PAC committee discussed whether there should have been base hospital contact for G.M. by the paramedics. As a result of the PAC committee meeting presentation, Dr. Smith conducted his own investigation into the matter. As part of his investigation, Dr. Smith reviewed the TriCity Medical Center records for G.M., as well as the pre-hospital records from OFD, including the ePCR and other documents regarding the emergency response on May 17, 2015. Dr. Smith is very familiar with AMA waivers and the criteria necessary to be able to give an AMA waiver. His review of the records and information related to the assessment and treatment of G.M. led him to conclude that the AMA waiver obtained from G.M. was proper and met all required criteria, and there was no requirement that the paramedics contact the base hospital for G.M. because the criteria necessary to make such contact had not been met. Dr. Smith stated there was no reason to believe the information in the ePCR was inaccurate, falsified or otherwise incorrect regarding G.M.’s vital signs and mental state.

Dr. Smith testified he believes the reason the G.M. case was presented at the pre-PAC and the PAC committee meetings was because there was such a dramatic difference in the way G.M. presented at his home on the evening of May 17, 2015, and how he presented

when he arrived at the emergency room 20 minutes later. However, Dr. Smith stated the rapid deterioration of G.M.'s condition did not concern him because such rapid deterioration of patients does happen, particularly with older patients. Dr. Smith stated he has seen such rapid change in conditions of elderly patients in his practice as a clinician. Dr. Smith stated G.M.'s case was unfortunate and had a horrible outcome, but G.M.'s rapid deterioration could not have been predicted by the paramedics.

44. Dr. Smith further testified that after the PAC committee meeting where G.M.'s case was presented, Dr. Haynes informed Dr. Smith he intended to refer the case to the EMSA for investigation into the actions of the paramedics for possible discipline because he wanted to "send a message to OFD." Dr. Smith stated that he strongly disagreed with Dr. Haynes, and Dr. Haynes could not clearly articulate to Dr. Smith a viable reason why the paramedics should be investigated for disciplinary purposes.

LEGAL CONCLUSIONS

1. EMSA is the state agency "responsible for the coordination and integration of all state activities concerning emergency medical services." (Health and Saf. Code, § 1797.1.) Emergency medical services (EMS) are "the services utilized in responding to a medical emergency." (Health & Saf. Code, § 1797.72.)

2. The Authority has jurisdiction to proceed in this matter pursuant to Health and Safety Code section 1798.200. Administrative proceedings to revoke, suspend, or impose discipline on a professional license are non-penal; 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.)

3. 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" to a reasonable certainty. (*Ettinger v. Bd. of Med. Quality Assurance* (1982) 135 Cal.App.3d 853, 855-856.) 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.) Administrative proceedings to revoke, suspend or impose discipline on a professional license are non-criminal and non-penal; they are not intended to punish the licensee, but rather to protect the public. (*Hughes v. Board of Architectural Examiners* (1998) 17 Cal.4th 763, 785-786.)

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Applicable Law

4. Health and Safety Code section 1798.200 provides in relevant 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) . . .

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:

[¶]...[¶]

(2) Gross Negligence.

[¶]...[¶]

(4) Incompetence.

(5) The commission of any fraudulent, dishonest, or corrupt act that is substantially related to the qualifications, functions, and duties of prehospital personnel.

[¶]...[¶]

(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.

5. 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, § 100175, subd. (a).)

SDEMSA's Treatment Protocols

6. San Diego County EMSA has adopted and promulgated policies that define and govern the roles, responsibilities, and scope of practice of accredited prehospital responders. San Diego County EMSA Treatment Protocols S-415 and S-412 are at issue in this matter.

7. Protocol S-412 provides that “all emergency patients will be offered treatment and/or transport following a complete assessment” and that adult patients have:

[A] right to accept or refuse any and all professional care and transportation, provided that the decision to accept or refuse these treatments and transportation is made on an informed basis and provided that these adults have the mental capacity to make and understand the implications of such a decision.

S-412 further provides that for those patients who meet the base hospital contact criteria of S-415 and also “wish to sign AMA, prehospital personnel shall use their best efforts to make base hospital contact prior to . . . the responding unit leaving the scene.” S-412 provides that paramedics should contact the base hospital “in any situation in which the treatment or transport refusal is deemed life threatening or ‘high risk’ by the . . . paramedic.” S-412 also provides:

If the patient and EMS personnel . . . agree that the illness/injury does not require immediate treatment/transport via emergency/9-1-1 services, and the patient does not require the services of the prehospital system, the patient may be released at the scene.

8. Protocol S-415 provides under section (IV)(B) that base hospital contact is required by paramedics in the following situations:

- (1) Any emergency patient transport by paramedics, including transports by paramedic ambulance to a BL destination following downgrade to BLS.
- (2) Any emergency patient treatment involving ALS medications or skills (except EKG monitoring).

- (3) Any emergency patient assessment involving abnormal vital signs, or an altered level of consciousness.
- (4) Any suspicion that the emergency patient (or designated decision maker [DDM]) is impaired by alcohol or drugs.
- (5) The emergency patient/DDM is unable to comprehend or demonstrate an understanding of his/her illness or injury.
- (6) The emergency patient meets criteria as a trauma center candidate (T-460).
- (7) The emergency patient is >65 years of age and has experienced an altered/decreased level of consciousness, significant mechanism of injury, or any fall.
- (8) An emergency patient who is a minor is ill or injured or is suspected to be ill or injured.
- (9) Whenever paramedics have a question regarding appropriate treatment or disposition of the patient.

Evaluation

9. The only evidence provided by complainant to establish that G.M. was not conscious when paramedics arrived at his home, or had vital signs that were not normal, was the testimony of Mrs. Moon. However, Mrs. Moon's testimony was inconsistent with her prior statements to Mr. Kik and Ms. Curtis-Smith, and was inconsistent with basic information that is undisputed in this case regarding the events on the evening of May 17, 2015. For example, Ms. Moon testified at the hearing and in statements to others that she contacted 911 on May 17, 2015, at around 6:00 p.m., when in reality all records indicate that she called 911 after 10:00 p.m. that night. Mrs. Moon testified that by 10:00 p.m. that night she had left G.M. at the TriCity Medical Center, and G.M. was already dead. However, medical records of TriCity Medical Center establish that G.M. arrived at the emergency room at 11:21 p.m. Additionally, Mrs. Moon testified that Jose Paco drove the car with G.M. to the hospital that night, but Mrs. Moon told Mr. Kik that she drove the car. At times Mrs. Moon's testimony was rambling and disoriented. The multiple inconsistencies and contradictions of Mrs. Moon's testimony demonstrate that her testimony lacks credibility. By contrast, each of the four respondents in this matter provided testimony that was straightforward, believable and corroborated by other evidence. Each respondent directly answered questions he was asked, did not present himself as an advocate, did not exaggerate, and testified in a calm manner. The testimony of each respondent was credible.

Complainant provided no other evidence to establish that G.M. was not conscious, alert and communicating to the paramedics when they arrived at his home, and no other evidence to establish that G.M.'s vital signs were abnormal when paramedics arrived. The testimony of Dr. Haynes regarding his belief that G.M. was seriously ill and unconscious when the paramedic assessed G.M. in his home was based on "information he received" from others. Indeed, Dr. Haynes admitted that he had no basis to assert that the vital signs and other information on the ePCR were incorrect. Dr. Haynes also admitted that it was possible for G.M.'s vital signs and state of conscious to rapidly deteriorate within 20 minutes between the time he left his home and the time he arrived at the emergency room. Dr. Smith testified that such rapid deterioration is not unheard of with an elderly patient. Dr. Haynes relied on his own speculation to assert that respondents had engaged in fraudulent behavior by attempting to hide a serious health condition of G.M. and by refusing to transport G.M. in the ambulance. No evidence was presented to support Dr. Haynes speculation in that regard. Dr. Haynes also asserted that 14 minutes was an insufficient time for paramedics to assess and complete the emergency response to G.M.'s home. However, complainant provided no evidence to support Dr. Haynes' assertion that 14 minutes is an insufficient amount of time for a complete assessment and emergency response for G.M.

Complainant failed to establish that Mr. Finstuen violated any protocol of San Diego County EMS during his emergency response to G.M.'s home on May 17, 2015. The clear and convincing evidence established that G.M. was conscious, alert and verbally communicating when paramedics arrived at his home on May 17, 2015, and he remained in that mental state until he left his home in a private car. The clear and convincing evidence established that G.M. refused transportation by ambulance to the hospital and G.M. signed the AMA waiver on the ePCR on his own accord. The clear and convincing evidence established that Mr. Finstuen did not violate S-412. The clear and convincing evidence established that there was no reason pursuant to S-415 for Mr. Finstuen to contact base hospital for G.M.

Cause Does Not Exist to Discipline Respondent's EMT-P License

10. Cause does not exist to discipline Mr. Finstuen's Paramedic license pursuant to Health and Safety Code section 1798.200, subdivisions (c)(2) or (c)(4). Complainant failed to establish that Mr. Finstuen was grossly negligent or incompetent in his treatment of patient G.M.

11. Cause does not exist to discipline Mr. Finstuen's Paramedic license pursuant to Health and Safety Code section 1798.200, subdivision (c)(5). Complainant failed to establish that Mr. Finstuen committed any fraudulent, dishonest, or corrupt act substantially related to the qualifications, functions, and duties of prehospital personnel in his treatment of patient G.M.

12. Cause does not exist to discipline Mr. Finstuen's Paramedic license pursuant to Health and Safety Code section 1798.200, subdivision (c)(7). Complainant failed to establish that Mr. Finstuen violated, attempt to violated, assisted or abetted in the violation


of, or conspired to violate any provision or regulation adopted by the authority pertaining to prehospital personnel in his treatment of patient G.M.

13. Cause does not exist to discipline Mr. Finstuen's Paramedic license pursuant to Health and Safety Code section 1798.200, subdivision (c)(10). Complainant failed to establish that Mr. Finstuen repeatedly failed to comply with protocols, regulations, and statutes regarding prehospital personnel, including Protocols S-412 and S-415.

ORDER

The Accusation No. 15-0194 filed against respondent, Mark Finstuen, is dismissed.

DATED: April 7, 2017

DocuSigned by:

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DEBRA D. NYE-PERKINS
Administrative Law Judge
Office of Administrative Hearings