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

**In the Matter of the First Amended Accusation Against:**

**JEFFREY S. KLEIN, Respondent**

**Agency Case No. 23-0103**

**OAH Case No. 2024060198**

**In the Matter of the Accusation Against:**

**SCOTT W. CARAVALHO, Respondent**

**Agency Case No. 23-0106**

**OAH Case No. 2024060201**

**In the Matter of the Accusation Against:**

**SEAN M. HOLLEMAN, Respondent**

**Agency Case No. 23-0104**

**OAH Case No. 2024060209**

**In the Matter of the Accusation Against:**

**ERIC MUNSON, Respondent**

**Agency Case No. 23-0107**

**OAH Case No. 2024060208**

**In the Matter of the Accusation Against:**

**CLINTON R. SIMONS, Respondent**

**Agency No. 23-0105**

**OAH No. 2024060210**

## PROPOSED DECISION

Sean Gavin, Administrative Law Judge (ALJ), Office of Administrative Hearings (OAH), State of California, heard this matter from December 9 through 13, 2024, in Sacramento, California.

Phillip L. Arthur, Deputy Attorney General, represented complainant Kim Lew, Chief of the California Emergency Medical Services Authority (EMSA or the Authority), EMS Personnel Division.

Aaron E. Doyle, Attorney at Law, represented respondent Jeffrey Klein (respondent Klein), who was present throughout the hearing.

Nicole Valentine, Attorney at Law, represented respondents Scott Caravalho (respondent Caravalho) and Clinton Simons (respondent Simons) who were present throughout the hearing.

Maurice Sinsley, Attorney at Law, represented respondent Sean Holleman (respondent Holleman), who was present throughout the hearing.

Dana Martinez, Attorney at Law, represented respondent Eric Munson, who was present for portions of the hearing.

The matters were consolidated for hearing. Evidence was received, the record closed, and the parties submitted the matter for decision on December 13, 2024. Before the hearing concluded, complainant dismissed the accusation against Mr. Munson. Complainant requested one decision for the consolidated matter against the remaining four respondents.

After the matter was submitted for decision, the ALJ determined one video exhibit, which had been submitted via USB drive, could not be viewed in its entirety. The ALJ reopened the record and held a status conference with the parties to discuss the exhibit. Following the status conference, respondent Klein submitted a complete version of the exhibit. The record then reclosed and the matter was submitted for decision on January 31, 2025.

## FACTUAL FINDINGS

## Jurisdictional Matters

### RESPONDENTS' LICENSE HISTORY

1. On September 8, 1998, the Authority issued respondent Klein Emergency Medical Technician-Paramedic (EMT-P) license number P15057. The license was active at all relevant times and is scheduled to expire September 30, 2026, unless renewed. In June 2009, the Authority issued respondent Klein a warning letter for incidents in

March and May 2006. In February 2021, in EMSA case number 19-0315, the Authority fined respondent Klein $500 for functioning outside the supervision of medical control in the field care system operating at the local level.

2. On December 27, 2004, the Authority issued respondent Caravalho Emergency Medical Technician-Paramedic (EMT-P) license number P21870. The license was active at all relevant times and was scheduled to expire December 31, 2024, unless renewed. There was no evidence regarding whether respondent Caravalho renewed his license. Respondent Caravalho has no history of prior license discipline.

3. On August 20, 2009, the Authority issued respondent Holleman Emergency Medical Technician-Paramedic (EMT-P) license number P27586. The license was active at all relevant times and is scheduled to expire August 31, 2025, unless renewed. Respondent Holleman has no history of prior license discipline.

4. On February 10, 2011, the Authority issued respondent Simons Emergency Medical Technician-Paramedic (EMT-P) license number P29304. The license was active at all relevant times and is scheduled to expire February 28, 2025, unless renewed. Respondent Simons has no history of prior license discipline.

## ACCUSATIONS AGAINST RESPONDENTS

5. On April 16 and 17, 2024, complainant signed and thereafter filed separate but substantially similar Accusations against respondents. Complainant seeks to discipline respondents' licenses based on their care of a diabetic patient at his home on February 25, 2020. Specifically, complainant alleged respondents, while

working for the City of Sacramento Fire Department (SFD)[1] and responding to a medical call, failed to check the patient's pulse, airway, and breathing, and failed to move the patient out of the prone position after he became noncombative. Complainant alleged those failures constitute cause to discipline respondents' licenses for: (1) gross negligence; (2) incompetence; (3) violating, or attempting to violate, the regulations governing prehospital personnel; and (4) functioning outside the supervision of medical control in the field care system operating at the local level.

6. At hearing, complainant moved to amend the Accusation against respondent Klein to include his prior discipline and to correct a typographical error in his license number. Over objection, the motion was granted. Complainant subsequently filed a written First Amended Accusation against respondent Klein, which stated the correct license number and alleged, for disciplinary consideration, his prior warning letter and fine.

7. On or about April 22, 2024, respondent Klein filed a Special Notice of Defense and Objection to Accusation, which was deemed responsive to the First Amended Accusation. (Gov. Code, § 11506, subd. (c).) On or about April 24, 2024, respondent Holleman filed a Notice of Defense. On or about July 3, 2024, respondents Caravalho and Simons each filed a Supplemental Notice of Defense. This hearing followed.

---

[1] The Accusations incorrectly identified respondents' employer as the Sacramento County Fire Department.

## Events of February 25, 2020

8. On February 25, 2020, respondents were assigned to work the "A" shift for SFD Station 12. Respondent Klein was the A shift captain. Respondents Holleman and Simons were working as paramedics in an ambulance known as Medic 12. Respondent Caravalho was working as a paramedic on a fire engine known as Engine 12. Mr. Munson was the Engine 12 engineer.

9. At approximately 7:38 p.m., SFD received a call from a woman requesting medical help for her 48-year-old son (the patient). She reported the patient was diabetic and was acting abnormally. Respondents responded to the call in Medic 12 and Engine 12. When they arrived approximately five minutes later, they entered the patient's home and attempted to interact with him. They were unable to do so effectively because the patient was flailing his arms and legs, spitting, kicking, and repeatedly alternating between standing and sitting. The patient then displayed and waved his penis around.

10. Based on the patient's behavior, SFD personnel exited the home and waited by the front door. In consultation with the patient's mother, SFD contacted the City of Sacramento Police Department to request assistance.

11. Three police officers arrived to restrain the patient. Two of the officers, John Helmich and Kevin Moorman, testified at hearing. They explained they responded to the patient's home to restrain him so paramedics could evaluate and treat him safely. When the officers entered the house, the patient was on a couch in the living room. As the officers approached him, he slid from the couch onto the floor. The officers turned the patient face down on the floor and used their bodies to hold him still. One officer held him down near his shoulders as the other two officers held him

near his hips. One officer placed the patient's legs into a "figure four," with his left shin placed behind his right knee and his right ankle then positioned near his buttocks. The officers also placed the patient's arms and hands behind his back and handcuffed him in that position. The officers were responsible for restraining the patient from the time they first interacted with him until the time respondents strapped the patient to the gurney using soft restraints. At that time, the officers transferred custody of the patient to respondents. Much of the officers' and respondents' activities was captured via the officers' body-worn cameras.

12. Once the police officers had the patient restrained, respondents were able to approach him. As seen on the officers' body cameras, approximately 30 seconds after the officers locked the handcuffs, respondent Simons used a lancet to prick the patient's finger to get a blood sample to check his blood sugar. Approximately 65 seconds after testing the patient's blood sugar, respondent Simons prepared to administer an intramuscular shot of Glucagon into the patient's shoulder. Respondent Simons used trauma shears to cut a hole through the patient's sweatshirt and undershirt to expose the patient's skin at his shoulder. Approximately two minutes later, respondent Simons injected Glucagon into the patient's shoulder and applied a bandage. Throughout the entire time, the patient moved his limbs and hands and made sounds.

13. Approximately one minute after the Glucagon shot, an unidentified person asked whether the patient's heart was "still beating." An individual who cannot be identified on the body camera footage checked the patient's carotid artery, confirmed a pulse, and announced "yeah."

14. Within a few seconds thereafter, respondent Caravalho began applying soft restraints on the patient's limbs to prepare him to be moved to a gurney and

carried to the ambulance outside. Respondents Holleman and Simons moved about the room with their eyes toward the patient. They appeared to be observing him. Respondents Holleman, Caravalho, Simons, and Munson then lifted the patient onto the gurney. The officers then released the handcuffs, and respondents Holleman and Caravalho immediately turned him onto his back. Respondents Holleman, Caravalho, and Simons then secured the soft restraints to the gurney. Respondents Holleman and Caravalho raised the gurney and began wheeling the gurney toward the front door. Respondent Holleman was near the patient's head the entire time and looking at the patient's face continually.

15. From the time the officers released the handcuffs to the time respondents turned the patient on his back, approximately four seconds elapsed. From the time the patient was supine on the gurney until respondents began wheeling him from the house, approximately 55 seconds elapsed.

## Authority's Investigation of Respondents' Actions

16. In April 2023, the Authority learned of the incident in question via a newspaper article. Shortly thereafter, the Authority assigned Dennis Gallagher to investigate respondents' conduct regarding the incident.

17. Mr. Gallagher has worked as an investigator for the Authority since the summer of 2021. As part of his job, he investigates potential paramedic misconduct. Before the Authority, Mr. Gallagher worked as an investigator for an insurance company. From 1984 through 1999, he worked as a deputy for the Contra Costa County Sheriff's Office. He has never held an EMT or paramedic license and has no experience working as any kind of healthcare provider.

18. Mr. Gallagher reviewed documents and interviewed witnesses, including respondents. He also interviewed Chad Augustin, Deputy Chief of the Sacramento Fire Department; Fire Service Medical Director Kevin Mackey; and EMS Coordinator Brian Pedro, RN. In his written reports, he described those individuals as "experts on pre-hospital care as required in SCEMSA [Sacramento County EMSA] protocol for Sacramento Fire Department paramedics." He relied on those individuals' opinions, but did not specify what training or background made them experts.

19. Following his investigation, Mr. Gallagher prepared written reports related to each respondent. For clarity, his reports, which are substantially similar, are referred to collectively as his "report." At hearing, he testified consistently with his report.

20. In his report, Mr. Gallagher included an "Investigative Summary" in which he wrote, in relevant part:

> The police gained control of the patient, placing him in handcuffs and in a prone position, and Glucagon was administered to increase his blood sugar level. From there, however, there was a lack of monitoring of the patient and he was not moved out of the prone position until placed on a gurney. The patient's condition deteriorated without detection, and he was found to be in cardiac arrest upon reaching the ambulance.

21. Mr. Gallagher also included the following "Analysis" in his report:

> There were five paramedics inside a living room on a medical aid call in which the police department had to

> restrain the patient in order to provide him medical care. The patient was the focal point of the call and it should have been very evident to those there that his affect and behavior changed dramatically in a short period of time. It was evident the patient was in a prone position longer than necessary, particularly in light of the those [*sic*] changes. In addition, it was also very evident that none of the medical personnel were "hands on" in monitoring him.

22. At hearing, Mr. Gallagher confirmed he has no personal experience as a paramedic. Rather, he "learned through osmosis" from working on other cases. His finding that "the patient was in a prone position longer than necessary" was based on his personal opinion.

## Report and Testimony of Authority's Expert, Samuel Stratton, M.D.

23. In September 2024, the Authority hired Samuel Stratton, M.D., to review the incident in question and opine as to respondents' conduct. Dr. Stratton has been a licensed physician in California since 1976. He graduated from medical school in 1975 and completed a residency in internal medicine from 1975 through 1978. Following his residency, he worked for almost 10 years as a hospital emergency physician. Over the next 30 years, he held a variety of positions for several organizations, including Assistant Medical Director at a hospital emergency department, Medical Director of the Paramedic Training Institute in Los Angeles, Flight Physician for the Los Angeles County Fire Department, and Medical Director of the Los Angeles County Emergency Medical Services Authority.

24. Currently, Dr. Stratton is the Medical Director for the Redondo Beach Fire Department, a Senior Program Analyst for the Orange County Health Care Agency/Emergency Medical Services Authority, and an affiliate faculty member at the University of California, Los Angeles (UCLA). He is board certified by the American Board of Internal Medicine and the American Board of Emergency Medicine, from which he also maintains a subspecialty in Emergency Medical Services.

25. To form an opinion in this matter, Dr. Stratton reviewed several items, including the police officers' body camera footage and Mr. Gallaher's report. He did not interview any witnesses, but did discuss the matter with unspecified "Authority investigators." Based thereon, Dr. Stratton prepared written reports assessing whether he agreed with the allegations in the Accusations. For clarity, Dr. Stratton's reports for each respondent, which are substantially similar, are referred to collectively as his "report." At hearing, he testified consistently with his report.

26. As explained in his report, Dr. Stratton concluded respondents committed two errors while caring for the patient. The first was: "Failure to move the patient from the prone position to the lateral or supine position once restraints were secure. Prone positioning, particularly when a person is agitated and restrained, is associated with interference of ventilation." He went on to explain the correct procedure respondents should have followed:

> The standard of practice for paramedicine in California is for a paramedic dispatched to the scene of a medical emergency to assure that timely paramedic assessments and procedures are performed. In this case the standard of practice for paramedicine in California is to avoid prone positioning of a patient, particularly when the patient is

restrained. The preferred position for a restrained patient is lateral or supine. Prone positioning in the setting of a restrained patient is associated with respiratory depression and cardiac arrest. Further, the prone position interferes with conducting patient assessments and vital signs.

27. Dr. Stratton also opined respondents second error was their:

> Failure to obtain vital signs and conduct a physical assessment of the patient for approximately five minutes after administration of Glucagon for hypoglycemia and physical change from vigorous muscle movement and breathing to relaxed (flaccid) physical state. Need for resuscitative measures not recognized moving patient from house to the loading onto the transport ambulance.

28. Dr. Stratton explained the correct procedure respondents should have followed was:

> The standard of practice for paramedicine in California is to assure that a paramedic assessment is performed for a patient with a medical emergency, including a focused ALS exam for patients that may have a serious medical condition. The paramedic assessment should be performed as soon as possible, to allow for appropriate ALS interventions and management to stabilize a patient found to be medically unstable. Additionally, vital signs and an

assessment are standard following administration of a medication intramuscularly.

29. At hearing, Dr. Stratton clarified that respondents should have checked the patient's blood pressure, respiratory rate, heart rate, and pulse oximetry, which is a measure of the patient's oxygen saturation in the blood. He said the standard of practice is to check these vital signs anytime there is a change in the patient's acute status, when the patient receives medication, or, absent those circumstances, every five to ten minutes. In this case, he believes respondents should have checked the patient's vital signs "immediately" once the patient received the Glucagon injection and his breathing changed. He did not explain what respondents should have done in response to those measurements, nor did he explain how respondents should have taken the blood pressure of a man who was handcuffed behind his back with three police officers kneeling on him.

30. Dr. Stratton opined that respondents' actions were grossly negligent. He did not define his understanding of gross negligence in his report. At hearing, he testified respondents were grossly negligent because "the standard of practice was not adhered to." He also explained his belief that a single negligent act constitutes simple negligence, while multiple negligent acts constitute gross negligence. Therefore, in his view, both of respondents' departures from the standard of practice were simple negligence, but because two such departures occurred, together they constitute gross negligence.

31. In his report, Dr. Stratton did not include any opinion about whether respondents' conduct constated incompetence. At hearing, he confirmed he made no such finding after his review of the matter.

32. Finally, Dr. Stratton reviewed three SCEMSA polices in his review of this matter: 8062.10, 8002.02, and 8061.19. In his report, he did not discuss those specific policies. At hearing, he testified those SCEMSA policies defined the applicable standard of care. On cross-examination, he confirmed that two of those policies, 8062.10 and 8002.02, were not in effect as of February 2020. He therefore agreed he should not have relied on them when forming his opinions, but he also declined to amend his opinions once he realized, at hearing, that those policies did not apply. He did not explain what specific actions respondents took or failed to take to violate the SCEMSA policy 8061.19.

## Respondents' Evidence

### REPORT AND TESTIMONY OF CLAYTON KAZAN, M.D.

33. Respondents Caravalho and Simons hired Clayton Kazan, M.D., to review the matter and evaluate their care of the patient. Dr. Kazan was a licensed EMT from 1994 through 1997, during which time he worked on an ambulance for UCLA emergency medical services. He has been a licensed physician in California since 2002. He graduated from medical school in 2001 and completed a residency in emergency medicine from 2002 through 2005. In the approximately 10 years following his residency, he held a variety of positions for several organizations, including physician at a hospital emergency department, part-time clinical faculty at UCLA's department of emergency medicine, Commissioner of the Los Angeles County EMS Commission, and Medical Director and Chairman of the emergency department at a hospital.

34. Currently, Dr. Kazan is the Medical Director for the Los Angeles County Fire Department, a per diem attending emergency physician at a hospital, and an assistant clinical faculty member at the UCLA school of medicine. He is board certified

by the American Board of Emergency Medicine, from which he also maintains a subspecialty in Emergency Medical Services. He is also a fellow of the American College of Emergency Physicians and of the National Association of EMS Physicians.

35. To form an opinion in this matter, Dr. Kazan reviewed several items, including the police officers' body camera footage and deposition transcripts related to the events. He also interviewed respondents Caravalho and Simons. Based thereon, Dr. Kazan prepared written reports assessing those respondents' actions during the incident in question. For clarity, Dr. Kazan's reports for both respondents, which are substantially similar, are referred to collectively as his "report." At hearing, he testified consistently with his report.

36. Dr. Kazan explained in his report, "At the scene of an EMS call in which there is a co-response with EMS and law enforcement, EMS does not direct the restraint applied by law enforcement any more than law enforcement dictates the medical care provided by EMS." Based on his review of the body camera footage, he opined, "There is a clear point of transition between law enforcement restraint and EMS restraint, and, from the time that EMS took over the restraint, the patient was immediately transitioned to a supine position." He further noted, "Until the restraint was transitioned from law enforcement personnel to EMS personnel, the manner of restraint is the responsibility of law enforcement."

37. Dr. Kazan also disagreed with an allegation in the Accusations. Specifically, he wrote:

> The description in the EMSA accusation that "from the time Glucagon was administered to the Patient until he was transported to the ambulance, nearly six minutes elapsed.

During that time, the Patient remained in the prone position on his stomach on the floor, in handcuffs, and no one appropriately checked the Patient's pulse, airway, or breathing" is inaccurate. EMS personnel, once they transitioned the patient from law enforcement restraint and the handcuffs were removed, immediately flipped the patient onto his back on the stretcher. His pulse was checked, and he was noted to be breathing. The quality of the body cam footage is not adequate to assess the breathing for rate, rhythm, or tidal volume, though his mental status had apparently changed. Once on the stretcher, Mr. Carvalho and Mr. Simons stated that they observed that the patient's breathing had diminished and that he appeared to be "guppy breathing." This is consistent with the patient having a pulse on the pulse check.

38. Dr. Kazan further noted:

Mr. Carvalho and Mr. Simons state that, at the time of the pulse check, the patient was breathing. That cannot be substantiated nor refuted based on the body camera footage quality. It is clear that the patient's mental status has changed, but the image quality was not sufficient to assess rate, rhythm, or tidal volume of [the patient's] breathing.

39. Based on his review of the matter, Dr. Kazan concluded that respondents Caravalho and Simons were not grossly negligent nor incompetent in their treatment

of the patient. He further concluded they did not violate SCEMSA policies or act outside the supervision of medical control in the field care system operating at the local level. At hearing, he clarified that the standard of care in this situation would have required the responding paramedic team to do eight things: (1) ensure scene safety; (2) assess the patient; (3) check the patient's blood sugar; (4) administer Glucagon; (5) chose and follow the hypoglycemic protocol as laid out in the applicable SCEMSA policy; (6) transition the patient from handcuffs to soft restraints; (7) turn the patient supine once he was unhandcuffed and placed on the gurney; and (8) bring the patient to the ambulance. He opined respondents Caravalho and Simons, as part of the paramedic team responding to the call, did all eight actions in the correct order.

**REPORT AND TESTIMONY OF ERIC SAYLORS**

40. Respondent Klein hired Eric Saylors to review the matter and evaluate respondent Klein's actions related to the incident in question. Chief Saylors is the Chief of the El Cerrito/Kensington Fire Department. He has been a licensed paramedic in California since 1995. In his career as a firefighter, he has held positions as paramedic, engineer, captain, and battalion chief before taking his current job.

41. To form an opinion in this matter, Chief Saylors reviewed several items, including the police officers' body camera footage and the Sacramento City First Department Manual of Operations. Based thereon, Chief Saylors prepared a written report assessing respondent Klein's actions during the incident in question. At hearing, he testified consistently with his report.

42. As explained in his report, Chief Saylors opined that respondent Klein was not acting as a paramedic during the events in question. Rather, as the captain on scene, respondent Klein was the incident commander. In that role, his job was to

ensure the safety of the other firefighters on the scene. His job was to "separate [himself] from the immediate tasks to focus on the strategy that will determine the next steps of [the] incident." Those job duties specifically required that he not provide any patient care.

43. Additionally, Chief Saylors opined about the standard of care for the other respondents. Specifically, he explained in his report, "Law enforcement is a cooperating agency on the scene and does not operate within the chain of command of the fire department. Firefighters have no authority over people in custody unless permitted by the restraining agency." He further opined:

> The body cam footage presents [the patient] as a large, agitated, uncooperative male. Access to the patient is limited due to his size and the level of restraint required. Assessment metrics such as vitals and treatment such as intravenous access (IV) are restricted due to the patient's position and level of cooperation. The appropriate medication is administered in alignment with county protocols. The treating paramedic transitioned the patient to soft restraints and a prone position on the gurney to continue care and transported the patient to an emergency room.

44. At hearing, Chief Saylors clarified it is "not even possible" to tell from the body camera footage whether respondents assessed the patient's airway, breathing, and pulse. He noted, based on his decades as paramedic and firefighter, that paramedics responding to a medical emergency assess individuals' airway, breathing,

and pulse so regularly it is "almost involuntary." As a result, he would have difficulty imagining that respondents did not perform those tasks.

45. Chief Saylors also testified that assessing someone's airway, breathing, and pulse does not require physically touching that person. Rather, if someone said "hello" when greeted, that would indicate to a paramedic that the person can breathe and that their heart is sending blood to their brain.

46. Chief Saylors also explained that, in this specific instance, measuring the patient's blood pressure, heart rate, or oxygen level would have required equipment, would have delayed the patient's transport to the hospital, and would be unnecessary. Specifically, he explained that respondents already planned to bring the patient to the hospital in an ambulance. Therefore, measuring his exact blood pressure, heart rate, or oxygen saturation would not have provided them any additional useful information. Instead, it would prevent them from getting the patient to the hospital as quickly as possible.

47. Based on his observations, Chief Saylor concluded, "Considering the situation, the standard of care was appropriate for the call. The limited body cam footage can mislead a novice observer. However, the primary paramedic and assisting paramedics properly assessed and treated the patient within county protocol."

## REPORT AND TESTIMONY OF MARSHALL BENNETT

48. Respondent Klein hired Marshall Bennett to review the matter and evaluate respondent Klein's actions related to the incident in question. Mr. Bennett has been a licensed paramedic in California since 2004. From 2004 through 2010, he was a paramedic on an ambulance. From 2010 to 2014, he was an operations supervisor for the ambulance company. From 2014 through 2020, he was the Prehospital Care

Coordinator for the Contra Costa County Emergency Medical Services Authority (CCEMSA). Since 2020, he has been the Director of the CCEMSA. He is also a board member of the EMS Administrator's Association of California.

49. To form an opinion in this matter, Mr. Bennett reviewed several items, including the police officers' body camera footage, Mr. Gallagher's report, Dr. Stratton's report, and Dr. Kazan's report. Based thereon, Mr. Bennett prepared a written report assessing respondent Klein's actions during the incident in question. At hearing, he testified consistently with his report.

50. Through his report and testimony, Mr. Bennett confirmed that Health and Safety Code section 1798.6 governs who has authority to restrain a patient during an emergency medical call. According to Mr. Bennett, subdivision (c) of that section "explicitly defines the entity vested with authority for management of the scene of an emergency as a '. . . *public safety agency having primary investigative authority.*'" (Italics in original.)

51. Mr. Bennett explained his understanding of the statute as follows: "When a person or a patient is restrained or detained by a PSA [public safety agency], that person remains in the custody of that (PSA) agency until a transfer of custody to another agency or EMS provider occurs." He also explained the purpose of that statutory authority, writing:

> This statutory hierarchy of authority on the scene of an emergency ensures that scene management, which is analogous to scene safety, is managed by the entity (PSA) with the lawful authority, tools, and training to effectively

manage the scene and ensure all responders and the public are safe.

52. Based on his review of the events, Mr. Bennett concluded:

> Based on the scope of this report stated in section "I" and available evidence reviewed specific to this incident, my conclusion is that Captain Klein held no statutory authority for either patient care management or for management of the scene of an emergency while PSA agents were on scene. Additionally, as scene safety is a priority for all providers and the patient represented a physical threat to all providers: the patient was physically engaged and monitored continuously by personnel trained to recognize and treat respiratory arrest and cardiac arrest, and the patient transfer from PSA custody to EMS custody was conducted appropriately.

## RESPONDENTS' TESTIMONY

53. Each respondent testified at hearing. Collectively, they explained that when they first arrived at the patient's home, he was agitated and behaving unpredictably. Based on his size and physical demonstrations, they believed they could not safely care for him. As a result, respondent Klein consulted with the patient's mother, and they agreed to call the police for assistance restraining the patient.

54. Once the police officers arrived, they entered the house first and restrained the patient in handcuffs. Shortly thereafter, respondents attended to his medical care. Respondent Simons pricked the patient's finger to check his blood sugar.

He then cut a hole in the patient's shirt so he could inject Glucagon into the patient's shoulder. Shortly afterwards, the patient's pulse was confirmed via carotid artery check.

55. Respondents then applied soft restraints to the patient so he could be secured to the gurney. Respondents observed the patient throughout and confirmed he was breathing. Once they lifted the patient onto the gurney, the officers released the handcuffs and respondents immediately turned the patient onto his back, and they then secured the soft restraints to the gurney and wheeled the patient to the front door. They visually confirmed he was breathing throughout.

56. From the time respondents began interacting with the patient until he received the Glucagon shot, he was communicating, which indicated he could inhale and exhale. Respondents did not use equipment to verify his blood pressure, heart rate, or pulse oximetry because they had already decided to transport him to the hospital. As a result, those readings would not have caused them to change their plan of action, and instead would have delayed them from implementing their plan.

57. After the patient received the Glucagon shot, his pulse was confirmed. The patient continued to breath and did not display signs of distress until he was outside the house on the way to the ambulance. Respondents were watching him the whole time, which is how they noticed when he stopped breathing. They immediately began resuscitation efforts, which they continued while driving to the hospital. When the patient arrived at the hospital, he was once again breathing and had a pulse.

## Analysis

58. Complainant alleged respondents' misconduct consisted of two components: failing to check the patient's pulse, airway, and breathing, and failing to

move the patient out of the prone position after he became noncombative. Complainant did not prove either claim.

### CHECKING THE PATIENT'S PULSE, AIRWAY, AND BREATHING

59. In his written report, Dr. Stratton opined respondents failed to "obtain vital signs and conduct a physical assessment of the patient for approximately five minutes after administration of Glucagon for hypoglycemia and physical change from vigorous muscle movement and breathing to relaxed (flaccid) physical state." At hearing, he clarified that respondents should have checked the patient's blood pressure, respiratory rate, heart rate, and pulse oximetry.

60. Chief Saylors and Dr. Kazan disagreed with Dr. Stratton. Chief Saylors testified it is "not even possible" to tell from the body camera footage whether respondents assessed the patient's airway, breathing, and pulse. He clarified that those tasks are so routinized for paramedics responding to a medical emergency that it would be difficult to imagine respondents not performing them.

61. Similarly, Dr. Kazan explained in his written report, "The quality of the body cam footage is not adequate to assess the breathing for rate, rhythm, or tidal volume, though [the patient's] mental status had apparently changed." At hearing, he clarified there is no way to determine from watching the body cam footage who performed what assessments or when they did so. He credibly explained that for trained emergency responders, "assessment is hard to turn off." Respondents all independently confirmed that opinion. They each explained they regularly and routinely visually assess the airway and breathing of those around them in their daily lives.

62. Respondents' evidence, including the opinions of Chief Saylors and Dr. Kazan, was more persuasive than Dr. Stratton's opinion for two reasons. First, Dr. Stratton's opinions conflicted with not only his own summary of the events, but also with allegations within the Accusations. Specifically, Dr. Stratton wrote in his report that respondents failed to assess the patient "for approximately five minutes after administration of Glucagon." In his report, however, he noted that within 65 seconds of receiving the Glucagon injection: "Patient becomes still, no verbal or muscular response to restraint, no visible breathing in prone position, police officer checks for breathing and states breathing is present." He did not explain why respondents would have to independently check the patient's breathing when the officer announced the patient was breathing. Moreover, Dr. Stratton's summary is inconsistent with the Accusations, which allege, at paragraph 17, "[respondent Simons] then administered a Glucagon injection to the Patient in his shoulder. Almost one minute later, [respondent Caravalho] completed a two-to-three second carotid pulse check of the Patient." These inconsistencies call into question the credibility of Dr. Stratton's opinions.

63. Second, "an expert's opinion is only as good as the independent evidence establishing its underlying premises." (*Williams v. Illinois* (2012) 567 U.S. 50, 52.) Dr. Stratton is not, and has never been, a licensed paramedic. Rather, he has been a licensed physician since 1976. Although he was a local emergency medical services authority director and the medical director of a fire department, his opportunities to observe paramedics in circumstances like those in question here have been extremely limited. Specifically, he rode along with firefighter paramedics and rode on an ambulance in Los Angeles in 1992. His experience assessing patients as a physician is fundamentally dissimilar from assessing patients in the field as a paramedic.

64. As a result, when forming his opinion that respondents failed to check the patient's airway, breathing, and pulse, Dr. Stratton relied on the police officers' body camera footage and Mr. Gallagher's case summary. As Chief Saylors and Dr. Kazan credibly opined, the footage does not provide adequate information to support Dr. Stratton's conclusion. Moreover, Mr. Gallagher has no training that would qualify him to determine whether respondents behaved appropriately as paramedics.

65. In contrast, Chief Saylors has been a licensed paramedic since 1994. As a firefighter, he has served as a paramedic, engineer, captain, and battalion chief before his current position. He credibly explained that assessing a patient's airway, breathing, and pulse does not require physically touching the patient. For example, if an individual simply says "hello" in response to a greeting, a paramedic knows the person has an unobstructed airway, can inhale and exhale, and has a pulse.

66. Chief Saylors also credibly explained that, in this specific instance, measuring the patient's blood pressure, heart rate, or oxygen level with equipment would have been time consuming and unnecessary. As he put it, respondents already knew the patient needed to be brought to the hospital in an ambulance, so determining his exact blood pressure, heart rate, or oxygen saturation would not have provided them any additional actionable intelligence. Dr. Kazan, who was a licensed EMT and has experience working as a firefighter, agreed, as did each respondent.

67. Therefore, for the reasons stated above, complainant did not prove respondents failed to adequately check the patient's pulse, airway, and breathing. Consequently, that allegation does not provide cause to discipline their licenses for gross negligence, incompetence, violating the regulations governing prehospital personnel, or functioning outside the supervision of medical control in the field care system operating at the local level.

## MOVING THE PATIENT OUT OF THE PRONE POSITION

68. Dr. Stratton also opined in his report that respondents erred in their "failure to move the patient from the prone position to the lateral or supine position once restraints were secure." This opinion was also unpersuasive for two reasons.

69. First, Chief Saylors, Officers Helmich and Moorman, Dr. Bennett, Dr. Kazan, and each respondent persuasively and credibly testified that the police officers, not respondents, were responsible for the patient's physical positioning from the time the paramedics entered the home for the second time until the patient was placed in soft restraints on the gurney. Dr. Stratton recognized this in his written report, writing: "Patient [was] restrained by handcuffs by police in standard prone position . . . ." As Dr. Kazan concisely summarized in his written report, "Until the restraint was transitioned from law enforcement personnel to EMS personnel, the manner of restraint was the responsibility of law enforcement."

70. Relevant law confirms respondents' evidence. Specifically, Health and Safety Code section 1798.6, subdivision (c), provides that "authority for the management of the scene of an emergency shall be vested in the appropriate public safety agency having primary investigative authority." In this case, the Sacramento Police Department was the public safety agency with primary investigative authority. Consequently, the police officers, not respondents, were responsible for managing the scene, which included restraining the patient. In exercising that authority, the police officers placed the patient in the prone position from before respondents began treating the patient until the patient was placed on the gurney. Therefore, under the law, respondents had no control over the patient's physical positioning until they took custody of him and placed him on the gurney. Not only did Dr. Stratton's opinion fail to mention Health and Safety Code section 1798.6, subdivision (c), but he also

confirmed on cross-examination that he was unaware of that statute and its requirements.

71. Second, Dr. Stratton's opinion was ambiguous about when respondents' alleged failure occurred. Specifically, he wrote in his report that respondents failed to move the patient out of the prone position "once restraints were secure." He did not specify whether "restraints" meant the police officers' handcuffs or the respondents' soft restraints. If he meant the handcuffs, his opinion was unpersuasive as explained above. If he meant the soft restraints, his opinion was inconsistent with the facts. Indeed, once respondents took custody of the patient, they immediately placed him face up on the gurney and strapped him in place in that position. He remained supine for the remainder of the call.

72. Therefore, for the reasons stated above, complainant did not prove respondents failed to move the patient out of the prone position. Consequently, that allegation does not provide cause to discipline their licenses for gross negligence, incompetence, violating the regulations governing prehospital personnel, or functioning outside the supervision of medical control in the field care system operating at the local level.

## LEGAL CONCLUSIONS

### Burden and Standard of Proof

1. The standard of proof for this matter is "clear and convincing evidence." (*Ettinger v. Bd. of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) This means the burden rests on complainant to establish the charging allegations by proof that is clear, explicit and unequivocal, as to leave no substantial doubt, and sufficiently

strong to command the unhesitating assent of every reasonable mind. (*In re Marriage of Weaver* (1990) 224 Cal.App.3d 478, 487.)

2. In a disciplinary action such as this, rehabilitation is akin to an affirmative defense, and the burden of proof of establishing rehabilitation is therefore on the respondent. (*Whetstone v. Bd. of Dental Exam'rs* (1927) 87 Cal.App. 156, 164.) This is consistent with the general rule placing the burden of proof on one who asserts a claim or defense. (Evid. Code, § 500.) Except as otherwise provided by law, the burden of proof requires proof by a preponderance of the evidence. (Evid. Code, § 115.)

## Alleged Causes for Discipline

### GROSS NEGLIGENCE

3. The Authority may discipline a paramedic's license for gross negligence. (Health & Saf. Code, § 1798.200, subd. (c)(2).) Here, complainant alleged respondents' care for the patient was grossly negligent because they failed to check his airway, breathing, and pulse. As discussed in Factual Findings 59 through 67, above, complainant did not prove respondents failed to do so. As a result, there is no basis to discipline respondents' licenses for gross negligence based on this allegation.

4. Complainant further alleged respondent's care for the patient was grossly negligent because they failed to move him out of the prone position after he became noncombative. As discussed in Factual Findings 68 through 72, above, the evidence showed respondents moved the patient into the supine position as soon as they had control of his positioning. Before that, the police officers were responsible for the patient's restraint, pursuant to Health and Safety Code section 1798.6, subdivision (c). As a result, there is no basis to discipline respondents' licenses for gross negligence based on this allegation.

5. Furthermore, although Dr. Stratton opined that respondents' actions were grossly negligent, he did not define his understanding of gross negligence in his report. At hearing, he testified respondents were grossly negligent because "the standard of practice was not adhered to." He also explained his belief that a single negligent act constitutes simple negligence and multiple negligent acts constitute gross negligence. Therefore, in his view, each of respondents' departures from the standard of practice was simple negligence, but because two such departures occurred, together they constituted gross negligence.

6. California courts have defined gross negligence as "the want of even scant care or an extreme departure from the ordinary standard of care." (*Kearl v. Bd. of Medical Quality Assurance* (1986) 189 Cal.App.3rd 1040, 1052.) The standard of care applicable to a medical professional must be established by expert testimony. (*Elcome v. Chin* (2003) 110 Cal.App.4th 310, 317.) The standard of care typically requires the exercise of a reasonable degree of skill, knowledge, and care that is ordinarily possessed and exercised by members of the medical profession under similar circumstances. It is often a function of custom and practice. (*Osborn v. Irwin Memorial Blood Bank* (1992) 5 Cal.App.4th 234, 280.) Simple negligence is merely a departure from the standard of care. A single instance of negligent treatment is not grounds for discipline of a licensed medical professional. (*Gromis v. Medical Bd.* (1992) 8 Cal.App.4th 589, 600.)

7. Here, Dr. Stratton did not persuasively articulate what made respondents' actions grossly negligent. His concept that respondent's two simple acts of alleged negligence combine to constitute gross negligence is inconsistent with caselaw. It is also inconsistent with the statute authorizing the Authority to discipline paramedics. Specifically, Health and Safety Code section 1798.200, subdivision (c)(2), authorizes

license discipline for gross negligence. Subdivision (c)(3) authorizes license discipline for "repeated negligent acts." Yet Dr. Stratton opined that respondent's acts were grossly negligent because they were multiple acts. Such an understanding would render subdivisions (c)(2) and (c)(3) redundant.

**INCOMPETENCE**

8. The Authority may discipline a paramedic's license for incompetence. (Health & Saf. Code, § 1798.200, subd. (c)(4).) Here, neither Dr. Stratton nor any other witness opined that respondents' actions were incompetent. As a result, complainant did not prove that respondents' licenses are subject to discipline for incompetence.

**VIOLATING REGULATIONS PERTAINING TO PREHOSPITAL PERSONNEL AND FUNCTIONING OUTSIDE THE SUPERVISION OF MEDICAL CONTROL IN THE FIELD CARE SYSTEM OPERATING AT THE LOCAL LEVEL**

9. The Authority may discipline a paramedic's license for "[v]iolating or attempting to violate directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this division or the regulations adopted by the authority pertaining to prehospital personnel." (Health & Saf. Code, § 1798.200, subd. (c)(7).) The Authority may also discipline a paramedic's license for "[f]unctioning 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." (Health & Saf. Code, § 1798.200, subd. (c)(10).)

10. Here, complainant alleged respondents violated three SCEMSA policies when caring for the patient: policies 8062.10, 8002.02, and 8061.19. However, only one of those policies, 8061.19, was effective as of February 2020. That policy is titled

"Decreased Sensorium" and describes the procedures EMTs and paramedics must follow when assisting "patients exhibiting signs and symptoms of decreased sensorium."

11. Notably, no witnesses testified as to whether SCEMSA policy 8061.19 applied in this case, or whether another policy superseded it. Dr. Stratton opined respondents violated SCEMSA policy 8061.19, but he did not explain what specific actions they took or failed to take to violate it. However, the premise of Dr. Stratton's opinions and of the Accusations was that respondents failed to check the patient's airway, breathing, and pulse, and failed to place him in the correct position. As explained above, complainant did not prove respondents failed in those regards. Consequently, complainant did not prove respondents violated SCEMSA policy 8061.19, and no cause exists to discipline their licenses pursuant to Health and Safety Code section 1798.200, subdivision (c)(7) or (10).

## ORDER

The First Amended Accusation against respondent Jeffrey Klein, and the Accusations against respondents Scott Caravalho, Sean Holleman, and Clinton Simons, are DISMISSED.

DATE: March 3, 2025

SEAN GAVIN
Administrative Law Judge
Office of Administrative Hearings