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BEFORE THE
EMERGENCY MEDICAL SERVICES AUTHORITY
STATE OF CALIFORNIA

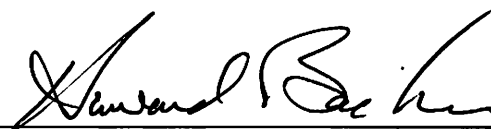
In the Matter of the Emergency Medical Technician- Paramedic License Held by:) Enforcement Matter No.: 15-0314
) OAH No.: 2017110229
)
MARCO A. BARROS) **DECISION AND ORDER**
License No. P25283)
)
Respondent.)

The attached Proposed Decision and order dated June 8, 2018, 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 of signature.

It is so ordered.

DATED:
June 11, 2018


Howard Backer, MD, MPH, FACEP
Director
Emergency Medical Services Authority

BEFORE THE
EMERGENCY MEDICAL SERVICES AUTHORITY
STATE OF CALIFORNIA

In the Matter of the Accusation Against:

MARCO A. BARROS,

License No. P25283

Respondent.

Case No. 15-0314

OAH No. 2017110229

PROPOSED DECISION

Administrative Law Judge Karen Reichmann, State of California, Office of Administrative Hearings, heard this matter on April 2, 3, 4, and 19, 2018, in Oakland, California.

Cheryl W. Hsu, Staff Counsel, represented complainant Sean Trask, Chief, Emergency Medical Services Authority, EMS Personnel Division.

Joe Rose, Attorney at Law, represented respondent Marco A. Barros, who was present at the hearing.

The record was left open for the submission of written closing arguments. The parties' submissions were timely submitted and marked and received into evidence as follows: complainant's closing argument is exhibit 43, respondent's closing argument is exhibit T, and complainant's reply brief is exhibit 44.

The matter was submitted for decision on May 25, 2018

FACTUAL FINDINGS

1. Complainant Sean Trask filed the accusation in his official capacity as Chief of the Emergency Medical Services Authority EMS Personnel Division.

2. On September 13, 2007, the Emergency Medical Services Authority (EMSA) issued Emergency Medical Technician-Paramedic License Number P25283 to respondent Marco A. Barros. This license was valid at all times relevant to the matters alleged in the accusation.

3. Respondent is accredited by Coastal Valley EMS, the Local EMSA for Sonoma County.

4. Pursuant to the Health and Safety Code, Coastal Valley EMS has promulgated policies which govern EMS care provided in its jurisdiction.

Policy No. 9802 pertains to Pediatric Endotracheal (ET) Intubation. Policy 9802.2, subdivision (j), directs that the paramedic performing this procedure must select the proper sized endotracheal tube (ET tube or ETT) based on the patient's length as measured by resuscitative tape. Policy 9802.2, subdivision (r), provides that upon intubating a pediatric patient, the paramedic must confirm that the ET tube is in the correct position with at least three of the following methods:

1. Direct endotracheal visualization
2. Esophageal intubation detector
3. Absence of epigastric sounds
4. Presence of bilateral breath sounds
5. Equal chest rise
6. Misting or fogging in the ETT
7. CO₂ detection device

Policy No. 9705 pertains to newborn resuscitation. Among other things, it sets forth that the appropriate size ET tube for an infant weighing between 2,000 and 3,000 grams is 3.5 mm, and that the appropriate size for an infant greater than 3,000 grams is 3.5 to 4.0 mm.

Policy No. 9814 is titled "End-Tidal CO₂ Monitoring." This policy directs that

It is the purpose of this policy to ensure proper use of End Tidal CO₂ (ETCO₂) Monitor: to provide optimal care to all intubated patients utilizing end tidal CO₂ monitoring, to confirm correct placement of the endotracheal tube and/or measure the adequacy of ventilation and perfusion of patients utilizing ventilatory assist devices.

[¶ . . . ¶]

If equipped, all endotracheally intubated patients will have ETCO₂ monitoring provided.

End-Tidal CO₂ monitoring is also referred to as capnography. It is a means of assessing ventilation in an intubated patient. Intubating a patient – especially an infant – is a difficult procedure.

Emergency Call on November 18, 2015

5. On November 18, 2015, at 13:51, a baby was born at the Santa Rosa Women's Health & Birth Center (Birth Center), which is located less than two miles from Santa Rosa Memorial Hospital. The baby was delivered by Elizabeth Smith, a certified nurse midwife and registered nurse. Another registered nurse was present. The infant was full-term and there was no indication of fetal distress during labor. At birth, the umbilical cord was loosely wrapped around the baby and copious thick meconium was present. The infant weighed approximately 3,000 grams, was limp and had an abnormally low heartrate, no pulse, was blue in color, was not breathing, and did not respond to stimuli. Birth Center staff called 911 about one minute after birth and immediately began resuscitation efforts.

6. A fire engine staffed by three firefighters who are all licensed paramedics (Captain Steven Suter, Firefighter/Paramedic Jaime Harcos, and Firefighter/Paramedic Andrew Ihlendfeldt) arrived at the Birth Center at around 14:00. Birth Center Staff were administering oxygen to the infant patient with a bag valve mask and performing chest compressions. The firefighters assisted them in moving the patient away from the mother into an adjoining room and engaged in further life support activities, including cardiac monitoring.

Captain Suter communicated on the radio channel that it was a "code blue" and that they would be bringing the patient to the ambulance as soon as it arrived. His intention was to communicate to the ambulance crew that it was a "grab and go" emergency and that the infant needed to be transported to the hospital as soon as possible.

7. American Medical Response (AMR) provides emergency medical services in Sonoma County. After the emergency call came in, ambulance 759, staffed by paramedic Kenneth Chaffee and EMT Matthew Browning, was assigned to respond.

Respondent was on duty with EMT Melissa Griffin on a different unit, ambulance 793. They were on the way to pick up a patient for transfer from one facility to another, a non-emergency call. Respondent consulted a GPS map aboard the ambulance which demonstrates the location of all AMR ambulances. He believed that a third ambulance was closest to the Birth Center. He contacted that unit, but the paramedic declined to intervene. Respondent thought that he and Griffin were closer to the Birth Center than the assigned unit and got on the radio channel to communicate this belief. It was ultimately agreed that both respondent's unit and unit

759 would head to the Birth Center and whichever ambulance arrived first would respond to the call. Respondent heard Captain Suter's communication over the radio and understood what was intended – that the patient should be transported to the hospital as quickly as possible.

8. Ambulance 759 arrived at the birthing center at 14:06:28. Browning exited the driver's seat and walked to the back of the ambulance to prepare the gurney for the patient. Chafee also exited the ambulance and walked to the back.

Respondent's ambulance arrived approximately 30 seconds after the other unit and pulled up behind it. Respondent quickly exited the ambulance and told Chaffee, "I'll take the call." Chaffee was surprised but did not want to delay the call by engaging in further discussions, so he assented. Chafee and Browning both thought it was odd that respondent wanted to "jump the call" because calls involving children are considered "the worst nightmare" by most paramedics. They both concluded that respondent was trying to be a hero. Respondent explained that he offered to take the call because there were members of the public in the area and he did not want to engage in an argument with the other ambulance crew about who should respond to the call.

9. Respondent directed Griffin to prepare the ambulance and followed a Birth Center employee into the Birth Center. Griffin prepared the ambulance by clearing equipment off the gurney, retrieving the "pedi bag" containing supplies for infants and children, and placing it on a bench near the gurney. Ambulance 759 left the scene.

10. Respondent entered the facility and found resuscitation efforts underway. Respondent took over ventilating the patient and assisted in carrying the patient to the ambulance on a flexible board. The patient was not secured to the board and the board was not secured to the gurney. Smith, Suter, and Ihlendfeldt agreed to accompany respondent and Griffin in the ambulance in order to continue treating the patient. As a registered nurse, Smith has medical authority over a paramedic.

11. The ride to the hospital took about four minutes, from approximately 14:12:45 to 14:17:05. Lights and siren were activated and the ambulance was driven by Griffin. Respondent's actions during the ambulance ride are at the heart of the accusation and there is some dispute about what transpired.

Once in the ambulance, respondent continued ventilating the patient with the bag valve mask. Respondent felt resistance and did not believe that it was effectively ventilating the patient. He decided to intubate the patient to achieve better ventilation. Respondent had never performed an intubation on a neonate. The

Broselow tape¹ was removed from the pedi bag and used to measure the patient. The measurement determined that the patient should be intubated with a 3.5 mm ET tube. The pedi bag was stocked with small ET tubes, including the 3.5 mm size.

Respondent grabbed a 5.0 mm ET tube and removed it from its plastic bag. The size was marked on the tube and on the plastic bag. Respondent later stated and testified that while in the ambulance he mistakenly believed that he had grabbed a 4.0 mm ET tube. Respondent failed to confirm that he had the correct size tube prior to intubation.

Respondent suctioned the patient's mouth. He observed meconium which he thought might be obstructing the airway and suctioned the patient's mouth again. He then used a laryngoscope blade to move the epiglottis and access the trachea.

Respondent maintains that he visualized the patient's vocal chords and saw the ET tube pass between them - meaning that he was inserting the tube into the trachea rather than into the esophagus - and that he inserted the tube until it was approximately 10 cm from the gum line, which would be the appropriate placement of the tube into the lungs of an infant the size of the patient. Respondent held the tube in place with his hand as he administered oxygen from a bag in his other hand.

Respondent then asked Ihlendfeldt to confirm that there were lung sounds. Respondent and Ihlendfeldt both testified that Ihlendfeldt used a stethoscope and listened to both lungs. Ihlendfeldt reported that he heard movement in both, which would indicate that the patient was being ventilated. He also listened in the epigastric area and heard nothing which would indicate that the ETT was improperly placed into the patient's stomach. Ihlendfeldt felt confident that he heard lung sounds and no epigastric sounds, confirming that the tube was properly placed. He also observed the patient's color improve and observed the patient's chest rise with each ventilation, which is also a confirmation that the tube is correctly placed. Ihlendfeldt reported his findings to respondent. Respondent believed that he had sufficient confirmation of the ET tube's placement to comply with the directives of Policy No. 9802.

Respondent did not use the CO₂ monitoring device which was present on the ambulance. He explained that both his hands were occupied and he was unable to stop what he was doing to retrieve the monitor. He asked Ihlendfeldt to get the monitor, but Ihlendfeldt was occupied helping Suter administer epinephrine. The ambulance arrived at the hospital shortly thereafter. In respondent's experience, the monitor can sometimes take up to a several minutes to warm up after it is turned on. Respondent's priority was to move the patient into the hospital and not delay

¹ The Broselow tape is used in emergency medicine to quickly measure the length of a child to give an estimate as to the child's size. The resulting measurement is expressed in color codes. The color code is used to determine the size of equipment to be used on the patient as well as medication doses.

transport further by hooking up the CO₂ monitor and possibly having to wait for it to start providing readings.

12. During the ambulance ride, Captain Suter inserted an intraosseous in the patient's femur and epinephrine was administered through it. Captain Suter observed that the patient's skin color improved during the transport, and he documented this observation in a Pre Hospital Care Report he wrote shortly after the call was completed. He confirmed this observation in his testimony.

Captain Suter testified that he could not see what respondent was doing during the ride because he was focused on his own efforts. He heard respondent announce that there was condensation in the ET tube but did not observe the tube. He did not see anyone listen for breath sounds with a stethoscope and did not hear anyone announce that they heard breath sounds.

Suter believes that respondent made some mistakes, but did not observe anything that he found to be grossly negligent or incompetent during the call. He continues to hold respondent in high regard as a paramedic.

13. Smith gave a statement to the EMSA investigator but did not testify at the hearing. The EMSA investigator's summary of Smith's interview statement was admitted into evidence as administrative hearsay. Her statement contradicts the testimony and statements of respondent, Ihlendfeldt, and Suter regarding the events in the ambulance. Smith was critical of the conduct of the firefighter paramedics and of respondent, and was very upset by the length of the time it took to transport the infant to the hospital. Smith stated that in the ambulance, she observed respondent intubating the infant:

using what I identified as very clearly the wrong tube. I asked him, "what size tube is that? He said "It's a 4" I said, "are you sure." He said, "Yes." He said he was in and I said great. . . . I never noticed chest rise and I asked at least two or three times, are you getting chest rise and he didn't say anything. So I said "do you have a stethoscope to listen for breath sounds." He said "It's behind you." I just looked at him because I was doing chest compressions and I wasn't going to stop, but thought to myself why would I stop, when there is another person here who can listen for breath sounds? . . . [In] the rig, nobody listened for breath sounds, I never noticed chest rise. I brought that to the attention of the paramedic. I never observed anybody listening for breath sounds. I asked if there was chest rise, and I also asked if they were using their CO₂ monitor. He responded, "I have vapor in the tube" So I said "what's your CO₂ monitor

say?" He did not answer. I realize now, in retrospect that the markings on the endotracheal tube were way too deep to be in the lungs.

None of the other three others in the ambulance recalled Smith asking these questions during the ambulance ride.

14. Upon arrival at the hospital, the gurney was removed from the ambulance and pushed into the emergency department where a large crew was assembled awaiting the arrival of the patient. Respondent climbed onto the head of the gurney in order to keep administering ventilation to the patient. Riding on the gurney is not something a paramedic or EMT would ordinarily do. At some point during the transfer of the patient in the hospital, the gurney began to tip, likely due to the weight of respondent riding at the head. Several people grabbed on to the gurney to steady it and respondent hopped off and lost his grip on the ET tube. The infant was transferred to the care of hospital personnel. As hospital staff took over caring for the patient, respondent observed that the ET tube was now inserted to the 20 cm mark. Respondent asserts that as the gurney tipped, the ET tube he was holding was jostled out of place. He maintains that the ETT was dislodged from the trachea and moved into the patient's stomach.

15. Alan Shotkin, M.D., was the neonatologist on duty at Santa Rosa Memorial. When the infant arrived, Dr. Shotkin quickly observed that the ET tube was the wrong size for a newborn and was inserted to the 20 cm mark. This is too deep to be properly inserted into the trachea of a newborn infant. Dr. Shotkin concluded that the tube was inserted into the infant's stomach. He immediately removed the tube and performed an intubation using a 3.5 mm tube. It took him two attempts to succeed. After the infant was successfully intubated, Dr. Shotkin observed the patient's skin color improve significantly and the heart rate increased. The patient never resumed breathing normally. Ultimately Dr. Shotkin determined that the patient had suffered severe brain damage and that further treatment was not indicated. The infant was removed from life support and died later that evening.

Dr. Shotkin believes that the infant was never properly intubated prior to arrival at the hospital. He does not believe that the infant's anatomy could accommodate the 5.0 mm tube. Had a tube this size been inserted into the trachea, Dr. Shotkin believes it would have caused injury to the trachea. No such injury was identified in the autopsy report. Dr. Shotkin also believes that the infant was not ever intubated in light of the dramatic improvement in skin color he observed after he properly intubated the infant within minutes of its arrival at the hospital.

It was initially reported to AMR that Dr. Shotkin concluded that the infant had been without oxygen for "20 minutes" prior to arrival at the hospital. At the hearing, Dr. Shotkin stated that the patient appeared to have been without oxygen for "five to ten minutes or more" prior to arriving at the hospital.

Dr. Shotkin spoke with respondent at the hospital and told him that he believed the patient had been intubated incorrectly. Respondent called Dr. Shotkin later in the day and expressed his belief that he had intubated the patient properly. Dr. Shotkin told him it was not possible. Dr. Shotkin described his interaction with respondent as a “conversation” and not an argument.

AMR investigation

16. Ailyn Risch was the Clinical Manager for AMR at the time of the incident and is now the Corporate Division Project Manager. Risch was respondent’s training officer when he joined AMR. She found him to be honest and competent. There had been some issues with respondent’s documentation in the past. Risch conducted an investigation of the November 18, 2015, incident on behalf of AMR.

Risch reviewed respondent’s patient care report and had concerns about his decision to intubate the patient in the first place. As part of her investigation, Risch interviewed respondent on November 30, 2015, and found him to be cooperative. Shortly after the interview, respondent resigned from employment with AMR and Risch concluded her investigation.

Risch reached the following conclusions as the result of her investigation:

- 1) Respondent violated AMR’s dispatch policy by “jumping the call.” She determined that this was a “system design failure.”
- 2) Respondent violated AMR’s documentation policy by failing to include all pertinent positives and pertinent negatives in his patient care report.
- 3) Respondent violated AMR policy by riding on the gurney.
- 4) Respondent violated Policy 9802.2 by using the wrong-sized ET tube.
- 5) Respondent violated Policy 9802.2 by failing to use end-tidal capnography to confirm tube placement.

Risch forwarded her investigation to Coastal Valley EMS and submitted a Paramedic Investigation Request to EMSA regarding the incident. Because respondent resigned employment, AMR did not impose any discipline.

Coastal Valley EMS investigation

17. Coastal Valley EMS reviewed AMR's investigation, conducted its own interviews, and issued a report. In its report, Coastal Valley directed follow up actions to respondent as follows: 1) attend and pass a pediatric intubation training including hands-on skills and assessment; 2) participate in one year of 100 percent pediatric chart audit by provider and EMS Agency staff; 3) complete provider-agency based pediatric patient management training to include all emergency pediatric equipment on responding unit; and 4) drill monthly with a field training officer on agency defined pediatric intubation sequence. Respondent was not otherwise disciplined by Coastal Valley EMS. The report also included follow up actions for AMR and for the Coastal Valley EMS agency.

EMSA's investigation

18. EMSA's investigation was conducted by Linda Curtis-Smith. Curtis-Smith had been working for EMSA for approximately two and one-half years at the time she began the investigation; she was previously an investigator for the Department of Public Health. Curtis-Smith gathered documents and interviewed witnesses. She prepared summaries of the interviews. Respondent's interview was recorded and a transcript was generated. Curtis-Smith found respondent to be forthcoming and cooperative, although she noted that his attorney answered many of her questions instead of respondent.

Curtis-Smith notably did not find the statements of Andrew Ihlendfeldt at his interview to be credible. She perceived a change in his speech and demeanor when she asked him whether he heard the patient's breath sounds during the ambulance ride. Curtis-Smith felt that Ihlendfeldt was intimidated during the interview by the presence of his supervisors. Also, Ihlendfeldt reported that he and respondent were friends and former roommates and Curtis-Smith believed this relationship might have had an effect on his interview statement.

EMSA's medical expert

19. Joseph Barger, M.D., reviewed EMSA's investigation materials and wrote a three-page letter with his findings. Dr. Barger testified at hearing as an expert witness. Dr. Barger is an emergency medical physician and the former director of Contra Costa County EMSA.

Dr. Barger explained that pediatric intubation is a high-risk procedure that is rarely performed in the prehospital setting. Because of the high risk, diligent attention to protocol is extremely important. Once a patient is intubated, continuous monitoring is essential. ET tubes can be easily dislodged, especially in a pediatric patient. End-tidal capnography is the "gold standard" for endotracheal monitoring and the best means of confirming proper ET tube placement.

Dr. Barger concluded that respondent's actions constituted gross negligence and incompetence because he failed to select the appropriately sized tube and was deficient in his monitoring of the tube's placement. Dr. Barger believes that respondent had a "false sense" that he inserted the ET tube properly. Dr. Barger believes that respondent should have used the capnography monitor which was aboard the ambulance to assess the patient's ventilation. Dr. Barger believes that the ET tube was never in the proper place and that respondent's actions "likely contributed to the poor outcome." Dr. Barger does not believe that "running out of time" is a valid excuse for the failure to use capnography, because he believes that a paramedic should be readying the monitor as he or she is performing the intubation, so that immediate readings can be taken.

Dr. Barger also questioned respondent's decision to intubate the patient in the first place, noting that it is a high-risk procedure that is rarely done in the pre hospital setting. Intubation of infants by paramedics is not allowed in some jurisdictions. Dr. Barger believes that respondent should have continued with bag valve mask ventilation during the brief transport to the hospital. However, he did not conclude that respondent's decision to intubate reflected incompetence or gross negligence. Dr. Barger also did not conclude that respondent's decision to ride the gurney constituted gross negligence or incompetence.

Respondent's evidence

20. Respondent admits inadvertently using the incorrect sized ET tube, but contends that he successfully intubated the patient. He asserts that he personally visualized the vocal chords, observed condensation in the ET tube, saw the patient's chest rise, saw Ihlenfeldt use the stethoscope to listen for breath and epigastric sounds, and relied on Ihlenfeldt's report of what he heard. Respondent maintains that the ET tube was inserted to 10 cm from the gum line and that he observed that it was still in this location as the gurney was being pushed into the hospital. He continues to believe that the ET tube was dislodged from its proper placement into the esophagus when the gurney started to tip during the transport of the patient.

21. Respondent has taken corrective actions in response to the incident. He consulted with physicians, who taught respondent intubation protocols which he has adapted as his practice. Respondent now places CO₂ capnography on the ET tube prior to intubation, so that he has readings immediately. He also has a colleague confirm that he is using the proper size ET tube prior to insertion. Respondent noted that he has talked about the call as a teaching example with students and trainees.

In order to comply with the corrective requirements imposed by Coastal Valley EMS, described in Finding 17, respondent's employer provided in-house training in pediatric intubation and pediatric patient management and audited all of his patient care reports, with no need for corrective measures noted. Respondent also took a Pediatric Advanced Life Support class.

22. Respondent had performed numerous intubations during his career, however this was the first time performing one on a neonate. His intubation success rate while working for AMR was about 77 percent, which is within the normal range.

Respondent was traumatized in the aftermath of the incident and sought therapy. Respondent denied that he resigned from AMR as a result of the incident. He decided prior to the incident to resign because he was having difficulty committing to working the required three shifts per month in addition to his full-time position in Bodega Bay.

23. Respondent worked as an emergency department technician for about 10 years at Petaluma Valley Hospital. Susan Buren, M.D., is a board-certified emergency medicine physician at the hospital who testified at the hearing and wrote a letter in support of respondent.

Although respondent has not worked at the hospital since 2014, Dr. Buren has had ongoing contact with him when he has brought patients to the hospital as a paramedic, and she has been impressed with his performance, particularly his patient reports. Dr. Buren holds respondent in very high regard and believes that he has a high level of honesty and integrity and is extremely hardworking.

Dr. Buren is aware of the accusation and underlying allegations, but has not personally reviewed any of the medical records or investigation reports. She believes in respondent and believes that it is possible to ventilate a neonate with the wrong size ET tube. She noted that there are variances in anatomy and that neonates have flexible tissue. She also explained that an ET tube can be dislodged easily.

Dr. Buren does not believe that respondent poses a threat to patients and instead believes him to be an asset to the EMS system

24. Respondent has been employed as a firefighter/paramedic with the Bodega Bay Fire Protection District for around five years. Several of his colleagues testified and wrote letters on his behalf.

Fire Chief Sean Grinnell wrote a letter dated March 31, 2017. He confirmed that respondent has worked full-time for the district since July 2015. Grinnell wrote that respondent is an employee in good standing who has proven his abilities and skills on numerous occasions. Grinnell added that there has not been a "single incident here that would call his paramedic skillset into question."

David Bynum is respondent's supervising captain; he both testified and wrote a letter on behalf of respondent. He has been a licensed paramedic for 14 years. He described respondent as honest and straightforward. Bynum has no concerns about

respondent's skills and has been impressed that respondent has a "natural sense of what to do next." Bynum has a basic understanding of the accusation and has "no doubt that respondent did his best under the circumstances." He believes that revoking respondent's license would be a loss to the community.

Stephen Herzberg is a retired law professor, consultant, and volunteer EMT for Bodega Bay. Herzberg testified at the hearing and submitted a letter. He has spent a lot of time in the firehouse with respondent since they met in 2014, and has found him to be forthright, direct, and honest, trustworthy, and extremely competent. Respondent treated Herzberg's wife during a cardiac incident and Herzberg felt at ease knowing that respondent was providing care. Herzberg related being on a call with respondent during which respondent intubated a 19-year-old drowning victim with skill and continued to confirm the intubation during transport.

James Levy is a firefighter paramedic for Bodega Bay and serves as its EMS coordinator and field training officer. In a letter dated April 2, 2017, Levy wrote that he coordinated with respondent to oversee the follow-up actions directed by the Coastal Valley EMS after the incident. Levy has reviewed protocols and drilled respondent with equipment. He has personally reviewed every patient care report and call that respondent has participated in. He has been searching for a training center so that respondent can undergo pediatric intubation training. Levy believes that respondent is a safe and responsible paramedic and trusts him to train volunteers and interns.

Urban Anderson is a licensed paramedic who works for the Petaluma Fire Department. Anderson testified at the hearing and wrote a letter. Anderson was formerly licensed as an EMT and worked with respondent when he was an EMT, including for the Bodega Bay Fire Protection District. Anderson believes that respondent is honest and highly competent. He has observed respondent performing intubations with good skills. Anderson believes that respondent continues to learn and grow in his profession. Anderson currently lives with respondent and three other paramedics/firefighters.

Emily Scott is a volunteer EMT for Bodega Bay and has worked with respondent since 2014. Scott submitted a letter. She finds respondent to be honest, sincere, skilled, forthright, and professional. She has been on numerous emergency calls with him and has not known him to make mistakes. She also attested to respondent's participation in community events.

25. In a letter dated March 30, 2017, Gabe Kearney, Council Member, City of Petaluma, wrote that he has known respondent since 1997. Kearney volunteered alongside respondent at the Old Adobe Union School District outdoor education camp and has worked with him professionally. Kearney described respondent as trustworthy, compassionate, and dedicated to providing the highest standard of care for his patients.

26. Respondent teaches paramedic skills at Santa Rosa Junior College. Scott Snyder, a full-time instructor at SRJC testified on respondent's behalf. Snyder has been a licensed paramedic since 1994. In addition to teaching at SRJC, he works part time as a paramedic for AMR, but has never worked alongside respondent. Respondent teaches paramedic skills acquisition, including airway management skills.

Snyder trusts respondent and has found him to be very responsive to direction. Snyder has found respondent to be fair and impartial in evaluating students, including failing a student who was an acquaintance.

Snyder is aware of the basic facts underlying the accusation and maintains a high opinion of respondent. He believes respondent is an asset to the community and has a reputation for competence and compassion.

27. Numerous other paramedics and firefighter colleagues wrote letters on respondent's behalf. Kyle Bruce Marshall, Hannah Barnett-Powell, Nick Gonzalez-Pomo, Raymond Hill, Art Hsieh, all wrote letters praising respondent's dedication, work ethic, paramedic skills, honesty, integrity, and devotion to his young son.

28. Respondent is divorced and has a seven-year-old son. His former wife, Autumn Stone, and former mother-in-law, Elaine Stone, wrote letters on his behalf. Autumn Stone met respondent in 2005, when they worked together as EMTs. She admired the way he prioritized patients, safety, and ethics, and his dedication and leadership skills. She added that respondent has been supporting her and their son while she has been suffering a long illness. Elaine Stone wrote that respondent is deeply committed to his profession and his family and is a dedicated father.

29. Respondent has received numerous commendations for rescue efforts, including a Certificate of Special Congressional Recognition from the United States House of Representatives, Certificates of Commendation from the Bodega Bay Fire Protection District, and a Certificate of Recognition from the California State Legislature.

30. Respondent has volunteered for the Wilmar Fire Department since 2004. He has also volunteered for numerous organizations, including the Petaluma homeless shelter, the Red Cross in Spain, Habitat for Humanity, Santa Rosa Junior College Paramedic Program, the Bodega Bay Firefighter Association, and his son's sports team.

Ultimate Findings

31. Clear and convincing evidence established that respondent was grossly negligent and incompetent in his intubation of the patient in two respects: his failure

to use the correct size ET tube and his failure to use capnography to monitor the intubation. This finding is based on the persuasive testimony of Dr. Barger.

It was not established by clear and convincing evidence that respondent's "jumping the call," his decision to intubate the patient rather than continue to use the bag valve mask, or his decision to ride the gurney constituted gross negligence or incompetence. No expert testified that respondent was grossly negligent or incompetent by having performed these acts.

32. It was not established by clear and convincing evidence that the ET tube was never properly inserted. Nor was it established by clear and convincing evidence that the ET tube was properly inserted, as respondent asserts. The conflicting evidence could not be resolved so as to support a finding one way or the other.

33. It was not established by clear and convincing evidence that respondent's acts caused actual harm to the patient. There was no evidence that the patient suffered pain or discomfort as a result of respondent's actions. Dr. Shotkin's assessment that the patient had been without oxygen for possibly 20 minutes tends to corroborate respondent's assertion that the resuscitation efforts prior to intubation were not effective and that the patient was not being properly ventilated by the bag valve mask method. The patient's condition at birth was dire and there is no way to know whether any intervention would have resulted in a better outcome for the patient.

34. It was established that respondent violated Coastal Valley EMS Policy 9705 by using the wrong sized ET tube and violated Policy 9814 by failing to use end-tidal capnography to perform ongoing monitoring.

It was not established that respondent violated Coastal Valley EMS Policy 9802.2, subdivision (r), regarding the initial intubation confirmation. The evidence established that respondent confirmed placement of the ET tube by more than three methods: visualization of the vocal chords, condensation, chest rise, and the report of another paramedic of breath sounds and the absence of sounds in the epigastric region.

LEGAL CONCLUSIONS

1. The standard of proof applied in making the factual findings set forth above is clear and convincing evidence to a reasonable certainty. (*Ettinger v. Bd. of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.)

2. Health and Safety Code section 1798.200, subdivision (c)(2), provides that disciplinary action may be taken against a licensee for gross

negligence. Gross negligence is defined as an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a reasonable and prudent paramedic. Subdivision (c)(4) provides that disciplinary action may be taken against a licensee for incompetence.

Incompetence is defined as the lack of possession of the degree of knowledge, skill, and ability ordinarily possessed and exercised by a licensed and accredited paramedic. Subdivision (c)(10) provides that disciplinary action may be taken against a licensee for “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.” This includes violating local EMSA policies.

First Cause for Discipline

3. As set forth in Factual Finding 31, respondent’s use of the incorrect 5.0 mm ET tube to intubate the patient and his failure to adequately monitor the patient after performing the intubation constituted gross negligence and incompetence. Cause for discipline under Health and Safety Code section 1798.200, subdivisions (c)(2) and (c)(4) was established.

Second Cause for Discipline

4. Complainant alleges that respondent is subject to discipline pursuant to Health and Safety Code section 1798.200, subdivision (c)(10), for violating local EMSA policies, including Coastal Valley EMS Policy Numbers 9802, 9705, and 9814.

As set forth in Finding 34, respondent violated Policy Number 9705 by using the wrong size ET tube, and he violated Policy Number 9814 by failing to use a CO₂ monitor during intubation. A violation of Policy Number 9802 was not established. Cause for discipline pursuant to Health and Safety Code section 1798.200, subdivision (c)(10), was established, for respondent’s failure to abide by the local EMSA policies in effect in his jurisdiction.

Disciplinary considerations

5. EMSA’s Recommended Guidelines for Disciplinary Orders provide a range of discipline. The maximum discipline for a violation of Health and Safety Code section 1798.200, subdivisions (c)(2),(4), and (10) is revocation. The minimum discipline is a stayed revocation with a one-year probation.

6. California Code of Regulations, title 22, section 100176, provides that when considering the denial, placement on probation, suspension, or revocation of a license pursuant to Health and Safety Code section 1798.200, the following criteria shall be considered:

1. Nature and severity of the act(s) or crimes under consideration.
2. Evidence of any act(s) committed subsequent to the act(s) or crime(s) under consideration as grounds for denial, placement on probation, suspension, or revocation.
3. The time that has elapsed since commission of the act(s) or crimes(s) referred to above.
4. The extent to which the licensee has complied with any terms of parole, probation, restitution, or any other sanctions lawfully imposed against the person.
5. If applicable, evidence of expungement proceedings pursuant to Section 1203.4 of the Penal Code.
6. Evidence of rehabilitation submitted by the licensee.

7. The Disciplinary Guidelines require that the administrative law judge use the following disciplinary consideration factors as a guide in making a recommendation for discipline:

1. Nature and severity of the act(s) or crimes under consideration;
2. Actual or potential harm to the public;
3. Actual or potential harm to any patient;
4. Prior disciplinary record;
5. Prior warnings on record or prior remediation;
6. Number and/or variety of current violations;
7. Aggravating evidence;
8. Mitigating evidence;
9. Any discipline imposed by the paramedic's employer for the same occurrence of that conduct;
10. Rehabilitation evidence;

11. In case of a criminal conviction, compliance with terms of sentence and/or court-ordered probation;
12. Overall criminal record;
13. Time that has elapsed since the act(s) or offense(s) occurred;
14. If applicable, evidence of expungement proceedings pursuant to Penal Code section 1203.4.

Analysis

8. This accusation arose from respondent's actions during a single emergency call. Respondent arrived to a chaotic and stressful scene. The newborn patient was in grave distress and resuscitation efforts were already underway. Respondent was motivated to help the patient and was perhaps overzealous in his efforts. He believed that bag valve mask resuscitation was not working and attempted to intubate the patient during the ambulance transport, with sirens blaring. Given the high risk of the procedure, it was incumbent upon respondent to act with extreme deliberation when he decided to intubate the patient. Respondent's actions in intubating the infant fell below the standard of care in that he selected the wrong size ET tube and did not make use of capnography monitoring to confirm ventilation. Of additional concern is respondent's unwillingness to acknowledge the possibility that the patient might not have ever been properly intubated. Respondent steadfastly insisted that the intubation was successful even in the face of the contradictory conclusion of the treating neonatologist.

As set forth in Finding 33, it was not established by clear and convincing evidence that respondent's actions caused actual harm to the patient. This is not to minimize respondent's errors; obviously there is the potential for grave harm to a patient if the paramedic fails to intubate properly and fails to monitor the patient's ventilation using capnography.

Respondent has used this experience as an opportunity for improvement. He consulted medical experts and has abided by the follow up measures directed by the local EMS authority, including taking a pediatric life support course and undergoing additional training with his field training officer. Respondent has corrected his intubation practices to ensure that he does not repeat his errors. Respondent is highly regarded as a skilled paramedic and educator. Respondent is a valued employee of the Bodega Bay Fire Protection District and instructor at Santa Rosa Junior College. Respondent is passionate about his profession and has a history of community service.

Respondent has been licensed for more than 10 years and has not been subject to prior license discipline. There was no evidence of any deficient acts by respondent subsequent to the events of November 18, 2015.

It has not been demonstrated that respondent poses such a threat to the public safety as to warrant revocation. A two-year period of probation falls within the Disciplinary Guidelines and will afford EMSA the opportunity to monitor respondent's performance. In light of the remedial measures already imposed by the Coastal Valley EMS, the standard conditions of probation are adequate and no special conditions are necessary.

ORDER

Emergency Medical Technician-Paramedic License Number P25283, issued to respondent Marco A. Barros, is revoked. However, the revocation is stayed and respondent is placed on probation for two years, upon the following terms and conditions:

1. Probation Compliance

Respondent shall fully comply with all terms and condition of the probationary order. Respondent shall fully cooperate with EMSA in its monitoring, investigation, and evaluation of respondent's compliance with the terms and conditions of his probationary order.

Respondent shall immediately execute and submit to EMSA all Release all Information forms that EMSA may require of respondent.

2. Personal Appearances

As directed by EMSA, respondent shall appear in person for interviews, meetings, and/or evaluations of respondent's compliance with the terms and conditions of the probationary order. Respondent shall be responsible for all of his costs associated with this requirement.

3. Quarterly Report Requirements

During the probationary period, respondent shall submit quarterly reports covering each calendar quarter which shall certify, under penalty of perjury, and document compliance by respondent with all the terms and conditions of his probation. If respondent submits his quarterly reports by mail, it shall be sent as certified mail.

4. Employment Notification

During the probationary period, respondent shall notify EMSA in writing of any EMS employment. Respondent shall inform EMSA in writing of the name and address of any prospective EMS employer prior to accepting employment.

Additionally, respondent shall submit proof in writing to EMSA of disclosure, by respondent, to the current and any prospective EMS employer of the reasons for and terms and conditions of respondent's probation.

Respondent authorizes any EMS employer to submit performance evaluations and other reports which EMSA may request that relate to the qualifications, functions, and duties of prehospital personnel.

Any and all notifications to EMSA shall be by certified mail.

5. Notification of Termination

Respondent shall notify EMSA within 72 hours after termination, for any reason, with his prehospital medical care employer. Respondent must provide a full, detailed written explanation of the reasons for and circumstances of his termination.

Any and all notifications to EMSA shall be by certified mail.

6. Functioning as a Paramedic

The period of probation shall not run anytime that respondent is not practicing as a paramedic within the jurisdiction of California.

If respondent, during his probationary period, leaves the jurisdiction of California to practice as a paramedic, respondent must immediately notify EMSA, in writing, of the date of such departure and the date of return to California, if respondent returns.

Any and all notifications to EMSA shall be by certified mail.

7. Obey All Related Laws

Respondent shall obey all federal, state, and local laws, statutes, regulations, and local written policies, protocols and rules governing the practice of medical care as a paramedic. Respondent shall not

engage in any conduct that is grounds for disciplinary action pursuant to section 1798.200. To permit monitoring of compliance with this term, if respondent has not submitted fingerprints to EMSA in the past as a condition of licensure, then respondent shall submit his fingerprints

by Live Scan or by fingerprint cards and pay the appropriate fees within 45 days of the effective date of this decision.

Within 72 hours of being arrested, cited or criminally charged for any offense, respondent shall submit to EMSA a full and detailed account of the circumstances thereof. EMSA shall determine the applicability of the offense(s) as to whether respondent violated any federal, state and local laws, statutes, regulations, written policies, protocols and rules governing the practice of medical care as a paramedic.

Any and all notifications to EMSA shall be by certified mail.

8. Completion of Probation

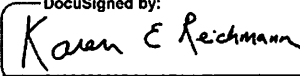
Respondent's license shall be fully restored upon successful completion of probation.

9. Violation of Probation

If during the period of probation respondent fails to comply with any term of probation, EMSA may initiate action to terminate probation and implement actual license revocation. Upon the initiation of such an action, or the giving of a notice to respondent of the intent to initiate such an action, the period of probation shall remain in effect until such time as a decision on the matter has been adopted by EMSA license revocation shall be initiated and conducted pursuant to the hearing provisions of the California Administrative Procedure Act.

The issues to be resolved shall be limited to whether respondent has violated any term of his probation sufficient to warrant termination of probation and implementation of actual revocation. Respondent and EMSA shall be bound by the admissions contained in the terms of probation and neither party shall have a right to litigate the validity or invalidity of such admissions.

DATED: June 8, 2018

DocuSigned by:

KAREN REICHMANN
Administrative Law Judge
Office of Administrative Hearings