

**BEFORE THE
EMERGENCY MEDICAL SERVICES AUTHORITY
STATE OF CALIFORNIA**

In the Matter of the Accusation Against:

THOMAS JONES, Respondent.

EMT-P License No. P35339

Agency Case No. 18-0077

OAH No. 2019070886

PROPOSED DECISION

Administrative Law Judge David Benjamin, State of California, Office of Administrative Hearings, heard this matter on November 14, 2019, and January 14, 2020, in Oakland, California.

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

Lucy S. McAllister, Attorney at Law, represented respondent Thomas Jones, who was present.

The record closed and the matter was submitted on January 14, 2020.

FACTUAL FINDINGS

1. On August 25, 2015, the Emergency Medical Services Authority (EMSA) of the State of California issued Emergency Medical Technician – Paramedic (EMT-P) License No. P35339 to respondent Thomas Jones. The license was in effect at all times relevant to this matter, and will expire on August 31, 2021, unless it is renewed.

2. On June 11, 2019, Sean Trask, acting in his official capacity as the Chief, Emergency Medical Services Personnel Division of EMSA, issued an accusation against respondent. The accusation alleges that, on March 25, 2018, respondent violated the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act (Health & Saf. Code, § 1797 et seq.; the "Act") in his care of a homeless man. Respondent filed a notice of defense and this hearing followed.

Events of March 25, 2018

3. In March 2018, respondent was employed as a paramedic by Rural/Metro Ambulance in Santa Clara. He had been with the company for almost two years. Respondent and his partner of three months, Kyle Wowak, were assigned to an ambulance, call sign "Medic 48." Wowak was an emergency medical technician (EMT) and the driver of the ambulance. As a paramedic with a higher scope of practice, respondent was the most responsible provider; Wowak's role was to support respondent. The ambulance was equipped with audiovisual recording equipment that captured conversations in the cab and, to a certain extent, activities occurring in the rear of the vehicle and outside of the vehicle.

4. On March 25, 2018, at about 3:40 a.m., respondent and Wowak were 20 minutes from the end of their 12-hour shift and heading back to their base when they

received a dispatch from County Communications to proceed "Code 3" (lights and siren) to 1610 Monterey Road in San Jose. That address – an abandoned retail store – was known to them to attract a large number of homeless people who take shelter outside the building. The dispatch report told them "[m]an down been sick for a couple of days, can't get up, difficulty breathing, 50-year-old male, conscious, breathing."

5. Respondent and Wowak were not happy; they had had about 14 calls on their shift. When they received the dispatch, they had the following exchange:

Wowak: Fuck. Are you fucking serious right now?

Respondent: It sounds like a homeless guy."

Wowak: We definitely beat Fire and we'd tell them to fuck off, right?

Respondent: Yeah.

Wowak: And we're not going to fucking fuck around, right?

Respondent: We'll see what he's got.

Wowak: Well sick for a couple of days, fuck you. I know exactly where this is, too.

6. Units from the San Jose Fire Department were first on the scene. Paramedic Paul Tran spoke to the subject of the call – later identified as RT¹ – who told Tran that he had been sick for a couple of days and wanted his medications refilled.

¹ Initials are used to protect his privacy.

Tran was on scene for less than two minutes when respondent and Wowak arrived. Tran gave a quick report to respondent and then the Fire Department, which is not a transporting agency, left the scene.

7. Respondent saw RT get up from the ground where he was sitting and walk over to the ambulance. Wowak told respondent that he has seen the patient before and says to RT, "Before you get in here I want to know what's bothering you right now. I don't care what happens when you leave here, I don't care about anything like that." Respondent got out of the ambulance and talked to RT, who told him that he had been sick for a couple of days. Without offering any medical attention to RT – respondent did not take a history from him, did not check his vital signs and did not perform a physical examination – respondent discouraged RT from going to the hospital by telling him that hospitals did not want to see people with "flu-like" symptoms. RT told respondent he had run out of medications. Respondent did not ask him what medications he had been taking, what the medications were for, who had prescribed them, or when he had run out. Respondent discouraged RT from going to the hospital by telling him – falsely – that he could not take him to the hospital just to get pills, that "the hospital doesn't write prescriptions" and that needing a prescription is not a medical complaint. Wowak also discouraged RT from going to the hospital.

Having received no medical attention, and having been discouraged by respondent and Wowak from being transported to the hospital, the patient walked back to the spot where he had been sitting when Medic 48 arrived, and sat down again. Wowak and respondent got into the ambulance and drove away, leaving RT there. They were on scene for about 12 minutes.

8. Back inside the ambulance, respondent and Wowak had the following exchange about RT:

Respondent: Piece of shit. Fuck you.

Wowak: Look at all of them just fucking, just like out here like little fucking dogs.

[T]

Wowak: He [RT] walked away. Am I right?

Respondent: Fucking A he did. Fuck that guy.

9. Respondent called County Communications and cleared the call by using the code "N-norah." That code is used when a unit arrives on scene and finds that there is no patient, or when the ambulance is cancelled by another agency with the authority to do so, such as the fire or police department. Neither circumstance was true in this case.

10. Respondent and Wowak returned to their base and went off shift at 4:00 a.m., as scheduled.

11. Under Policy #500 of the Santa Clara County Emergency Medical Services System, a Prehospital Care Report (PCR) must be completed for every EMS response. (Policy #500, subd. III.A.) The PCR form documents (among other things) the patient's name and other identifying information; his chief complaint; vital signs; physical assessment; and the emergency treatment provided. (Cal. Code Regs., tit. 22, § 100171, subd. (e).)

Under the System's Policy #502, a paramedic must use and complete a PCR and a Santa Clara County EMS Refusal of Service form, "to document that an individual

legally authorized to refuse care acknowledges understanding the information provided before deciding to refuse service." (Policy #502, section IV.D.3.)

Respondent did not prepare a PCR or a Refusal of Service form for the run to 1610 Monterey Road. All Rural/Metro and its crews knew about the call came from respondent's use of the N-norah code, which led respondent's employer and County Communications to believe that Medic 48 had arrived on scene and had not found a patient, or had been cancelled by another agency.

12. At about 8:30 a.m. that same morning, March 25, County Communications dispatched fire and ambulance crews Code 3 to 1610 Monterey Road on a report of a "possible dead person, male not moving." Medic 47 and the San Jose Fire Department arrived on scene and found RT in cardiac arrest. Resuscitation efforts were unsuccessful and he was pronounced dead at the scene. The coroner determined that RT's manner of death was "accident," and that his death was due to methamphetamine toxicity complicating cirrhosis of the liver. Cardiomegaly was identified as another significant condition.

13. At the scene, witnesses told San Jose police officers that medics had seen RT earlier in the morning. The members of Medic 47 were unaware that respondent and Wowak had seen the patient hours earlier, as respondent had not completed a PCR or a Refusal of Service form.

14. Rural/Metro put respondent and Wowak on administrative leave, pending an investigation. Respondent was interviewed twice by his employer. In the first interview, respondent said that he had told RT "I can take you to the ER if you like" but the patient had told him "No." Respondent later asked for a second interview, in which he blamed Wowak for being rude and talking down to RT; in the second

interview respondent said that if Wowak had not spoken to RT the way he did, they would have transported the patient. Respondent accepted responsibility for “messing up on the paperwork,” but did not otherwise acknowledge responsibility for his own failure to provide care to the patient. Respondent was terminated from employment in April 2018.

15. Respondent was obligated to offer care and transport to RT. Respondent, however, provided no meaningful medical attention to RT: he did not take a history, did not check his vital signs, and did not perform a physical assessment. Respondent used his official position as a paramedic to discourage RT from going to the hospital to obtain the medical care he wanted and needed. Respondent and Wowak then agreed on a false story to cover-up their misconduct – that the patient had declined medical care by walking away. Respondent further covered-up their misconduct by using the N-nora code to cancel the call, and by not completing a PCR.

Respondent’s evidence

16. Respondent has no history of prior license discipline.

17. Since June 2018, respondent has been employed by the City of South Lake Tahoe Fire Department as a firefighter/paramedic. He successfully completed his probationary period with that agency in December 2019.

Kim George is a Captain Paramedic at the South Lake Tahoe Fire Department; she wrote a letter in support of respondent, and she appeared at hearing. George feels that respondent’s conduct in this case must have been due to bullying by Wowak. In George’s experience, respondent has demonstrated excellence as a paramedic. Respondent does not have to complete PCR’s routinely in his job at South Lake Tahoe, because that department is not a transporting agency. The PCR’s that respondent has

completed, however, have been thorough and accurate. If respondent's paramedic license were placed on probation by EMSA, South Lake Tahoe Fire Department would honor it and monitor him.

Jim Drennan is a Battalion Chief for the South Lake Tahoe Fire Department; like George, he wrote a letter on behalf of respondent and also appeared at hearing. In Drennan's experience, respondent has shown sound decision-making and competence as a paramedic. There have been no issues regarding his performance. Drennan has not reviewed the documents or the video recording in this case. His knowledge of this case comes entirely from respondent. Respondent told Drennan that when Medic 48 arrived on the scene, he received a limited passdown from the Fire Department concerning the patient's condition; that respondent and the patient had a "colorful" conversation; and that the patient "refused care and walked away at the end of the encounter." Respondent told Drennan that he should have completed a form showing that the patient refused care against medical advice.

18. Kevin Brown worked for Rural/Metro as an EMT for seven years; he is now a deputy sheriff. For about six months in 2017, Brown was respondent's EMT partner. Brown was surprised by the allegations in this case. When they worked together, respondent treated everyone equally, and he never saw respondent treat anyone with disrespect, including the homeless.

19. Four persons wrote letters on behalf of respondent: Leslie Asbury, a Captain Paramedic at South Lake Tahoe Fire Department; Brennen Davis, an Engineer Paramedic at that agency; and Dustin Winter and Daniel Vallejo, both Firefighter/Paramedics with the same agency. All of the authors praise respondent as thorough, highly competent, calm and compassionate. Their letters do not demonstrate any knowledge of the matters at issue in this case.

20. Respondent argues that he did not need to complete a PCR because RT was not a "patient" within the meaning of Policy #500. Under that policy, a person becomes a "patient" if he has a "chief complaint." Respondent asserts that the reason for the call – that the patient had shortness of breath – turned out not to be accurate and that the patient had no chief complaint. But, whether or not it was the same condition described by dispatch, RT had a chief complaint: he told Paramedic Tran that he had been sick for one or two days and that he had run out of medications. Tran conveyed that complaint to respondent, and RT told respondent the same thing, RT was a "patient" within the meaning of Policy #500, and respondent was required to complete a PCR.

21. At hearing, respondent asserted, as he has before, that RT "walked away," that is, that he declined medical care; respondent told the same thing to his supervisor at the South Lake Tahoe Fire Department, Battalion Chief Drennan. Respondent's assertion is false. RT did not decline medical care. He wanted medical care, but respondent and Wowak dissuaded him from seeking it. The assertion that RT "walked away" is the false narrative respondent and Wowak agreed to when they left the scene on March 25, to cover up their misconduct.

22. Respondent asserts that he was "bullied" by Wowak and that, due to exhaustion, he failed to stand up to Wowak.

Respondent's testimony on this point is not persuasive. Respondent was the paramedic and the team lead on Medic 48. At the time of this incident, respondent had worked with Wowak for three months and was well-aware of his bad attitude. Respondent did not report any concerns to his supervisors and never asked for a transfer. Moreover, respondent's failure to provide any treatment to RT patient during

the call, and his statements about RT after the call, reveal that he shared Wowak's attitude toward the patient.

Respondent testified that he has seen a therapist to help him try to understand why he did not stand up to Wowak. No evidence to corroborate this testimony was presented.

23. At hearing, respondent testified that he feels his conduct on March 25 was, in his words, "immoral," that he should have treated RT with the dignity and respect that everyone deserves, and that he should have tried to put a stop to Wowak's behavior.

But respondent still maintains that RT declined treatment and walked away: respondent testified to that in this hearing, and he gave the same explanation to Battalion Chief Drennan. This false version of events shifts blame from himself to the patient. Respondent has not fully or candidly acknowledged his misconduct.

LEGAL CONCLUSIONS

1. The standard of proof applied to this matter is clear and convincing evidence to a reasonable certainty.

First Cause for Discipline

2. An EMT-P license may be disciplined if the EMT-P license holder has committed gross negligence or incompetence. (Health & Saf. Code, § 1798.200, subs. (b), (c)(2) & (4).) "Gross negligence" is defined as an extreme departure from the ordinary standard of conduct, or the want of even scant care. (*Cooper v. Board of Medical Examiners* (1975) 49 Cal.App.3d 931, 941.) The term "incompetence" generally

indicates "an absence of qualification, ability or fitness to perform a prescribed duty or function." (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1054-1055.) 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. 1055.)

3. Respondent was grossly negligent in his care of RT on March 25. Respondent provided no care to RT, and discouraged RT from seeking care. He and Wowak wanted to end their shift on time, resented being assigned to the run, and were contemptuous of the patient. (Findings 5, 7, 8 & 15.) Cause for discipline exists under Health and Safety Code section 1798.200, subdivision (c)(2).²

4. The evidence did not establish that respondent is incompetent. No cause for discipline exists under Health and Safety Code section 1798.200, subdivision (c)(4).

Second Cause for Discipline

5. An EMT-P license may be disciplined if the EMT-P license holder violates or attempts to violate directly or indirectly, or assists in or abets the violation of, or conspires to violate, any of the provisions of the Act or the regulations adopted by local Emergency Services Agency. (Health & Saf. Code, § 1798.200, subd. (c)(7).)

² Under Health and Safety Code section 1798.200, subd. (c)(5), the commission of "any fraudulent, dishonest, or corrupt act that is substantially related to the qualifications, functions, and duties of prehospital personnel" is cause for discipline. EMSA investigator Linda Curtis-Smith concluded that respondent had violated subdivision (c)(5), but cause for discipline under this provision was not alleged in the accusation.

6. Respondent violated Policy #500 of the Santa Clara County Emergency Medical System, by failing to complete a PCR for regarding patient RT. (Finding 11.) Insofar as respondent maintains that RT refused service, respondent also violated Policy #502 of the local System by failing to complete a refusal of service form for RT. (Finding 11.) Cause for discipline exists under Health & Safety Code section 1798.200, subdivision (c)(7).

Third Cause for Discipline

7. An EMT-P license may be disciplined if the EMT-P license holder "functions outside the supervision of medical control in the field care system operating at the local level" (Health & Saf. Code, § 1798.200, subd. (c)(10).)

8. Respondent functioned outside the supervision of medical control by the Santa Clara County Emergency Medical System when he discouraged RT from obtaining medical care and transport, in violation of Policy #500. (Findings 7 & 11.) The evidence fails to establish that RT refused service; however, insofar as respondent maintains that he did so, respondent also functioned outside the supervision of medical control when he failed to complete a refusal of service form, as required by Policy #502. (Findings 11 & 15.) Cause for discipline exists under Health & Safety Code section 1798.200, subdivision (c)(10).

Discussion

9. Cause for discipline having been established, the issue is the degree of discipline to impose. The EMSA disciplinary guidelines have been considered. They state that the maximum discipline for gross negligence and for violating any local EMSA regulations is license revocation; the recommended discipline is a stayed revocation, a 60-day suspension, and three years' probation; and the minimum

discipline is a stayed revocation and one year's probation. The burden of demonstrating rehabilitation is on respondent.

This case involves respondent's misconduct on a single run. It is the only documented instance of misconduct in respondent's career as a paramedic. He has no history of prior license discipline, and his work for the South Lake Tahoe Fire Department over the past 18 months has been exemplary. Numerous colleagues and superior officers praise respondent's competence and professionalism. Respondent has taken numerous continuing education classes since he was terminated by Rural/Metro. Respondent appears to be genuinely committed to his career. Looking back on it, respondent now recognizes that, at least in certain respects, his conduct on March 25, 2018, was immoral. All of this is to respondent's credit.

Evidence of rehabilitation, however, must be measured by the seriousness of the misconduct. The more serious the misconduct, the stronger the evidence of rehabilitation must be. (*In re Gossage* (2000) 23 Cal.4th 1080, 1096.) While this case involves just one incident of gross negligence, it was an incident so callous and inhumane, and so contrary to the obligations of a paramedic, that a compelling and unequivocal demonstration of rehabilitation is required. Respondent has not made such a showing.

While respondent has no prior license discipline, he had been a paramedic for less than three years when he refused to treat RT in March 2018. It is recognized that, in the past two years, no similar instances of misconduct have occurred; that respondent's work performance at South Lake Tahoe Fire Department has been excellent; and that he has kept up-to-date on his continuing education requirements. But, two years is too short a period of time for respondent to demonstrate his rehabilitation from such serious misconduct. (See *In re Gossage, supra*, 23 Cal.4th at

1096.) And, throughout that time, respondent has been on probation at the South Lake Tahoe Fire Department and under investigation by EMSA. Good conduct under those circumstances is expected. (*Id.* at p. 1099.) Respondent's work performance over the past two years is therefore accorded little weight in assessing his rehabilitation.

Respondent's claim that he was bullied into committing professional misconduct by Wowak is not believable; assuming for the sake of argument that it is true, there is no evidence to reassure EMSA that respondent is no longer at risk of submitting to bad influences in the future.


And while respondent states that he recognizes his conduct was immoral, he also continues to parse the issue of whether RT was truly a patient; continues to blame his partner for events for which he is also personally responsible; and continues to assert unpersuasively that RT declined treatment and walked away.

This record does not demonstrate the compelling and unequivocal evidence of rehabilitation called for by respondent's egregious misconduct. It would be contrary to the public interest to allow respondent to retain his paramedic license, even on a probationary basis.

ORDER

Emergency Medical Technician – Paramedic (EMT-P) License No. P35339 issued to respondent Thomas Jones is revoked.

DATE: January 31, 2020

DocuSigned by:

DAVID BENJAMIN

Administrative Law Judge

Office of Administrative Hearing

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

BEFORE THE
EMERGENCY MEDICAL SERVICES AUTHORITY
STATE OF CALIFORNIA

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

THOMAS JONES,
License No. P35339

Respondent.

)
) Enforcement Matter No. 18-0077
) OAH No. 2019070886
)


) **DECISION AND ORDER**
)
)
)
)

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

This Decision shall become effective thirty (30) days after the date below. It is so ordered.

DATED:

2/3/2020



Dave Duncan MD,
Director
Emergency Medical Services Authority