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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:  
**JESSE WATTSON,**  
License No. P22087  
Respondent.

)  
) Enforcement Matter No.: 17-0011  
) OAH No.: 2018010895  
)

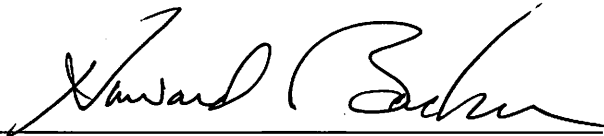
) **DECISION AND ORDER**  
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The attached Proposed Decision and Order dated March 5, 2019, is hereby adopted by the  
Emergency Medical Services Authority as its Decision in this matter. The decision shall  
become effective 30 days after the date of signature.

It is so ordered.

DATED:

*March 11, 2019*



**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:

JESSE WATTSON

License No. P22087,

Respondent.

Case No. 17-0011

OAH No. 2018010895

**PROPOSED DECISION**

Adam L. Berg, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter on February 4, 2019, in San Diego, California.

Cynthia Curry, Attorney, represented complainant, Sean Trask, Chief, EMS Personnel Division, Emergency Medical Services Authority, State of California.

Rizza Gonzales, Attorney at Law, represented, respondent, Jesse Wattson.

The matter was submitted on February 4, 2019.

**FACTUAL FINDINGS**

*Background*

1. On March 8, 2005, the authority issued Emergency Medical Technician-Paramedic (EMT-P) license number P22087 to respondent. There is no history of discipline imposed against respondent's license.

2. On October 19, 2017, complainant signed the accusation seeking the revocation of respondent's license. The accusation alleged the following: On November 21, 2016, respondent was dispatched to a 911 call at the home of a 74-year-old male complaining of headache, nausea, and vomiting. The patient's wife reported that he had fallen three days before and bumped his head on the wall. Respondent contacted the patient who was in bed receiving dialysis, for which he was taking blood thinners. Respondent dismissed the patient's wife's concerns and insisted the patient had the flu. He advised her to give the patient Tylenol or ibuprofen to address his headache. When the patient's wife informed

respondent that she had been monitoring his blood pressure, which was unusually high, respondent said the patient would be more comfortable at home than in a hospital. Ultimately, the patient's wife completed paperwork for an Against Medical Advice (AMA) refusal of medical care. Respondent failed to contact the base hospital during the AMA process, although he indicated in the patient care report (PCR) that such contact had been made.

Several hours later, the patient's wife called 911 a second time. Respondent was again dispatched to the residence. Although the patient's wife requested an ambulance transport the patient to the hospital, respondent refused to transport the patient. Instead, respondent assisted the patient's wife into her car so she could drive him herself. Respondent refused the wife's request to follow her as she drove to the hospital. Respondent failed to complete a full paramedic assessment or paperwork regarding the second call. When the patient arrived at the hospital, he was unable to stand. Hearing of the fall several days before, hospital personnel ordered a head scan, which revealed acute bilateral subdural hematomas as well as a subarachnoid hemorrhage. The patient was transferred to University of California, San Diego (UCSD) Medical Center, where he underwent a craniotomy. However, he became unresponsive, was placed in hospice, and passed away several weeks later.

The accusation also alleged that respondent committed gross negligence; was incompetent; committed a fraudulent, dishonest, or corrupt act; violated or attempted to violate any law or regulation pertaining to prehospital personnel; and functioned outside the supervision of medical control in the field care system operating at the local level.

3. Respondent timely submitted a notice of defense; this hearing ensued.

### *Complainant's Evidence*

#### DECLARATION OF ELSA CARACAS

4. Complainant submitted a declaration<sup>1</sup> by Elsa Caracas, dated May 1, 2018. The declaration is summarized as follows: Mrs. Caracas was married to her late husband, Ephraim Caracas, for 44 years. In November 2016, Mr. Caracas had been on home-dialysis for approximately a year. Mrs. Caracas was his primary caretaker. On November 19, 2016, Mr. Caracas fell and bumped his head. Mrs. Caracas and her husband stayed at home the next day as he was not "feeling his best." The second day, they went out briefly, but by the

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<sup>1</sup> All of the declarations offered by complainant were received under Government Code section 11514, which provides that prior to a hearing, a party can provide notice to the opposing party that it is introducing an affidavit; if the opposing party fails to request to cross-examine the affiant, the affidavit can be admitted into evidence with the same effect as if the affiant had testified orally. Respondent did not object to the introduction of any of the declarations.

evening, he began vomiting and getting sicker. When he did not improve by midnight of November 21, 2016, she called 911 fearing that he was having a heart attack. In preparation for a trip to the hospital, she unhooked him from the dialysis machine.

When respondent arrived in the ambulance she told him that Mr. Caracas had been vomiting for a while, was weak and dizzy, and was breaking into a cold sweat. She told him she thought he might be having a heart attack and needed to get to the hospital. Respondent performed an electrocardiogram (EKG) and checked Mr. Caracas's blood pressure. Respondent advised Mrs. Caracas to give her husband Tylenol and ibuprofen to address his headache. Mrs. Caracas kept a journal of his blood pressure readings. She explained that Mr. Caracas had taken his blood pressure before the ambulance arrived and it was unusually high. She also told respondent that Mr. Caracas was on Eliquis, a blood thinner. Mrs. Caracas believed respondent was dismissive of the information.

Mrs. Caracas verbally and physically demonstrated for the ambulance personnel how Mr. Caracas had lost his balance and bumped the back of his head on the wall. Respondent said that a bump on the back of the head would not produce severe pain in the front of the head, as Mr. Caracas had described. Respondent insisted that Mr. Caracas had the flu that was going around and did not need to go to the hospital. He said "not to worry," advised that Mr. Caracas take some Tylenol, and instructed Mrs. Caracas to call 911 if the condition changed. Respondent asked Mr. Caracas to sign some papers and the ambulance personnel left.

Mrs. Caracas called 911 again at 3:30 a.m. the next morning because Mr. Caracas continued to vomit and "feel bad." When respondent arrived at her house, he said, "Didn't I tell you it's just the flu?" Mrs. Caracas said that because Mr. Caracas was not getting any better he needed to go to the hospital. Mrs. Caracas was shaking because she did not know what she would do if respondent did not help transport him to the hospital. She asked respondent to transport him, but respondent said it was not necessary. In response, she asked him to help get Mr. Caracas into her car. Respondent helped Mr. Caracas down the stairs and into the car. She asked respondent to follow her to the hospital but he refused. When she arrived at the hospital, hospital staff needed to help Mr. Caracas out of the car because he could not stand. Mr. Caracas was diagnosed with a bilateral subdural hematomas and subsequently had three surgeries. After the third surgery, he never regained consciousness. He died on December 17, 2016.

#### DECLARATION OF RAYMON MORELAND

5. Complainant submitted a declaration by Raymon Moreland, dated April 30, 2018, which is summarized as follows: Mr. Moreland is an EMT employed by Rural/Metro Ambulance.<sup>2</sup> Mr. Moreland was respondent's EMT partner on November 21, 2016. The

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<sup>2</sup> Rural/Metro Ambulance, which is now owned by American Medical Response, provides EMS coverage for the City of San Diego.

two were dispatched to a 911 call at the Caracas' residence at 11:47 p.m. Upon arrival, Mrs. Caracas explained that her 74-year-old husband was upstairs on home-dialysis. He was complaining of a headache, which began several days after he experienced a fall. Mrs. Caracas "appeared to be a good historian but was very anxious about her husband's condition." Respondent assessed Mr. Caracas in his wife's presence. She often answered for Mr. Caracas in relating his symptoms. While she appeared to be very concerned about his condition, Mr. Caracas himself was not complaining much and seemed well oriented to his condition and surroundings. Mr. Moreland observed respondent complete a patient assessment and stroke scale, "focusing on what might have caused the fall rather than the fall itself." To the best of his knowledge, Mr. Moreland stated respondent did not question either the patient or his wife regarding the facts surrounding the actual fall itself. Respondent explained to Mr. Caracas and his wife that it appeared Mr. Caracas had symptoms of the flu and suggested that he alternate taking Tylenol and ibuprofen. Mrs. Caracas wanted them to transport the patient to the hospital, but respondent said he did not believe it was necessary. Respondent suggested that he complete his dialysis at home and give the Tylenol time to do its work. While Mrs. Caracas was reluctant, she finally agreed.

Respondent initiated the AMA process. Mr. Moreland was not certain but believed that respondent contacted the base hospital. At 3:59 a.m. the following morning, Mr. Moreland and respondent responded to a second 911 call at the Caracas's residence. Upon arrival, respondent entered the residence while Mr. Moreland remained outside for one to two minutes. When Mr. Moreland entered the residence, respondent was helping Mr. Caracas down the stairs toward the front door. Mr. Caracas appeared normal with no distress. Respondent told Mr. Moreland that Mrs. Caracas was driving her husband to the hospital in their private vehicle. Respondent and Mr. Moreland assisted the patient into his car. Mr. Moreland did not observe any assessment of the patient on this visit, although it could have been done outside of his presence. Mr. Moreland did not speak to either Mr. or Mrs. Caracas on the second call, although he did hear Mrs. Caracas ask to have her husband transported to the hospital, or in the alternative, to have the ambulance follow her car to the hospital. Mr. Moreland was not aware if respondent generated a PCR for this call or contacted the base hospital.

#### DECLARATION OF SUSAN CHURCH, R.N.

6. Complainant submitted a declaration by Susan Church, R.N., dated July 20, 2018, which is summarized as follows: Ms. Church has been a registered nurse (R.N.) since 2009 and supervising RN in the emergency department at Scripps Mercy Hospital since 2012. On November 22, 2016, Ms. Church was on-duty in the emergency department when she became aware of a privately-owned vehicle in the parking lot with an elderly individual needing assistance. Ms. Church's first impression of Mr. Caracas was that he appeared weak, pale, and in distress. He could not stand on his own. He presented with a headache, weakness, nausea, and vomiting. Mrs. Caracas reported that he had suffered a fall and struck his head three days prior.

Mrs. Caracas told Ms. Church that she had reported the fall and the fact that her husband was on blood thinners to the paramedic. Ms. Church believed Mrs. Caracas to be a good historian of her husband's medical condition and history. They assisted Mrs. Caracas in the emergency department with a Tagalog interpreter. After tests revealed that Mr. Caracas had a subdural hemorrhage, he was transferred to UCSD Medical Center in acute status.

Based on the concerns of Mrs. Caracas, Ms. Church contacted San Diego Fire Department, who referred her to Rural/Metro. Ms. Church spoke to a supervisor regarding her concerns that respondent failed to transport the patient.

#### DECLARATION OF KRISTI KOENIG, M.D.

7. Complainant submitted a declaration of Kristi Koenig, M.D., dated July 13, 2018, which is summarized as follows: Dr. Koenig has been a physician since 1986 and has been the Medical Director for San Diego County Emergency Medical Services (SDCEMS) since 2016. On December 2, 2016, Dr. Koenig learned that an investigation had been initiated following the death of Mr. Caracas and complaint by Mrs. Church. Dr. Koenig recounted the circumstances that were related to her involving the encounter between the patient and respondent.

Dr. Koenig reviewed the PCR respondent completed for the call and found multiple inconsistencies. The PCR identified the patient as female. The report indicated that UCSD was the base hospital contacted when the hospital log showed no such entry for a call. Respondent initiated paperwork for the AMA process, which is governed by SDCEMS Policy No. S-412 "Prehospital Treatment and Transportation of Adults – Refusal of Care or Suggested Destination, Release." The PCR indicated, "Patient and his wife agreed that he wanted to stay and rest and contact pmd [primary medical doctor] in the a.m. Patient refused further treatment." However, Dr. Koenig was informed that the patient's wife said it was respondent who decided not to transport the patient, against, her wishes. Thus, the AMA would not be appropriate in this situation.

In addition, in the PCR, respondent documented "no history of recent trauma," and "no complaints of dizziness," which was not accurate according to the patient's wife. Dr. Koenig stated that audio tapes of the 911 call made by the patient's wife confirm that she volunteered information about the patient's fall, despite the fact that respondent denied knowing this information.<sup>3</sup>

During the investigation by Rural/Metro, Mr. Moreland indicated that the patient spoke better English than his wife with whom there was a language barrier. However, the patient's history appears to have been gained primarily by his wife. Moreover, the wife, not

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<sup>3</sup> Complainant introduced the transcripts of the 911 calls. However, the transcripts contain no mention by Mrs. Caracas that her husband had suffered a fall.

the patient, signed the AMA form. This would typically occur only if the patient were too ill or had an altered mental status and could not sign himself. In this situation, he would be designated an “emergency patient,” which is defined in SDCEMS Policy S-412, and requires all emergency patients to be offered treatment and/or transport following a complete assessment.

Respondent indicated that the second time he responded to the Caracas’s house, he did not take vital signs or perform an assessment because he did not consider Mr. Caracas a “patient.” However, it is unclear why an AMA form would have been completed,<sup>4</sup> and his wife clearly wanted medical care because they proceeded immediately to the emergency room even though respondent refused transport by ambulance.

SDCEMS Policy S-415, “Base Hospital Contact/Patient Transportation and Report – Emergency Patients” defines an “emergency patient” to include “Any person for whom the 911/EMS system has been activated” and has “a chief complaint or suspected illness or injury.” The policy requires EMS personnel to provide an “initial notification” to the base hospital for any emergency patient. “Initial notification” is defined in the policy as “A brief communication by the field personnel to provide the acuity, age, gender and chief complaint of the patient to the base hospital to assist in determining appropriate patient destination.” In other words, base hospital contact was not met because the patient had a “chief complaint.” Additionally, base hospital contact is required when the emergency patient is older than 65 years of age and has experienced an altered/decreased level of consciousness, significant mechanism of injury, or any fall.” The patient met the age and fall requirements, and was apparently too altered or ill to sign the AMA form himself. And while the AMA was used inappropriately, the completion of an AMA required base hospital contact. Respondent should not have indicated in the PCR that contact was made when it had not.

Finally, Dr. Koenig believed that respondent should have performed a proper assessment after responding to the second 911 call. The patient was extremely frail with multiple serious medical conditions such as renal failure. He presented with an acute worsening of his condition with excessive vomiting, altered level of consciousness, and weakness so severe he was unable to stand on his own when he arrived at the emergency department. Dr. Koenig believed that respondent violated SDCEMS Policies S-412 and S-15 with regard to the care of the patient.

#### *Relevant San Diego County EMS Policies*

8. SDCEMS Policy No. S-412 establishes procedures for a patient to refuse care (assessment, treatment, or transport). An “emergency patient” includes anyone who activates the 911 system and has a chief complaint or suspected illness or injury, or requires or requests field treatment or transport. Under the policy, “All emergency patients will be

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<sup>4</sup> There was no evidence that an AMA or PCR were completed following the second 911 call.

offered treatment and/or transport following a complete assessment.” However, adults have the right to refuse any prehospital care and transportation, provided that the refusal “is made in an informed basis” and the patient has the mental capacity to make and understand the implications of the decision. For those patients who wish to sign an AMA, base hospital contact is required. Finally, the policy specifies the information that should be documented when a patient is released AMA.

9. SDCEMS Policy No. S-415 establishes procedures for contacting a base hospital when encountering an emergency patient. Base hospital contact is required for any emergency patient with abnormal vital signs or altered level of consciousness, or who is older than 65 and has experienced an altered/decreased level of consciousness, significant mechanism of injury, or any fall.

#### PATIENT CARE REPORT

10. Complainant submitted a copy of the electronic PCR respondent signed following his first encounter with Mr. Caracas. The notable aspects of the report are summarized as follows: The report indicated Mr. Caracas’s gender was female. The history indicated that the patient had a history of hypertension and renal failure, had a headache since 8:00 p.m., developed chills with nausea and vomiting; and had a low-grade fever. Respondent found the patient “alert and oriented x 4 with full recall of incident. No obvious signs of trauma noted.” The patient complained of headache in front of his head. A stroke scale was negative. Respondent assessed vitals “per request of the wife.” Mr. and Mrs. Caracas “agreed that he wanted to stay and rest and contact pmd in the morning.” The report indicated that respondent contacted UCSD, the base hospital. Finally, the PCR stated that Mr. Caracas “refused further treatment” and “advised of risk and complications upto [sic] and including death. [A]dvised to contact 911 as needed.” Mr. Caracas’s blood pressure was 178/92.

The AMA portion of the report indicated the reason for the AMA was “wife wanted vitals assessed.” An AMA release checklist indicated “No” for the following questions: is patient alert and oriented to person, place, time, and event; is patient unimpaired by drugs and alcohol; is patient competent to refuse care; has patient been advised that 911 can be reassessed; have the risks and complications of refusal been discussed; is the patient 18 years or older or emancipated; and no medical care or only BLS care rendered.

#### TRANSCRIPT OF 911 CALLS

11. Complainant submitted certified transcripts of the two 911 calls by Mrs. Caracas. In the first call, Mrs. Caracas reported that her husband was throwing up and his blood pressure was too high. She said, “I need help, please. He threw up two times already.” The dispatcher obtained additional information and gave Mrs. Caracas instructions. At the end of the call she repeated that she needed an ambulance. It was clear from the transcript that Mrs. Caracas was quite agitated and concerned.



In the second call, Mrs. Caracas provided her contact information, followed by, "Please hurry up." The following was the exchange:

Q Okay, ma'am, what's wrong? Tell me what's happening.

A Throwing up and he's got high BP.

Q Okay. Ma'am –

A (Overlapping) the hospital right now.

Q Try and calm down, I have help coming for you, okay?

A Thank you.

[¶] . . . [¶]

Q Is he aware?

A Yes, hurry up.

Q Ma'am, ma'am, we are coming, you don't have to tell me to hurry up, okay, were coming there now. Is he breathing?

A Yes

Q Okay.

A He's very weak.

[¶] . . . [¶]

Q Okay, Is he bleeding or vomiting any blood?

A He (indiscernible), please, I need help.

At the conclusion, Mrs. Caracas again asked if the paramedics were on the way. It was clear from the second conversation that Mrs. Caracas was highly agitated and worried about her husband.

*Respondent's Statement to the Authority*

12. Respondent submitted an undated response to the authority regarding the complaint investigation, which is summarized as follows: On November 21, 2016, respondent was dispatched to a report of nausea and vomiting. They encountered an elderly

patient in bed, who said he had one episode of vomiting and was nauseous. The patient's wife called 911. The patient was on a home peritoneal dialysis machine lying in bed. The patient appeared to be in mild distress and was answering questions. The patient's wife answered the majority of questions. The patient's wife handled his medical care and kept records of everything. She reported that the patient began feeling ill that evening. He had one episode of vomiting in the bathroom, but walked himself to bed. During the assessment, respondent's EMT partner began taking vitals. Respondent saw medications on the dresser and asked the wife if that's all the patient took. The patient had a low grade fever during the assessment. Most of respondent's conversation was with the wife, while his partner spoke to the patient. The patient appeared to be acting appropriately and answered all questions without deficit. Respondent asked the wife what she wanted to do. He informed the wife that most of the symptoms appeared to be flu-like, but that they would take him to the hospital if she desired. "It was decided that the patient would rest in his bed and to see if there was any change throughout the night." Respondent completed AMA paperwork and they left the scene.

Several hours later, respondent was dispatched to the same address. There were multiple police vehicles outside when they arrived. Before entering the house, respondent spoke to the officer, who said there had been multiple 911 hang-ups at the address. When they approached the house, respondent asked the wife what had changed. She stated the patient was the same. He was not any worse or any better. They entered the house and went upstairs. Respondent asked the wife what her desire was. She appeared anxious. He attempted to calm her down, but it was hard to understand her English. When she calmed down, he again asked her what she desired. Respondent asked if she needed help getting him to the car, or if she wanted us to take him to the hospital. She indicated that she would like help getting him into the car and would take him herself. Respondent told her he wanted to talk to the patient briefly. The patient told respondent that everything was the same; he said he still felt ill but no real change. Respondent asked if he was strong enough to walk because this was the assessment tool to determine if he could go in a private vehicle. The patient exited the bed on his own and walked down the stairs under his own power. They assisted him with putting on slippers at the bottom of the stairs. Respondent and his partner were on either side of the patient walking down the stairs, but never needed to intervene. They helped the patient into the front seat of his car. The wife asked if they would follow her to the hospital, and respondent said they would not. The patient thanked him and drove away.

Respondent was notified about the complaint on November 23, 2016. Respondent said he acknowledged the mistake of not notifying the base hospital due to the age and vital signs. He admitted he should have contacted the base hospital and would not repeat that mistake. Regarding the cerebral hemorrhage, respondent was never informed of the fall he had prior to the incident. When he asked if anything recently happened to the patient, a fall was never mentioned. Respondent did not know if his question was not understood, or he had not been clear enough. However, respondent does not take head injuries or anticoagulants lightly. Respondent felt the wife might have misunderstood him regarding transport. Respondent never refuses transport to hospital. Respondent admitted that his documentation of the AMA was "lacking."

Respondent did not document the second call because he felt that assisting the patient to his car was more an "assist." He was somewhat confused of the wife's desire when they arrived, because there was no change in the patient's situation.

Respondent concluded by expressing recognition that he made mistakes and expressing sorrow for the patient's death.

### *Respondent's Testimony*

13. Respondent's testimony is summarized as follows: Respondent is 39 years old. He is married with four young children. He completed his paramedic studies and was licensed in 2005. In addition to working as a paramedic with Rural/Metro, he has been employed as a firefighter/paramedic for several fire departments. After he was terminated from Rural/Metro as a result of this incident, he was employed as a firefighter/paramedic with Cal Fire in San Diego. He was promoted to Engineer/Paramedic with Cal Fire, a supervisory position, and is currently stationed in San Mateo.

When he was working for Rural/Metro, respondent would respond to 5 to 10 emergency calls per shift. He would end up transporting approximately 5 to 10 patients to the hospital. He has never refused to transport a patient who has requested to go to the hospital. Under local EMS policy, he was not permitted to refuse transport to the hospital.

When respondent arrived on scene, Mrs. Caracas said Mr. Caracas had been feeling ill and vomiting and asked respondent to evaluate him to see if he needed to go to hospital. Respondent obtained a history from Mrs. Caracas, who said Mr. Caracas had been vomiting for a couple days, had a headache, and wasn't feeling well. Mr. Caracas was on home-dialysis, and Mrs. Caracas had disconnected him from the machine in case he needed to be transported to the hospital.

Respondent found Mr. Caracas in bed. Mr. Caracas appeared to be aware of what was happening, although he looked ill. Respondent's partner began taking Mr. Caracas's vitals while respondent spoke to Mrs. Caracas. Respondent reviewed his medications that were sitting on a dresser and asked Mrs. Caracas if Mr. Caracas was on a blood-thinner. Mrs. Caracas indicated that the medications on the vanity were his only medications (which did not contain a blood-thinner). Respondent did not make a list of the medications. Had he been aware that Mr. Caracas was on a blood-thinner, respondent would have transported him to the hospital. Respondent observed some oxygen tubing and clutter on the floor, and he asked Mrs. Caracas if it had been an issue. Mrs. Caracas said Mr. Caracas had been tangled up in it before but it had not been an issue. Respondent asked if Mr. Caracas had ever been hurt because of it, and she said that he had not.

Respondent then spoke to Mr. Caracas. Mr. Caracas said he felt ill "but not in a terrible way." Respondent believed Mr. Caracas was in mild distress, in that he did not feel well, but he did not appear to be in life threatening situation. Mr. Caracas did not indicate that he wanted to go to hospital. Mr. Caracas's blood pressure was elevated and he reported

having a headache. Respondent investigated the headache further. He checked Mr. Caracas's pupils, which were equal and reactive. He performed a stroke assessment which was negative. Neither Mr. Caracas nor Mrs. Caracas said anything to respondent about a fall. Had they, respondent would have investigated why he fell, would have suggested that Mr. Caracas be evaluated at the hospital, and would have transported him due to Mr. Caracas's age and other medical issues.

Respondent again spoke to Mrs. Caracas, who maintained a blood pressure log. She said Mr. Caracas had trouble keeping his blood pressure medication down. However, prior to respondent's arrival, Mr. Caracas had taken his medication and had kept it down. Respondent suggested that the medication could bring Mr. Caracas's blood pressure down to a normal level. Respondent told Mrs. Caracas that it appeared Mr. Caracas had flu-like symptoms. It is outside of respondent's scope of practice to make diagnoses, so he explained that it "looks like" Mr. Caracas had the flu based on his signs and symptoms. Respondent told Mrs. Caracas that he could transport Mr. Caracas to the hospital, but Mrs. Caracas decided to let Mr. Caracas continue to rest in bed to see if his fever would improve. Respondent recommended that she call Mr. Caracas's doctor the next day. Respondent said that she could give him Tylenol. Respondent never directs people to take medications, but if they ask about it, he shares the knowledge he has about the medication.

Mrs. Caracas's first language was Tagalog, and it was hard for respondent to understand her exact words. On occasion, respondent had to repeat himself. Respondent believed she understood her options and felt the information was clear enough for her to make a competent decision. Respondent disagreed that he refused to transport Mr. Caracas to the hospital. When the decision is "up in the air" whether a patient will be transported, respondent tells patients that it is their decision. Respondent discussed the AMA with Mrs. Caracas; Mr. Caracas was close enough to hear what was being discussed. Mrs. Caracas agreed to sign the AMA. Mr. Caracas was aware of what was going on. Since Mrs. Caracas appeared to handle most of Mr. Caracas's medical care, he was aware she was signing on his behalf. Mr. Caracas was looking at respondent and Mrs. Caracas as they discussed the options and heard what was being discussed. When respondent was performing his assessment, he asked Mr. Caracas if he wanted to go to hospital or rest; Mr. Caracas said he wanted to rest at home. It is not uncommon for a patient who does not want to sign an AMA to authorize a family member to sign on his or her behalf. In this case, Mr. Caracas was aware of what was happening and gestured that it was okay for his wife to sign the AMA.

Respondent admitted that he should have contacted the base hospital prior to having Mrs. Caracas sign the AMA because of his age and elevated blood pressure. He told Mrs. Caracas that if anything changed or she changed her mind about transport, she could call 911 again. Respondent reiterated that nobody reported that Mr. Caracas had fallen or had a bump on his head. Respondent did not discuss his plan for Mr. Caracas with his EMT partner, Mr. Moreland.

When they were dispatched to the Caracas's house the second time, there were police cars in front. The officers told respondent that there had been multiple 911 hang-ups.

Respondent met Mrs. Caracas at the door. She told respondent that Mr. Caracas was still sick. He asked her if Mr. Caracas was getting any worse; she responded that he was not getting any worse but not getting better either. Respondent asked her what she wanted him to do – did she want respondent to take Mr. Caracas to the hospital or did she want help getting him into their private vehicle. She asked if it was possible for her to take Mr. Caracas to the hospital herself. Respondent said either she or respondent could take him to the hospital. Mrs. Caracas decided she would drive Mr. Caracas to the hospital. Respondent disagreed that he refused to take Mr. Caracas to the hospital because he never refuses transport for those who request to go to the hospital. Respondent told her he would go upstairs to see if Mr. Caracas was any better or worse.

Respondent spoke to Mr. Caracas, who said he was still feeling ill and was not getting better. Mr. Caracas was “ambivalent” about going to the hospital; respondent told him that his wife wanted him to get evaluated and asked if he could walk to the car under his own power. Mr. Caracas said he could walk downstairs to his car on his own. Respondent assisted him downstairs. Respondent helped put Mr. Caracas’s slippers on, got him to his car, and buckled his seat belt. He told Mrs. Caracas that he would not be following them to the hospital, but she could pull over and call 911. He was not permitted to follow someone to the hospital because it would mean leaving his district.

Respondent did not complete a PCR for this call or have the patient sign an AMA. He viewed this call as an extension to previous call, and treated it as a “public assist.” He did not perform an evaluation or assessment of other than what he could ascertain from Mr. Caracas’s appearance and statement that he was feeling the same.

Respondent admitted that he made multiple mistakes in the PCR and it is the paramedic’s responsibility to ensure that all of the information was accurate. He explained that some of the information could have been entered by this EMT partner, although it was his job to verify the information. He believed that his partner had selected the box indicating that respondent had contacted the base hospital.

Two days later, respondent was notified by his supervisor about the complaint. The incident has caused respondent to become hyper-vigilant; he is now rarely comfortable doing an AMA. He asks a lot more questions and is more likely to call base hospital now. Not a day has gone by that he does not think about the incident. He has had no other patient complaints and has never been disciplined by any other EMS employer or local EMS agency.

#### *Additional Evidence*

14. Respondent submitted a probationary employee performance evaluation from Cal Fire dated October 31, 2018. Respondent received “standard” and “outstanding” ratings.

15. Respondent submitted an undated letter from Brent Brainhard. Mr. Brainhard worked with respondent when they were assigned to the same fire station. Mr. Brainhard, a firefighter, responded to emergency calls along with respondent on a regular basis. Mr.

Brainhard discussed the incident, and he believed that had respondent been provided the full information, he would have transported the patient. Respondent also recognized his failure to contact base hospital as required. Mr. Brainhard believes that respondent has learned from his mistakes and has worked to improve himself as a paramedic.

16. Respondent submitted an undated letter from Mark Neill, a flight paramedic, who worked with respondent for several years. Mr. Neill was respondent's field training officer at Rural/Metro (now AMR). He found respondent to be thorough clinically and compassionate with communicating with patients. As a faculty advisor at a local community college, Mr. Neill has also observed respondent work with paramedic interns. Mr. Neill believes that respondent uses sound clinical judgment, follows protocols, and does not cut corners. He has discussed the incident with respondent, and Mr. Neill believes that the allegations that respondent refused to transport an ill patient do not align with what he knows of respondent's personality and character.

17. Respondent submitted a letter from Donald R. Bennett, M.D., dated January 31, 2019. Dr. Bennett worked with respondent in 1998, when they were both partners on an ambulance. After Dr. Bennett completed his emergency medicine training, he returned to San Diego and would interact with respondent at the emergency department. He has found respondent's character to be above reproach, and clinically respondent is a dependable medic. Dr. Bennett has spoken to respondent about the incident; but Dr. Bennett does not believe these actions are consistent with the years of behavior he has witnessed while working with and around respondent.

#### *Evaluation of the Evidence*

18. Although the declarations submitted by complainant were received as non-hearsay, it is not required that the information contained in them be accepted as true. A trier of fact may "accept part of the testimony of a witness and reject another part even though the latter contradicts the part accepted." (*Stevens v. Parke Davis & Co.* (1973) 9 Cal. 3d 51, 67.) The trier of fact may also "reject part of the testimony of a witness, though not directly contradicted, and combine the accepted portions with bits of testimony or inferences from the testimony of other witnesses thus weaving a cloth of truth out of selected material." (*Id.* at 67-68, quoting from *Neverov v. Caldwell* (1958) 161 Cal. App. 2d 762, 767.) Further, the fact finder may reject the testimony of a witness, even an expert, although it is not contradicted. (*Foreman & Clark Corp. v. Fallon* (1971) 3 Cal. 3d 875, 890.)

Mrs. Caracas and Mr. Moreland were percipient witnesses to the events that occurred on scene. However, all of the declarations complainant offered were in the same format, indicating they were prepared by someone other than the declarant. There was no evidence regarding how the declarations were prepared, or from where and when the information was obtained. Considering that the declarations were all signed approximately a year-and-a-half after the events, the absence of information about the proximity of the information reported to the events lessens the ability to evaluate the strength of the evidence.

19. Regarding the issue of whether Mr. Caracas's fall was reported to respondent, both Mrs. Caracas and Mr. Moreland stated that Mrs. Caracas had reported that Mr. Caracas had experienced a fall and struck his head. However, neither individual explicitly stated in their declarations that respondent had actually heard this information. Considering that respondent and his partner were speaking to both Mr. Caracas and Mrs. Caracas independently, there is a reasonable possibility that the information regarding the fall could have been reported to Mr. Moreland, but not to respondent. Ms. Church also indicated that Mrs. Caracas used a Tagalog interpreter when at the hospital, clearly indicating there was some sort of language barrier. As such, clear and convincing evidence did not establish respondent was actually aware of this information at the time he assessed the patient.

However, even had it been established that respondent had been informed about the fall and failed to transport the patient, the accusation alleged this constituted gross negligence or incompetence. In order to establish negligence or incompetence, expert testimony is required to establish that either respondent departed from the standard of care, or lacked the appropriate knowledge or training. No expert testimony was presented on this issue. At most is Dr. Koenig's opinion that respondent violated local EMS protocols in handling of the patient. Although this might be sufficient to establish negligence (a departure from the standard of care), it is insufficient to establish gross negligence or incompetence.

20. Regarding the allegation that respondent refused to transport Mr. Caracas, respondent maintained that the decision by Mr. Caracas to stay at home was fully informed. Mrs. Caracas and Mr. Moreland both stated that Mrs. Caracas wanted her husband to be transported to the hospital, but respondent ultimately convinced her that he believed Mr. Caracas had the flu and would be better off staying at home. Thus, it was respondent's recommendation that the patient not go to the hospital. Because the patient was elderly and had a chief complaint, he was an emergency patient under SDCEMS Policy No. S-412. Respondent was required by policy to contact base hospital before obtaining an AMA. By failing to do so, he functioned outside the supervision of medical control.

Respondent's testimony regarding the second 911 call is far less credible. The transcript of Mrs. Caracas's call to 911 shows that she was almost in a panic. Yet, according to respondent, when he arrived on scene the second time, he offered to transport her husband by ambulance; however, she decided that she would transport him herself. It is simply not plausible to believe that Mrs. Caracas, who moments before had been panicking about her husband's condition and requesting an ambulance response, would then elect to take her husband to the hospital herself. Instead, her declaration that she requested respondent to transport her husband is far more credible and plausible given the circumstances. In addition, Ms. Church's statement that when Mr. Caracas arrived at the emergency department he was unable to get out of the car on his own is more credible than respondent's testimony that Mr. Caracas was able to walk on his own power.

Nevertheless, whether respondent committed an extreme of gross departure from the standard of care was not established by expert testimony. As previously noted, the fact that

respondent violated local EMS policy is insufficient in and of itself to establish gross negligence or incompetence.

## LEGAL CONCLUSIONS

### *Burden and Standard of Proof*

1. Complainant bears the burden of proof of establishing that the charges in the accusation are true. (Evid. Code § 115.) The standard of proof in an administrative action seeking to suspend or revoke a professional license is “clear and convincing evidence.” (*Ettinger v. Bd. of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) Clear and convincing evidence requires a finding of high probability, or evidence so clear as to leave no substantial doubt; it requires sufficiently strong evidence to command the unhesitating assent of every reasonable mind. (*Katie V. v. Sup. Ct.* (2005) 130 Cal.App.4th 586, 594.)

### *Applicable Statutes*

2. EMT-Paramedics are subject to the provisions of the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act (Act), contained in Health and Safety Code section 1797 et seq. Regulations pertaining to paramedics are contained in California Code of Regulations, title 22, section 100135 et seq.

3. Health and Safety Code section 1798.200 provides:

(b) The authority may deny, suspend, or revoke 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). Proceedings against any EMT-P license or licenseholder shall be held in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

(c) Any of the following actions shall be considered evidence of a threat to the public health and safety and may result in the denial, suspension, or revocation of a certificate or license issued under this division, or in the placement on probation of a certificate holder 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 [Sections 1797 through 1799.207] 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.

#### *Case Law Relating to Gross Negligence*

4. “Gross negligence” long has been defined in California as either a “want of even scant care” or “an extreme departure from the ordinary standard of conduct.” (*Gore v. Board of Medical Quality Assurance* (1980) 110 Cal.App.3d 184, 195-198; *City of Santa Barbara v. Superior Court* (2007) 41 Cal.4th 747, 753-754.) The standard of care is that level of skill, care, and knowledge that a reasonable and prudent practitioner would exercise under the same or similar circumstances. The standard of care is a matter peculiarly within the knowledge of experts; it presents the basic issue and can only be proved by expert testimony unless the conduct required by the particular circumstances is within the common knowledge of the layman. (*Williamson v. Prida* (1999) 75 Cal.App.4th 1417, 1424; see also *N.N.V. v. American Assn. of Blood Banks* (1999) 75 Cal.App.4th 1358, 1384.)

#### *Case Law Relating to Incompetence*

5. The term “incompetency” generally indicates “an absence of qualification, ability or fitness to perform a prescribed duty or function”. (*Pollack v. Kinder* (1978) 85 Cal.App.3d 833, 837.) Incompetence is distinguishable from negligence, in that one “may be competent or capable of performing a given duty but negligent in performing that duty.” (*Id.*, at p. 838.) Thus, “a single act of negligence . . . may be attributable to remissness in discharging known duties, rather than . . . incompetency respecting the proper performance.” (*Ibid.*)

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## *Cause Exists to Discipline Respondent's License*

### FIRST CAUSE FOR DISCIPLINE

6. Cause does not exist to discipline respondent's license pursuant to Health and Safety Code section 1798.200, subdivision (c)(2), gross negligence. Because the accusation did not specify what conduct in particular was alleged to constitute gross negligence, all the facts alleged under this cause for discipline were considered. Complainant offered no expert testimony. The closest thing was Dr. Koenig's declaration; however, the declaration primarily related to respondent's compliance with local EMS policies. Dr. Koenig did not state anywhere that respondent's actions constituted an extreme departure of the standard of care required of a paramedic. It is undisputed that respondent violated several local EMS policies in the care of the patient; however, the mere violation of policy does not equate to gross negligence.

7. Cause does not exist to discipline respondent's license pursuant to Health and Safety Code section 1798.200, subdivision (c)(3), incompetence. In this case, clear and convincing evidence did not establish that respondent lacks the knowledge, skill, or ability to perform the duties of a paramedic.

### SECOND CAUSE FOR DISCIPLINE

8. Cause does not exist to discipline respondent's license pursuant to Health and Safety Code section 1798.200, subdivision (c)(5), commission of a fraudulent, dishonest, or corrupt act. The accusation did not specifically identify the conduct alleged to be fraudulent, dishonest, or corrupt, but the factual allegations contained in the second cause for discipline primarily relate to respondent's completion of the PCR. It was undisputed that the PCR respondent completed and certified contained information that was not true. Some of the information, such as incorrectly identifying the patient's gender as female, and answering "No" to all the AMA questions (which included clearly erroneous answers such as that the patient was under 18 years of age) were clearly not fraudulent or dishonest.

The accusation alleged that respondent's documentation that the patient was "alert and oriented x4," had "full recall of incident," and that respondent conducted a stroke scale, served as respondent's acknowledgement that respondent had been aware that the patient had suffered a fall. Thus, his contention that he was unaware that the patient had suffered trauma was dishonest, according to the accusation. However, this was not necessarily the case. Mr. Caracas's chief complaint was nausea, vomiting, and a headache. Respondent's documentation that Mr. Caracas had "full recall of incident" could refer to his knowledge of the onset or duration of his complaint. In other words, there is an equally plausible explanation for the "incident" to be something other than a fall. Likewise, because respondent complained of a headache, the fact that respondent performed and documented a stroke scale is not necessarily indicative that respondent was aware of past head trauma, as a headache and stroke could have been caused by a medical reason. Thus, clear and

convincing evidence did not establish that either respondent's documentation or statements in this regard were fraudulent, dishonest, or corrupt.

The accusation alleged that respondent falsely documented that he contacted the base hospital. This fact was not contested, and when questioned by his supervisors about the call, he immediately admitted that he had not contacted the base hospital, and the indication in the PCR was in error. His testimony that he did not intentionally provide inaccurate or misleading information was credible. Although it is expected that a paramedic would complete a PCR accurately, certain information in the report may have been initially entered by respondent's EMT partner. Of course, it does not exclude his obligation to ensure that the ultimate report is accurate, but it does provide a plausible explanation for why information on the base hospital could have been entered. Mr. Moreland in his declaration stated that he was unaware whether respondent had contacted the base hospital. Clear and convincing evidence failed to establish that respondent was intentionally dishonest or committed a fraudulent or corrupt act. A finding cannot be predicated on an inference that is "based on suspicion alone, or on imagination, speculation, supposition, surmise, conjecture or guesswork." (*Traxler v. Thompson* (1970) 4 Cal.App.3d 278, 289.) Moreover, fraud is never presumed, and the burden of proving it rests on the party who asserts it. (Code Civ. Proc., § 1963; *Dorn v. Pichinino* (1951) 105 Cal.App.2d 796, 801.) Thus, although respondent's completion of the PCR was careless, it was not dishonest, fraudulent, or corrupt.

9. Cause does not exist to discipline respondent's license pursuant to Health and Safety Code section 1798.200, subdivision (c)(7), for violating or attempting to violate any provision of the Act or regulations adopted by the authority related to prehospital personnel. The accusation did not cite any statutes or regulations respondent is alleged to have violated; rather, complainant alleged respondent failed to follow local protocols for prehospital care. However, violation of a local policy does not constitute a violation of a statute or regulation promulgated by the authority. While the Act and regulations authorize local EMS agencies to develop policies and protocols within their jurisdiction (Health & Saf. Code, § 1798.220, Cal. Code Regs., tit. 22, § 100170), these provisions cannot be "violated" by a licensee. Accordingly, the violation of local EMS policy is not cause for discipline under subdivision (c)(7).

### THIRD CAUSE FOR DISCIPLINE

10. Cause exists to discipline respondent's license pursuant to Health and Safety Code section 1798.200, subdivision (c)(10). Respondent operated outside the supervision of medical control in the field care system operating at the local level by failing to comply with SDEMS Policies S-412 and S-415, when he did not make an "initial notification" to the base hospital for an "emergency patient" and further failed to contact the base hospital prior to

obtaining an AMA.<sup>5</sup> He further violated policy by failing to transport an emergency patient who had requested transport to the hospital.<sup>6</sup>

### *Appropriate Level of Discipline*

11. Health and Safety Code section 1798.211 provides that in considering disciplinary action “the administrative law judge, shall give credit for discipline imposed by the employer and for any immediate suspension imposed by the local EMS agency for the same conduct.”

12. California Code of Regulations, title 22, section 100176, subdivision (a), requires the authority to consider the following criteria in evaluating the rehabilitation of a licensee that are applicable to this case are: the nature and severity of the acts, evidence of any acts committed subsequent to the acts under consideration, the time that has elapsed since commission of the acts, and evidence, if any, of rehabilitation submitted by the person.

13. The administrative law judge must use the “EMS Authority Recommended Guidelines for Disciplinary Orders and Conditions of Probation,” dated July 26, 2008, (Guidelines) as a guide in making any recommendations to the authority for discipline of a paramedic license holder found in violation of Section 1798.200. (Cal. Code Regs., tit. 22, § 100173, subd. (d).) For violations of subdivision (c)(10), the maximum discipline is revocation; the recommended discipline is a stayed revocation, 15-day suspension, and 1-year probation; and the minimum discipline is a stayed revocation with one-year probation. Optional probation terms 5 (ethics course) and 8 (skills test) are recommended.

14. In addition to the factors outlined in the regulations, the Guidelines provide additional factors that must be considered when determining appropriate discipline. The factors relevant to this case are: actual or potential harm to the public; actual or potential harm to any patient; prior disciplinary record; prior warnings on record or prior remediation; number and/or variety of current violations; aggravating evidence; mitigating evidence; and rehabilitation evidence.

15. Administrative proceedings to impose discipline on a professional license are noncriminal and nonpenal; they are not intended to punish the licensee, but rather to protect the public. (*Sulla v. Bd. of Registered Nursing* (2012) 205 Cal.App.4th 1195, 1206.) Rehabilitation is a state of mind and the law looks with favor upon rewarding with the opportunity to serve, one who has achieved reformation and regeneration. (*Pacheco v. State*

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<sup>5</sup> The accusation also alleged respondent violated SDCEMS Policy S-141, relating to treatment protocol for pain management. No evidence regarding this policy was introduced.

<sup>6</sup> Although complainant alleged respondent failed to provide the minimum level of care and properly assess the patient, complainant did not establish how doing so constituted operating “outside the supervision of medical control” as prohibited in this subdivision.

*Bar* (1987) 43 Cal.3d 1041, 1058.) The evidentiary significance of a licensee's misconduct is greatly diminished by the passage of time and by the absence of similar, more recent misconduct. (*Kwasnik v. State Bar* (1990) 50 Cal.3d 1061, 1070.) Further, fully acknowledging the wrongfulness of past actions is an essential step towards rehabilitation. (*Seide v. Committee of Bar Examiners* (1989) 49 Cal.3d 933, 940.)

16. For the established violation, the Guidelines recommend one-year probation and a 15-day suspension. In mitigation, respondent has been licensed for the past 14 years without any disciplinary record or prior warnings. He accepted responsibility for his errors in the PCR and failure to contact the base hospital as required by local policy. His reference letters spoke very highly of his character and skills as a paramedic. Although Mr. Caracas ultimately died as a result of his injuries, there was no evidence that this outcome was the result of having been delayed transport to the hospital by approximately three hours.

In aggravation, respondent failed to comply with local EMS protocols in multiple regards. The PCR he completed contained multiple errors and incorrect information. However, the most concerning aspect of the case was respondent's lack of credible testimony regarding whether he offered to transport Mr. Caracas to the hospital. Respondent failed to acknowledge any wrongdoing regarding the actual care he provided for the patient, and maintained that he acted appropriately. For these reasons, an upward departure from the Guidelines is warranted. A stayed revocation for three years is sufficient for public protection. In addition to the standard terms of probation, respondent will be required to complete an ethics course and pass a practical skills examination. However, the imposition of any suspension would be unduly punitive and not advance public protection.

## ORDER

License Number P22087 issued to respondent, Jesse Wattson, is revoked. However, such revocation is stayed and respondent is placed on probation for three years upon the following terms and conditions:

### 1. Probation Compliance:

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

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

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**2. Personal Appearances:**

As directed by the EMSA, respondent shall appear in person for interviews, meetings, and/or evaluations of the respondent's compliance with the terms and conditions of the probationary order. Respondent shall be responsible for all of his/her 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/her probation. If the respondent submits his quarterly reports by mail, it shall be sent as Certified Mail.

**4. Employment Notification:**

During the probationary period, respondent shall notify the EMSA in writing of any EMS employment. Respondent shall inform the 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 the EMSA of disclosure, by the respondent, to the current and any prospective EMS employer of the reasons for and terms and conditions of the respondent's probation.

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

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

**5. Notification of Termination:**

Respondent shall notify the EMSA within seventy-two (72) hours after termination, for any reason, with his/her 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 the EMSA shall be by certified mail.

**6. Functioning as a Paramedic:**

The period of probation shall not run anytime that the 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, the respondent must immediately notify the EMSA, in writing, of the date of such departure and the date of return to California, if the respondent returns.

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

**7. Obey All Related Laws:**

Respondent shall obey all federal, state and local laws, statutes, regulations, 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 the respondent has not submitted fingerprints to the EMSA in the past as a condition of licensure, then the respondent shall submit his/her 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, the respondent shall submit to the EMSA a full and detailed account of the circumstances thereof. The EMSA shall determine the applicability of the offense(s) as to whether the 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 the 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, the EMSA may initiate action to terminate probation and implement actual license suspension/revocation. Upon the initiation of such an action, or the giving of a notice to the 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 the EMSA. An action to terminate probation and implement actual license suspension/revocation shall be initiated and conducted pursuant to the hearing provisions of the California Administrative Procedure Act.

The issues to be resolved at the hearing shall be limited to whether the respondent has violated any term of his/her probation sufficient to warrant termination of probation and implementation of actual suspension/revocation. At the hearing, the respondent and the 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.

**10. Ethical Practice of EMS:**

Within 60 days of the effective date of this decision, the respondent shall submit to the EMSA, for its prior approval, a course in Ethics. Respondent must complete this course during his/her probation period.

Upon completion by the respondent of the Ethics course, respondent shall submit proof to the EMSA that he/she fulfilled all course requirements.

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

**11. Practical Skills Examination:**

Within 100 days of the effective date of this decision, the respondent shall submit to and pass a skills examination in subjects substantially related to the accusation based upon the U. S. Department of Transportation (DOT) and/or the National Registry of Emergency Medical Technicians (NREMT) skills examination, when applicable. If not addressed in the DOT or NREMT, an approved local standard shall be identified and utilized. The skills examination shall be administered by a board selected by the EMSA using the pre-established criteria (See Section VII: Review Board for criteria).

If respondent fails the examination, the respondent may function as a paramedic only while under the direct supervision of a preceptor. Respondent shall not be allowed to function as a sole paramedic until the respondent passes the examination. Respondent has the option and right to repeat the examination. There shall be at least a two-week period between examinations. No more than three attempts to pass the examination shall be allowed. If respondent fails to pass the exam after three attempts, or chooses not to retake the examination, the respondent's license shall be revoked.

DATED: March 5, 2019

DocuSigned by:



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ADAM L. BERG

Administrative Law Judge

Office of Administrative Hearings