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BEFORE THE
PARAMEDIC DISCIPLINARY REVIEW BOARD
EMERGENCY MEDICAL SERVICES AUTHORITY
STATE OF CALIFORNIA

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

Jeffrey S. Klein
License No. P15057

Sean M. Holleman
License No. P27586

Clinton R. Simons
License No. P29304

Scott V. Carvalho
License No. P21870

Respondents (consolidated).

Enforcement Matter Nos. 23-0103, 23-0104,
23-0105, and 23-0106

OAH Cases Nos. 2024060198, 2024060209,
2024060210, and 2024060201

DECISION AND ORDER

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DECISION AFTER NON-ADOPTION

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

Phillip L. Arthur, Deputy Attorney General (DAG), represented Complainant Kim Lew
in her official capacity as Licensing, Standards, and Training Branch Chief, Emergency Medical
Services Authority (EMSA or the Authority), State of California.

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

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

1 Nicole Valentine, Attorney at Law, represented Respondent Clinton R. Simons
2 (Respondent Simons) and Scott V. Carvalho (Respondent Carvalho), who were present
3 throughout the hearing.

4 Dana Martinez, Attorney at Law, represented E.M.¹, who was present for portions of the
5 hearing.

6 The matters were consolidated for hearing. Evidence was received, the record closed,
7 and the parties submitted the matter for decision on December 13, 2024. Before the hearing
8 concluded, Complainant dismissed the accusation against E.M. Complainant requested one
9 decision for the consolidated matter against the remaining four respondents.

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

15 The ALJ issued a proposed decision on March 3, 2025. On March 13, 2025, the
16 Paramedic Disciplinary Review Board (PDRB or the Board)² issued a Notice Concerning
17 Proposed Decision and Written Hearing, pursuant to California Government Code section
18 11517(c)(2)(E)³. PDRB requested transcripts of the hearing, which were received on April 10,
19 2025. Written argument on the matter was taken under submission by PDRB on April 30, 2025.
20 DAG Phillip Arthur submitted written argument on behalf of Complainant. Nicole Valentine,
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23 ¹ This former co-respondent's name has been redacted (instead referenced by their initials) in this decision.

24 ² California Health and Safety Code section 1797.125 grants PDRB authority to make a final determination after an
appeal of licensure discipline and/or licensure denial.

25 ³ California Government Code section 11517(c)(2) authorizes agencies, including PDRB, to “[r]eject the proposed
decision, and decide the case upon the record, including the transcript, or upon an agreed statement of the parties,
with or without taking additional evidence.”

1 Aaron E. Doyle, and Maurice Sinsley submitted a joint written argument on behalf of
2 Respondents Klein, Holleman, Simons, and Carvalho (collectively, Respondents). PDRB,
3 having read and considered the entire record, including the transcript and the exhibits, and
4 having considered the written argument, hereby enters this Decision After Non-Adoption.

5 SUMMARY

6 Complainant requests that PDRB discipline Respondents' Emergency Medical
7 Technician-Paramedic (EMT-P)⁴ licenses, alleging that Respondents violated the Emergency
8 Medical Services System and Prehospital Emergency Medical Care Personnel Act (EMS Act)⁵
9 when they responded to a patient in a diabetic emergency on February 25, 2020, and (a) failed
10 to check the patient's pulse, airway, or breathing after Glucagon was administered and (b) failed
11 to move the patient out of the prone position once the patient became non-combative.

12 Complainant argues that Respondents' delays and omissions in examining and treating the
13 patient constitute gross negligence, incompetence, violation of regulations adopted by EMSA
14 pertaining to prehospital personnel, and functioning outside the supervision of medical control,
15 and that they therefore evidence a threat to the public health and safety. Further, Respondent
16 Klein has already been disciplined as an EMT-P licensee for functioning outside the supervision
17 of medical control on a separate occasion.

18 Respondents argue that Complainant failed to prove any of these allegations by clear
19 and convincing evidence. According to Respondents, law enforcement officers' restraint of the
20 patient irretrievably compromised Respondents' ability to examine the patient or, after
21 administering Glucagon, to continue treatment in the manner required by local protocol.

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24 ⁴ The California Health and Safety Code, section 1797.84 defines Emergency Medical Technician-Paramedic as
25 "an individual whose scope of practice to provide advanced life support is according to standards prescribed by this
division and who has a valid certificate issued pursuant to this division."

⁵ The EMS Act is codified at California Health and Safety Code section 1797 et seq.

1 Respondent Klein additionally contends that legal requirements applicable to EMT-P licensees
2 should not apply to him while employed as a captain, regardless of his active EMT-P license.
3 Furthermore, Respondents assert that PDRB is precluded from taking additional evidence⁶, and
4 that rejecting the ALJ's proposed decision would inherently constitute an abuse of discretion.

5 Based on its exhaustive review of the record and the parties' written arguments, PDRB
6 concludes that the ALJ correctly determined that Complainant did not prove incompetence or
7 violation of regulations adopted by EMSA pertaining to prehospital personnel by any of the
8 Respondents, or gross negligence by Respondents Holleman, Simons, and Carvalho. However,
9 PDRB concludes that the ALJ erred as to the other issues. Specifically, PDRB concludes that
10 the failure to promptly and adequately examine and treat the patient did constitute functioning
11 outside the supervision of medical control by all Respondents, and gross negligence by
12 Respondent Klein.

13 Complainant argues that all Respondents' paramedic licenses should be placed on
14 probation with requirements for remedial education in topics related to errors made during these
15 events, and Respondents Klein and Holleman should each be required to serve a suspension.
16 PDRB agrees with respect to probation and tailored remedial education, but declines to suspend
17 Respondents' licenses. Consequently, revocation of each Respondent's EMT-P license is
18 stayed, pending successful completion of a probationary period that includes education
19 requirements.

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⁶ Complainant's written argument proffered a prior version of a local behavioral crisis/restraint policy that had been referenced in the Accusations but excluded at hearing as not yet in effect at the time of these events.

1 **FACTUAL FINDINGS**

2 **Jurisdictional Matters**

3 PDRB adopts Factual Findings 1–7 from ALJ Gavin’s proposed decision, as accurate as
4 of the date of that hearing.⁷ Accordingly, PDRB finds as follows:

5 Respondents’ License History

6 1. On September 8, 1998, the Authority issued Respondent Klein EMT-P license
7 number P15057. The license was active at all relevant times and is scheduled to expire
8 September 30, 2026, unless renewed. In June 2009, the Authority issued Respondent Klein a
9 warning letter for incidents in March and May 2006. In February 2021, in EMSA case number
10 19-0315, the Authority fined Respondent Klein \$500 for functioning outside the supervision of
11 medical control in the field care system operating at the local level.

12 2. On December 27, 2004, the Authority issued Respondent Carvalho EMT-P
13 license number P21870. The license was active at all relevant times and was scheduled to
14 expire December 31, 2024, unless renewed. There was no evidence regarding whether
15 Respondent Carvalho renewed his license. Respondent Carvalho has no history of prior
16 license discipline.

17 3. On August 20, 2009, the Authority issued Respondent Holleman EMT-P license
18 number P27586. The license was active at all relevant times and is scheduled to expire August
19 31, 2025, unless renewed. Respondent Holleman has no history of prior license discipline.

20 4. On February 10, 2011, the Authority issued Respondent Simons [EMT-P]
21 license number P29304. The license was active at all relevant times and is scheduled to expire
22 February 28, 2025, unless renewed. Respondent Simons has no history of prior license
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25 ⁷ PDRB acknowledges the possibility that one or more Respondents may have renewed their EMT-P license(s)
since the December 2024 hearing before ALJ Gavin. However, such a nuance would not alter the analysis or
outcome of this decision.

1 discipline.

2 Accusations Against Respondents

3 5. On April 16 and 17, 2024, Complainant signed and thereafter filed separate but
4 substantially similar Accusations against Respondents. Complainant seeks to discipline
5 Respondents' licenses based on their care of a diabetic patient at his home on February 25,
6 2020. Specifically, Complainant alleged Respondents, while working for the City of
7 Sacramento Fire Department (SFD)⁸ and responding to a medical call, failed to check the
8 patient's pulse, airway, and breathing, and failed to move the patient out of the prone position
9 after he became noncombative. Complainant alleged those failures constitute cause to
10 discipline Respondents' licenses for: (1) gross negligence; (2) incompetence; (3) violating, or
11 attempting to violate, the regulations governing prehospital personnel; and (4) functioning
12 outside the supervision of medical control in the field care system operating at the local level.

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

18 7. On or about April 22, 2024, Respondent Klein filed a Special Notice of Defense
19 and Objection to Accusation, which was deemed responsive to the First Amended Accusation.
20 (Gov. Code, § 11506, subd. (c).) On or about April 24, 2024, Respondent Holleman filed a
21 Notice of Defense. On or about July 3, 2024, Respondents Carvalho and Simons each filed a
22 Supplemental Notice of Defense. This hearing [before ALJ Gavin] followed.

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⁸ ALJ Gavin's proposed decision indicates that the Accusations incorrectly identified Respondents' employer as the Sacramento *County* Fire Department.
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1 **Events of February 25, 2020**

2 PDRB adopts ALJ Gavin’s proposed Factual Findings 8–10 and 12. Additionally, PDRB
3 partially adopts proposed Factual Finding 11, but rejects the portions of that paragraph which
4 comprise conclusory legal findings, as those issues will instead be addressed later in this
5 decision. PDRB also rejects proposed Factual Findings 13–15 and instead makes its own
6 findings based on its review of the record and body of admitted evidence, including the events
7 and chronology shown in body-worn camera videos admitted into evidence. Accordingly,
8 PDRB finds as follows:

9 8. On February 25, 2020, Respondents were assigned to work the “A” shift for
10 SFD Station 12. Respondent Klein was the A shift captain. Respondents Holleman and Simons
11 were working as paramedics in an ambulance known as Medic 12. Respondent Carvalho was
12 working as a paramedic on a fire engine known as Engine 12. [E.M.] was the Engine 12
13 engineer.

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

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

24 11. Three police officers arrived to restrain the patient. Two of the officers, John
25 Helmich and Kevin Moorman, testified at hearing. They explained they responded to the

1 patient's home to restrain him so paramedics could evaluate and treat him safely.⁹ When the
2 officers entered the house, the patient was on a couch in the living room. As the officers
3 approached him, he slid from the couch onto the floor. The officers turned the patient face
4 down on the floor [prone position]) and used their bodies to hold him still. One officer held
5 him down near his shoulders as the other two officers held him near his hips. One officer
6 placed the patient's legs into a "figure four," with his left shin placed behind his right knee and
7 his right ankle then positioned near his buttocks. The officers also placed the patient's arms and
8 hands behind his back and handcuffed him in that position. Much of the officers' and
9 Respondents' activities was captured via the officers' body-worn cameras.¹⁰

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

20 13. a. At approximately the same time as Respondent Simons administered the
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24 ⁹ This testimony by Officers Helmich and Moorman is consistent with body camera footage of officers arriving on
scene and asking Respondents what kind of assistance is needed. Respondents ask the officers to "just physically
get him in a position where [Respondents] can poke his finger and get a sugar, then we [Respondents] can fix it."

25 ¹⁰ The footage captured via the officers' body-worn cameras also shows that SFD medical equipment, including an
EKG machine, was present in the room. However, the footage shows that Respondents did not use the EKG
machine for cardiac monitoring of the patient while in the room.

1 intramuscular injection of Glucagon, the patient stopped moving or making noise.

2 b. Approximately 20 seconds after the injection, an unidentified speaker
3 commented that “he’s feeling better already.” Another unidentified individual responds,
4 “Problem is that takes about 20 minutes to work, so we’re gonna restrain him.”

5 c. Approximately 50 seconds after the injection, an unidentified person asked, “He
6 go to sleep?” No response is heard in the body camera footage and the patient was still not
7 moving or making noise. The person then followed up to ask whether the patient’s heart was
8 “still beating.” An individual who cannot be identified on the body camera footage checked the
9 patient’s carotid artery, confirmed the presence of a pulse, and announced “yeah.”

10 14. a. Beginning within a few seconds thereafter, Respondent Carvalho worked to
11 apply soft restraints on the patient’s limbs to prepare him for eventual placement on a gurney
12 and relocation to the ambulance outside. Police officers appeared to remove handcuffs from the
13 patient in coordination with their replacement by the soft restraints. For approximately two
14 minutes during which the soft restraints were being applied, Respondents Holleman and
15 Simons moved about the room with their eyes generally toward the patient, as if observing him.
16 The patient still did not appear to be moving. Respondent Klein was also present, but body
17 camera footage clearly captures him discussing a local hospital’s updated policy about weapons
18 screening requirements with police officers rather than engaging in, or supporting the efforts of
19 his team toward, responding to the medical emergency still underway.

20 b. Approximately three minutes after the injection was administered, Respondents
21 Holleman, Carvalho, and Simons, together with E.M., lifted the patient on the gurney, on his
22 back (supine position). Respondents Holleman, Carvalho, and Simons then secured the
23 restraints to the gurney.

24 15. a. Approximately 30 seconds after the patient was placed supine on the gurney,
25 body camera footage shows the patient’s mother looking at the patient and calling his name as
she walks back into the room. Respondent Klein was still audibly gossiping about a hospital
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1 shooting and appeared to be ignoring the patient and ongoing response efforts by the other
2 Respondents.

3 b. Approximately one minute after the patient was placed supine on the gurney,
4 paramedics briefly lifted his upper back and head, and his head could be seen lolling as if the
5 patient were non-responsive. The patient’s mother asked, “you guys sedate him?” Without
6 examining the patient, Respondent Klein responded, “No, he burnt the available sugar he had
7 fighting, so now he just nodded out.” Respondent Klein informed her that Glucagon takes 25-
8 45 minutes to start working and promised her that “he’ll be right as rain when he comes home.”

9 c. Approximately two minutes after the patient was placed supine on the gurney,
10 Respondents Holleman and Carvalho raised the gurney and began wheeling the gurney toward
11 the front door, with Respondent Holleman near the patient’s head.

12 **Authority’s Investigation of Respondents’ Actions**

13 PDRB adopts ALJ Gavin’s proposed Factual Findings 16–17 and 19–21, and adopts
14 proposed Factual Finding 18 as modified below for relevance. PDRB rejects proposed Factual
15 Finding 22 as irrelevant to a non-expert witness, and instead makes its own finding based on its
16 review of the record and body of admitted evidence. Accordingly, PDRB finds as follows:

17 16. In April 2023, the Authority learned of the incident in question via a newspaper
18 article. Shortly thereafter, the Authority assigned Dennis Gallagher to investigate Respondents’
19 conduct regarding the incident.

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

18. Mr. Gallagher reviewed documents and interviewed witnesses, including
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1 Respondents. He also interviewed Chad Augustin, Deputy Chief of the Sacramento Fire
2 Department; Fire Service Medical Director Kevin Mackey; and EMS Coordinator Brian Pedro,
3 RN. In his written reports, he described those individuals as “experts on prehospital care as
4 required in Sacramento County Emergency Medical Services Agency (SCEMSA) protocol for
5 Sacramento Fire Department paramedics,” and relied on those individuals’ opinions.

6 19. Following his investigation, Mr. Gallagher prepared written reports related to
7 each Respondent. For clarity, his reports, which are substantially similar, are referred to
8 collectively as his “report.” At hearing, he testified consistently with his report.

9 20. In his report, Mr. Gallagher included an “Investigative Summary” in which he
10 wrote, in relevant part:

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

18 21. Mr. Gallagher also included the following “Analysis” in his report:

19 There were five paramedics inside a living room on a medical aid
20 call in which the police department had to restrain the patient in
21 order to provide him medical care. The patient was the focal point
22 of the call and *it should have been very evident to those there that*
23 *his affect and behavior changed dramatically in a short period of*
24 *time. It was evident the patient was in a prone position longer than*
25 *necessary, particularly in light of those changes.* In addition, it was

also very evident that *none of the medical personnel were “hands*

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on” in monitoring him.

22. Mr. Gallagher’s report notes that the City’s disciplinary findings identified SCEMSA Document No. 8061.19 (Decreased Sensorium)¹¹ as including a protocol for suspected hypoglycemia and therefore relevant to the events in question. The Advanced Life Support (ALS)¹² portion of this protocol requires the following steps:

IV. If IV access is unavailable or delay is anticipated, treatment options are:

- Glucagon: 1 mg Intramuscular (IM), **OR**
- Dextrose 10-12.5 grams IO. If blood sugar remains \leq 60 mg/dl, give additional
- Dextrose 12.5-15 grams IO. May repeat for total of 50 grams.

NOTE: Concentrations of 10% Dextrose (D10) or 50% Dextrose (D50) may be used.

- IO access should be established if IV access is unavailable and if the blood sugar \leq 60 mg/dl or decreased responsiveness continues for more than five (5) minutes after administration of Glucagon. . . .

VI. Cardiac monitoring.

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

PDRB adopts ALJ Gavin’s proposed Factual Findings 23–28 and 31. Additionally, PDRB partially adopts proposed Factual Findings 29–30, but rejects the portions of those

¹¹ SCEMSA Document No. 8061.19 was also separately admitted into evidence, and lists an effective date of May 1, 2019. It is undisputed that this version of the policy was in effect as of February 2020.

¹² ALS corresponds to Respondents’ scope of practice as paramedics. (Cal. Health & Saf. Code, § 1797.84.)

1 paragraphs that are unrelated to Dr. Stratton’s subject matter expertise¹³ or comprise conclusory
2 legal findings, as those issues will instead be addressed later in this decision. PDRB rejects
3 proposed Factual Finding 32 and instead makes its own findings based on its review of the
4 record and body of admitted evidence. Accordingly, PDRB finds as follows:

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

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

20 25. To form an opinion on this matter, Dr. Stratton reviewed several items,
21 including the police officers’ body camera footage and Mr. Gallagher’s report. He did not
22 interview any witnesses, but did discuss the matter with unspecified “Authority investigators.”
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25 ¹³ It is perplexing that ALJ Gavin permitted extensive examination of medical experts regarding questions of law,
rather than limiting their testimony to matters for which their medical expertise is relevant (e.g., identifying the
applicable standard of care and whether Respondents’ conduct met that standard).

1 Based thereon, Dr. Stratton prepared written reports assessing whether he agreed with the
2 allegations in the Accusations. For clarity, Dr. Stratton's reports for each Respondent, which
3 are substantially similar, are referred to collectively as his "report." At hearing, he testified
4 consistently with his report.

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

10 The standard of practice for paramedicine in California is for a
11 paramedic dispatched to the scene of a medical emergency to
12 *assure that timely paramedic assessments and procedures are*
13 *performed.* In this case the standard of practice for paramedicine in
14 California is to *avoid prone positioning of a patient, particularly*
15 *when the patient is restrained.* The preferred position for a
16 restrained patient is lateral or supine. Prone positioning in the
17 setting of a restrained patient is associated with respiratory
18 depression and cardiac arrest. Further, the prone position interferes
19 with conducting patient assessments and vital signs.

20 27. Dr. Stratton also opined Respondents' second error was their:

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

1 28. Dr. Stratton explained the correct procedure Respondents should have followed
2 was:

3 The standard of practice for paramedicine in California is to *assure*
4 *that a paramedic assessment is performed for a patient with a*
5 *medical emergency, including a focused ALS exam for patients that*
6 *may have a serious medical condition.* The paramedic assessment
7 should be performed *as soon as possible*, to allow for appropriate
8 ALS interventions and management to stabilize a patient found to
9 be medically unstable. *Additionally, vital signs and an assessment*
10 *are standard following administration of a medication*
11 *intramuscularly.*

12 29. At hearing, Dr. Stratton clarified that Respondents should have checked the
13 patient’s blood pressure, respiratory rate, heart rate, and pulse oximetry, which is a measure of
14 the patient’s oxygen saturation in the blood. He said the standard of practice is to check these
15 vital signs anytime there is a change in the patient’s acute status, when the patient receives
16 medication, or, absent those circumstances, every five to ten minutes. In this case, he believes
17 Respondents should have checked the patient’s vital signs “immediately” once the patient
18 received the Glucagon injection and his breathing changed.

19 30. Dr. Stratton opined that Respondents’ actions were grossly negligent and “the
20 standard of practice was not adhered to.”

21 31. In his report, Dr. Stratton did not include any opinion about whether
22 Respondents’ conduct [constituted] incompetence. At hearing, he confirmed he made no such
23 finding after his review of the matter.

24 32. At hearing, Dr. Stratton testified that he reviewed the body camera recordings of
25 the incident and the patient care report prior to preparing his report, and that his opinion was
“based primarily on observing the body cam videos that were provided for review.” Dr.
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1 Stratton testified that paramedics are held to a national standard of care, a state standard of
2 care, and a local standard of care. At hearing, he emphasized that the California Health and
3 Safety Code, requirements for training, requirements for licensure, and local EMS medical
4 control policies establish the California standard of care, and seemed to focus his analysis
5 primarily on these standards. Dr. Stratton also testified that SCEMSA policies define the
6 Sacramento County standard of care and that he had reviewed three such SCEMSA policies in
7 his review of this matter: SCEMSA Document No. 8062.10 (Behavioral Crisis/Restraint),
8 SCEMSA Document No. 8002.02 (Diabetic Emergency), and SCEMSA Document No.
9 8061.19 (Decreased Sensorium); however, he did not discuss those specific policies in his
10 report. On cross-examination, Dr. Stratton confirmed that two of those policies, 8062.10 and
11 8002.02, were subsequent versions of the policies that may have been in effect as of February
12 2020. He therefore agreed that SCEMSA Document Nos. 8062.10 and 8002.02 should not be
13 relied upon in determining the applicable standard of care at the time of the events in question.
14 Dr. Stratton declined to amend his opinions once he realized, at hearing, that those policies did
15 not apply.¹⁴ It remains undisputed that SCEMSA Document No. 8061.19 was in effect as of
16 February 2020. At hearing, Dr. Stratton also opined that: (1) Respondents should have
17 repositioned the patient from prone to either lateral or supine as soon as the “cuffs” were
18 applied; (2) it is sometimes also easier to hold a patient in a lateral position while cuffed; and
19 (3) the paramedics could “actually ask the police officers to assist them.” Dr. Stratton further
20 testified that he believed the standard of care for paramedics required the paramedics to request
21 the officers to reposition the patient, or to allow the paramedics to reposition the patient. If the
22 police declined to move the patient, Dr. Stratton opined that the paramedics should persist by
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¹⁴ Dr. Stratton’s conclusions were not specific to SCEMSA document numbers 8062.10 and 8002.02, instead taking
a more generalized approach to explain the statewide standard of care.

1 stating, “We’re worried that he needs to be able to breathe, and we would prefer if you agree to
2 roll him over to his left side,” but that paramedics still could have checked for the four vital
3 signs even while the patient was in a prone position.

4 **Respondents’ Evidence**

5 PDRB adopts ALJ Gavin’s proposed Factual Findings 33–38, 40–43, 45–46, 48–50, and
6 53, and adopts proposed Factual Findings 54–57 as modified for clarity and to more accurately
7 reflect the record. Additionally, PDRB partially adopts proposed Factual Findings 39, 44, and
8 47, but rejects the portions of those paragraphs that exceed the scope of the particular expert
9 witness’s subject matter expertise or comprise conjecture or conclusory legal findings, as those
10 issues will instead be addressed later in this decision. PDRB rejects proposed Factual Findings
11 51–52 in their entirety for the same reasons, and instead makes its own findings based on its
12 review of the record and body of admitted evidence. Accordingly, PDRB finds as follows:

13 Report and Testimony of Clayton Kazan, M.D.

14 33. Respondents Carvalho and Simons hired Clayton Kazan, M.D. to review the
15 matter and evaluate their care of the patient. Dr. Kazan was a licensed EMT from 1994 through
16 1997, during which time he worked on an ambulance for UCLA emergency medical services.
17 He has been a licensed physician in California since 2002. He graduated from medical school
18 in 2001 and completed a residency in emergency medicine from 2002 through 2005. In the
19 approximately 10 years following his residency, he held a variety of positions for several
20 organizations, including physician at a hospital emergency department, part-time clinical
21 faculty at UCLA’s department of emergency medicine, Commissioner of the Los Angeles
22 County EMS Commission, and Medical Director and Chairman of the emergency department
23 at a hospital.

24 34. Currently, Dr. Kazan is the Medical Director for the Los Angeles County Fire
25 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
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1 of Emergency Medicine, from which he also maintains a subspecialty in Emergency Medical
2 Services. He is also a fellow of the American College of Emergency Physicians and of the
3 National Association of EMS Physicians.

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

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

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

21 The description in the EMSA accusation that "from the time
22 Glucagon was administered to the Patient until he was transported
23 to the ambulance, nearly six minutes elapsed. During that time, the
24 Patient remained in the prone position on his stomach on the floor,
25 in handcuffs, and no one appropriately checked the Patient's pulse,
airway, or breathing" is inaccurate. EMS personnel, once they

1 transitioned the patient from law enforcement restraint and the
2 handcuffs were removed, immediately flipped the patient onto his
3 back on the stretcher. His pulse was checked, and he was noted to
4 be breathing. The quality of the body cam footage is not adequate
5 to assess the breathing for rate, rhythm, or tidal volume, though his
6 mental status had apparently changed. *Once on the stretcher, Mr.*
7 *Carvalho and Mr. Simons stated that they observed that the*
8 *patient's breathing had diminished and that he appeared to be*
9 *"guppy breathing."* This is consistent with the patient having a
10 pulse on the pulse check.

11 38. Dr. Kazan further noted:

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

18 39. Based on his review of the matter, Dr. Kazan opined that Respondents
19 Carvalho and Simons were not grossly negligent nor incompetent in their treatment of the
20 patient. At hearing, he clarified that the standard of care in this situation would have required
21 the responding paramedic team to do eight things: (1) ensure scene safety; (2) assess the
22 patient; (3) check the patient's blood sugar; (4) administer Glucagon; (5) choose and follow the
23 hypoglycemic protocol as laid out in the applicable SCEMSA policy; (6) transition the patient
24 from handcuffs to soft restraints; (7) turn the patient supine once he is unhandcuffed and
25 placed on the gurney; and (8) bring the patient to the ambulance. He opined Respondents

Carvalho and Simons, as part of the paramedic team responding to the call, did all eight
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1 actions in the correct order.

2 Report and Testimony of Eric Saylor

3 40. Respondent Klein hired Eric Saylor to review the matter and evaluate
4 Respondent Klein's actions related to the incident in question. Chief Saylor is the Chief of the
5 El Cerrito/Kensington Fire Department. He has been a licensed paramedic in California since
6 1995. In his career as a firefighter, he has held positions as paramedic, engineer, captain, and
7 battalion chief before taking his current job.

8 41. To form an opinion in this matter, Chief Saylor reviewed several items,
9 including the police officers' body camera footage and the Sacramento City [Fire] Department
10 Manual of Operations. Based thereon, Chief Saylor prepared a written report assessing
11 Respondent Klein's actions during the incident in question. At hearing, he testified consistently
12 with his report.

13 42. As explained in his report, Chief Saylor opined that Respondent Klein was not
14 acting as a paramedic during the events in question. Rather, as the captain on scene,
15 Respondent Klein was the incident commander. In that role, his job was to "separate [himself]
16 from the immediate tasks to focus on the strategy that will determine the next steps of [the]
17 incident." Those job duties specifically required that he not provide any patient care.

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

23 The body cam footage presents [the patient] as a large, agitated,
24 uncooperative male. Access to the patient is limited due to his size
25 and the level of restraint required. Assessment metrics such as
vitals and treatment such as intravenous access (IV) are restricted

1 - due to the patient's position and level of cooperation. The
2 appropriate medication is administered in alignment with county
3 protocols. The treating paramedic transitioned the patient to soft
4 restraints and a prone position on the gurney to continue care and
5 transported the patient to an emergency room.

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

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

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

22 47. Based on his observations, Chief Saylor concluded, "Considering the situation,
23 the standard of care was appropriate for the call. . . . [T]he primary paramedic and assisting
24 paramedics properly assessed and treated the patient within county protocol."

25 Report and Testimony of Marshall Bennett

 48. Respondent Klein hired Marshall Bennett to review the matter and evaluate
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1 Respondent Klein’s actions related to the incident in question. Mr. Bennett has been a licensed
2 paramedic in California since 2004. From 2004 through 2010, he was a paramedic on an
3 ambulance. From 2010 to 2014, he was an operations supervisor for the ambulance company.
4 From 2014 through 2020, he was the Prehospital Care Coordinator for the Contra Costa County
5 Emergency Medical Services Authority (CCEMSA). Since 2020, he has been the Director of
6 CCEMSA. He is also a board member of the EMS Administrators Association of California.

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

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

17 51. In his report, Mr. Bennett states, “Captain Jeffrey Klein is fire engine captain
18 who by virtue of position and command structure does not engage in patient care when an
19 ambulance unit is on scene.”

20 52. Mr. Bennett further notes in his report: “Specific to this incident, body camera
21 video confirms that Captain Klein never approaches the patient or engages in patient care.”

22 Respondents’ Testimony

23 53. Each Respondent testified at hearing. Collectively, they explained that when
24 they first arrived at the patient’s home, he was agitated and behaving unpredictably. Based on
25 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
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1 for assistance restraining the patient.

2 54. Once the police officers arrived, they entered the house first and restrained the
3 patient in handcuffs. Shortly thereafter, Respondents Holleman, Simons, and Carvalho
4 attended to his medical care. Respondents Simons and Carvalho testified that Respondent
5 Carvalho got the glucometer and put in a blood glucose test strip. Respondent Simons pricked
6 the patient's finger to check his blood sugar, obtaining a blood glucose level of 51. Respondent
7 Holleman testified that he and Respondent Simons decided to treat the patient with Glucagon.
8 Respondent Holleman also testified he prepared the Glucagon, a two-step process of mixing
9 saline and powder.¹⁵ Respondent Simons cut a hole in the patient's shirt so he could inject
10 Glucagon into the patient's shoulder. Respondent Holleman handed Respondent Simons the
11 syringe and Respondent Simons administered the injection to the patient. Shortly after
12 administering the injection, the patient's pulse was confirmed present via carotid artery check.

13 55. Respondents Holleman, Simons, and Carvalho then began applying soft
14 restraints to the patient so he could eventually be secured to the gurney. They indicated they
15 had observed the patient throughout this process and visually confirmed he was breathing.
16 Respondents Simons and Carvalho testified that, once the patient was placed onto the gurney
17 and they had begun securing the soft restraints to it, they observed the patient was still
18 breathing but that his breathing had slowed noticeably. Respondents Simons and Carvalho
19 testified that, in response to observing patient's slowed breath, Respondents Simons and
20 Holleman had a brief conversation and then Respondent Simons went out to get the ambulance
21 ready for the patient. Respondent Simons explained that he "spiked an IV," got the IV

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25 ¹⁵ Respondent Holleman's testimony included a description that the Glucagon they carried in their supply consists of two vials, one with water and one with Glucagon powder. To prepare the injection, Respondent Holleman retrieved a syringe, withdrew the water from the water vial, inserted it into the powder vial, and shook that vial until the powder was diluted. He then drew the solution into a syringe and passed it to Respondent Simons.

1 equipment out and ready, turned on the monitor that was in the ambulance, and made sure the
2 electrodes were ready. Respondents Carvalho and Holleman finished securing the soft
3 restraints to the gurney and wheeled the patient to the front door.

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

10 57. After the patient received the Glucagon shot and his pulse was confirmed
11 present, the patient continued to breathe and Respondents did not observe signs of distress until
12 he was outside the house on the way to the ambulance. Respondents Holleman and Carvalho
13 indicated they were watching him the whole time as they were moving the gurney, which is
14 how they noticed that he stopped breathing. They immediately began resuscitation efforts,
15 which they continued while driving to the hospital. When the patient arrived at the hospital, he
16 was once again breathing and had a pulse.

17 **Analysis of Evidence**

18 PDRB rejects proposed Factual Findings 58–75 and instead makes its own findings
19 based on its review of the record and body of admitted evidence. Accordingly, PDRB finds as
20 follows:

21 58. Complainant alleged Respondents’ misconduct consisted of two components:
22 failing to adequately check the patient’s pulse, airway, and breathing, and failing to promptly
23 move the patient out of the prone position once he became noncombative. Complainant proved
24 both claims by clear and convincing evidence.

25 Checking the Patient’s Pulse, Airway, and Breathing

59. In his written report, Dr. Stratton explained that “[t]he standard of practice for
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1 paramedicine is for a paramedic dispatched to the scene of a medical emergency to assure that
2 timely paramedic assessments and procedures are performed,” and also credibly opined that
3 Respondents failed to “obtain vital signs and conduct a physical assessment of the patient for
4 approximately five minutes after administration of Glucagon for hypoglycemia and physical
5 change from vigorous muscle movement and breathing to relaxed (flaccid) physical state.” His
6 observation is consistent with body camera footage showing that at least five minutes passed
7 from the time Respondents administered the injection until they began to wheel the patient, on
8 a gurney, toward the front door, with no vital signs obtained or exam conducted in the interim.

9 60. At hearing, Dr. Stratton stated that “a paramedic assessment is performed for a
10 patient with a medical emergency, including a focused ALS exam for patients that may have a
11 serious medical condition. The paramedic assessment should be performed as soon as possible,
12 to allow for appropriate ALS interventions and management to stabilize a patient found to be
13 medically unstable.” He further clarified that the standard of practice is to check these vital
14 signs anytime there is a change in the patient’s acute status, when the patient receives
15 medication, or, absent those circumstances, every five to ten minutes. In contrast to testimony
16 by Respondents and their witnesses that falsely equated ‘assessment’ with passive observation,
17 Dr. Stratton’s testimony made clear that mere observation – as had been implied by Chief
18 Saylor’s and Dr. Kazan’s testimony that it was not possible to identify for sure in the body
19 camera footage who was conducting assessments and when – is not an adequate assessment of
20 the patient.

21 61. Dr. Stratton clarified that Respondents should have obtained the patient’s vital
22 signs, including measurements of the patient’s blood pressure, respiratory rate, and pulse
23 oximetry, and conducted a thorough paramedic assessment, including a focused ALS exam.
24 Chief Saylor credibly explained that, in this specific instance, measuring the patient’s blood
25 pressure, heart rate, or oxygen level would have required equipment. A hands-on, physical
assessment of this nature or using equipment to obtain the patient’s vital signs would certainly
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1 be apparent on body camera footage if it had occurred, but all three video sources show that no
2 such exam or measurement of vital signs took place at the scene.

3 62. At various points, Respondents or police officers briefly confirmed that the
4 patient was still breathing or that he still had a pulse; however, these are readily distinguishable
5 from obtaining all four vital signs and conducting a paramedic assessment of the patient,
6 including ALS exam.

7 63. Dr. Stratton stated in his report that “vital signs and an assessment are standard
8 following administration of a medication intramuscularly.” The SCEMSA Decreased
9 Sensorium protocol similarly requires paramedics to establish cardiac monitoring upon
10 administering an intramuscular injection of Glucagon. However, body camera footage and
11 Respondents’ testimony are consistent in that Respondents did not obtain the patient’s vitals,
12 conduct a physical assessment of the patient, or establish cardiac monitoring for at least five
13 minutes following the injection, until the patient arrived at the ambulance in need of
14 resuscitation.

15 64. Additionally, Dr. Kazan noted in his written report that “[the patient’s] mental
16 status had apparently changed.” This is consistent with Dr. Stratton’s report that, upon
17 receiving the Glucagon injection, “Patient becomes still, no verbal or muscular response to
18 restraint.” Dr. Stratton credibly testified that he believes Respondents should have checked the
19 patient’s vital signs “immediately” once the patient received the Glucagon injection and his
20 breathing changed. Although it was confirmed that the patient was still breathing, no one
21 obtained the patient’s vital signs at this point.

22 65. While the mere presence of breathing and a pulse were confirmed, but these do
23 not meet the standard of care identified for paramedics. Respondents testified that they already
24 knew the patient needed to be brought to the hospital in an ambulance and didn’t obtain the
25 patient’s vitals since they perceived that step as a delay to transporting the patient, but this was
not identified as an exception to the standard of care.

1 66. Although Respondents may not have expected monitoring the patient’s exact
2 vital signs to provide them any additional actionable intelligence, the patient required
3 resuscitation while loading the ambulance and on the way to the hospital. Promptly and
4 adequately measuring the patient’s vital signs and conducting a timely physical assessment
5 with focused ALS exam, and implementing the cardiac monitoring required by SCEMSA
6 Document No. 2061.19 immediately after administering Glucagon may well have facilitated
7 earlier intervention to prevent or mitigate the patient’s respiratory distress.

8 67. Therefore, for the reasons stated above, Complainant did prove Respondents
9 failed to adequately check the patient’s pulse, airway, and breathing. Consequently, that
10 allegation may provide cause to discipline their licenses for gross negligence, incompetence,
11 violating the regulations governing prehospital personnel, or functioning outside the
12 supervision of medical control in the field care system operating at the local level.

13 Moving the Patient Out of the Prone Position

14 68. Dr. Stratton also opined in his report that Respondents erred in their “failure to
15 move the patient from the prone position to the lateral or supine position once restraints were
16 secure.” This opinion was persuasive for two reasons.

17 69. Dr. Stratton recognized in his written report that “Patient [was] restrained by
18 handcuffs by police in standard prone position.” He credibly testified at hearing that
19 Respondents should have repositioned the patient from prone to either lateral or supine as soon
20 as the “cuffs” were applied. He added that, in these circumstances, Respondents should have
21 asked the police officers to either reposition the patient or allow Respondents to reposition him.

22 70. Chief Saylor, Dr. Kazan, and Mr. Bennett explained their belief that
23 Respondents did not have statutory authority to make demands of the officers with regard to
24 how they restrained the patient, but this is not remotely persuasive when applied to the facts
25 here. None of these individuals are legal experts with particular expertise to expound on the
meaning of a particular statute. Furthermore, police officers responded to the scene for the
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1 purpose of assisting Respondents and were very responsive to Respondents' requests to restrain
2 the patient *so that paramedics could evaluate and treat the patient*, as well as regarding the
3 later transition to soft restraints. There is no reason to assume that the officers would have
4 suddenly refused to cooperate with a request by Respondents for assistance with repositioning
5 the patient. Here, Respondents simply failed to communicate with officers about the need to
6 move patient out of the prone position.

7 71. Therefore, for the reasons stated above, Complainant did prove Respondents
8 failed to move the patient out of the prone position. Consequently, that allegation may provide
9 cause to discipline their licenses for gross negligence, incompetence, violating the regulations
10 governing prehospital personnel, or functioning outside the supervision of medical control in
11 the field care system operating at the local level.

12 LEGAL CONCLUSIONS

13 Burden and Standard of Proof

14 1. The standard of proof for this matter is "clear and convincing evidence."
15 (*Ettinger v. Bd. Of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) This means
16 the burden rests on Complainant to establish the charging allegations by proof that is clear,
17 explicit, and unequivocal, as to leave no substantial doubt, and sufficiently strong to command
18 the unhesitating assent of every reasonable mind. (*In re Marriage of Weaver* (1990) 224
19 Cal.App.3d 478, 487.)

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

1 **Alleged Causes for Discipline**

2 Gross Negligence

3 3. The Authority may discipline a paramedic’s license for gross negligence.
4 (Health & Saf. Code, § 1798.200, subd. (c)(2).) California courts have defined gross negligence
5 as “the want of even scant care or an extreme departure from the ordinary standard of care.”
6 (*Kearl v. Bd. of Medical Quality Assurance* (1986) 189 Cal.App.3rd 1040, 1052.) In contrast,
7 simple negligence is merely a departure from the standard of care.

8 4. The standard of care applicable to a medical professional must be established by
9 expert testimony. (*Elcome v. Chin* (2003) 110 Cal.App.4th 310, 317.) The standard of care
10 typically requires the exercise of a reasonable degree of skill, knowledge, and care that is
11 ordinarily possessed and exercised by members of the medical profession under similar
12 circumstances. It is often a function of custom and practice. (*Osborn v. Irwin Memorial Blood*
13 *Bank* (1992) 5 Cal.App.4th 234, 280.)

14 5. As discussed in Factual Findings 32, 59–61, and 69, above, expert witnesses
15 articulated both at hearing and in their written reports that the paramedic standard of care when
16 responding to the scene of a medical emergency includes: (1) obtaining the patient’s vital signs
17 anytime there is a change in the patient’s acute status, when the patient receives medication, or,
18 absent those circumstances, every five to ten minutes; (2) performing timely paramedic
19 assessments of the patient with a medical emergency, including a focused ALS exam; and (3)
20 avoid prone positioning of a patient, particularly when the patient is restrained.

21 6. As discussed in Factual Findings 59–67, Respondents failed to meet this
22 standard of care. While this breach may constitute negligence, a single instance of negligent
23 treatment is not grounds for discipline of a licensed medical professional. (*Gromis v. Medical*
24 *Bd.* (1992) 8 Cal.App.4th 589, 600.)

25 7. There is plentiful evidence in the record that, while Respondents Holleman,
Simons, and Carvalho made mistakes that amounted to a breach of the paramedic standard of
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1 care, they were acting in good faith and were motivated by a desire to efficiently transport the
2 patient to a hospital. This is readily distinguishable from the definition of gross negligence.

3 8. However, there is also clear and convincing evidence that Respondent Klein
4 showed a concerning disregard for his duties as a licensed paramedic while responding to a
5 medical emergency, such that his blatant inaction with regard to the patient's medical needs
6 during the emergency constitutes an extreme deviation from the applicable standards of care.
7 (See Factual Findings 14–15, 42, and 52, above.)

8 9. As discussed in Factual Findings 42 and 51, above, Respondent Klein asserts
9 that he was not acting in the role of a paramedic. However, this is not persuasive in a matter of
10 license discipline regarding an active licensee. (See Factual Finding 1, above.) A licensed
11 paramedic's statutory scope of practice¹⁶ is not altered by a change in their job title; nor does
12 the standard of care for paramedics responding to a medical emergency include any such
13 exclusion. Furthermore, as the captain on the scene, Respondent Klein ultimately bears
14 responsibility for failing to ensure that applicable standards of care are met.

15 10. Consequently, PDRB finds that the record does constitute clear and convincing
16 evidence that Respondent Klein's acts and omissions as a licensed paramedic responding to
17 this medical emergency amount to gross negligence. As such, cause exists to discipline his
18 license pursuant to Health and Safety Code section 1798.200, subdivision (c)(2).

19 11. However, PDRB finds no such evidence of similar disregard or extreme
20 deviation from the standard of care by Respondents Holleman, Simons, and Carvalho. As
21 such, no cause exists to discipline their licenses pursuant to Health and Safety Code section
22 1798.200, subdivision (c)(2).

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¹⁶ See California Health and Safety Code, section 1797.84.

1 Incompetence

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

6 Violating Regulations Pertaining to Prehospital Personnel

7 13. The Authority may discipline a paramedic’s license for “[v]iolating or
8 attempting to violate directly or indirectly, or assisting in or abetting the violation of, or
9 conspiring to violate, any provision of [the EMS Act] or the regulations adopted by the
10 authority pertaining to prehospital personnel.” (Health & Saf. Code, § 1798.200, subd. (c)(7).)
11 However, Complainant failed to identify any such statute or regulation which Respondents
12 were alleged to have violated or to have attempted, assisted, abetted, or conspired to violate. As
13 a result, Complainant did not prove that Respondents’ licenses are subject to discipline for
14 violating regulations pertaining to prehospital personnel.

15 Functioning Outside the Supervision of Medical Control

16 14. The Authority may also discipline a paramedic’s license for “[f]unctioning
17 outside the supervision of medical control in the field care system operating at the local level,
18 except as authorized by any other license or certification.” (Health & Saf. Code, § 1798.200,
19 subd. (c)(10).)

20 15. Here, Complainant alleged that Respondents violated three SCEMSA policies
21 when caring for the patient: SCEMSA Document No. 8062.10 (Behavioral Crisis/Restraint),
22 SCEMSA Document No. 8002.02 (Diabetic Emergency), and SCEMSA Document No.
23 8061.19 (Decreased Sensorium). However, as discussed in Factual Finding 32, above, only one
24 of those policies, SCEMSA Document No. 8061.19, was effective as of February 2020. That
25 policy is titled “Decreased Sensorium” and describes the procedures EMTs and paramedics
must follow when assisting “patients exhibiting signs and symptoms of decreased sensorium.”
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1 (See Factual Finding 22, above.)

2 16. As discussed in Factual Finding 32, above, Dr. Stratton opined that SCEMSA
3 Document No. 8061.19, which includes a protocol for suspected hypoglycemia, is part of the
4 paramedic standard of care under these circumstances. As discussed in Factual Findings 22 and
5 32, above, the suspected hypoglycemia protocol in this policy provides clinical guidelines for
6 administering either Glucagon or dextrose to a hypoglycemic patient, depending on their exact
7 circumstances. Consistent with this protocol, Respondents tested the patient's blood sugar and
8 administered the appropriate medication. (Factual Finding 12, above.)

9 17. However, as summarized in Factual Finding 22 and 32, above, the ALS protocol
10 for suspected hypoglycemia in SCEMSA Document No. 8061.19 requires more than simply
11 administering medication. Once Glucagon has been administered, this protocol requires that the
12 treating paramedic(s) provide specified follow-up medical care:

- 13 i. IO access should be established if IV access is unavailable and if
14 the blood sugar \leq 60 mg/dl or decreased responsiveness continues
15 for more than five (5) minutes after administration of Glucagon.
16 ii. Cardiac monitoring.

17 18. There is no indication that any of the Respondents re-tested the patient's blood
18 sugar in the relevant timeframe following the Glucagon injection. However, there is an
19 abundance of evidence in the record that the patient experienced decreased responsiveness for
20 more than five minutes, as discussed in Factual Findings 59 and 63, above. Accordingly,
21 Respondents still should have established IO access as indicated, but the substantial body of
22 admitted evidence demonstrates that Respondents ignored this part of the protocol.

23 19. Additionally, the ALS protocol for suspected hypoglycemia in SCEMSA
24 Document No. 8061.19 requires cardiac monitoring upon administering the medication. Clear
25 and convincing evidence demonstrates that Respondents failed to establish cardiac monitoring
during the relevant timeframe. Even though Respondents had their cardiac monitoring
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1 equipment in the room where they found the patient and began treatment, Respondents delayed
2 monitoring by at least five minutes, until they were at the ambulance instead of implementing
3 this requirement right away. (Factual Findings 13–15, 59, and 63, above.) Factual Findings 14,
4 46, and 55–56, above, demonstrate that Respondents instead prioritized the transition from
5 handcuffs to soft restraints and preparing for transport.

6 20. Respondents contend that they were not responsible for delays occurring while
7 the patient was restrained by police. Health and Safety Code section 1798.6 states:

8 (a) *Authority for patient health care management in an emergency*
9 *shall be vested in that licensed or certified health care professional,*
10 *which may include any paramedic or other prehospital emergency*
11 *personnel, at the scene of the emergency who is most medically*
12 *qualified specific to the provision of rendering emergency medical*
13 *care. If no licensed or certified health care professional is available,*
14 *the authority shall be vested in the most appropriate medically*
15 *qualified representative of public safety agencies who may have*
16 *responded to the scene of the emergency.*

17 ...

18 (c) Notwithstanding subdivision (a), authority for the management
19 of the scene of an emergency shall be vested in the appropriate
20 public safety agency having primary investigative authority. The
21 scene of an emergency shall be managed in a manner designed to
22 minimize the risk of death or health impairment to the patient and
23 to other persons who may be exposed to the risks as a result of the
24 emergency condition, and *priority shall be placed upon the*
25 *interests of those persons exposed to the more serious and*
 immediate risks to life and health. Public safety officials shall

1 *consult emergency medical services personnel or other*
2 *authoritative health care professionals at the scene* in the
3 determination of relevant risks. (Emphasis added.)

4 21. As discussed in Factual Findings 36, 43, 50, and 70, above, Respondents assert
5 that the police officers' restraint of the patient with handcuffs and in the prone position
6 prevented Respondents from establishing cardiac monitoring of the patient until police later
7 released the handcuffs. Respondents argue that Health and Safety Code, section 1798.6,
8 subdivision (c) should be interpreted as authorizing scene management efforts to interfere with
9 rendering emergency medical care, on the basis that its granting of scene management authority
10 to the "public safety agency having primary investigative authority" allocates full discretion
11 regarding the manner of restraint here to the assisting police officers, such that Respondents
12 had no authority to direct police officers to adjust the patient's restraints or physical position.

13 22. However, as discussed in Factual Finding 70, above, Respondents' argument is
14 not persuasive, as it disregards that police officers were present at Respondents' request and
15 restrained the patient for the express purpose of facilitating Respondents' evaluation and
16 treatment of the patient during a medical emergency. (Factual Findings 10–11 and 53, above.)
17 The evidence, including body camera footage, demonstrates that the officers were consistently
18 cooperative with Respondents and receptive to Respondents' guidance and requests, including
19 with regard to: restraint of the patient, facilitating Respondents' access to test the patient's
20 blood sugar levels and administer the Glucagon injection while the patient was restrained, and
21 transitioning the patient to other restraints for transport. (Factual Findings 12–15 and 54,
22 above.) In contrast, there is no evidence that Respondents even asked police to adjust their
23 restraint so that Respondents could establish cardiac monitoring, or any basis for assuming that
24 police would have rejected such a request.

25 23. Additionally, such an interpretation of Health and Safety Code section 1798.6
 would disregard (1) the statute's overarching purpose of facilitating collaboration between
 Decision and Order – Klein, et al.

1 health care professionals and public safety agencies responding to emergencies, with respect to
2 their complementary areas of expertise; (2) the role of SFD paramedics responding to this
3 medical emergency as both health care personnel and the public safety agency with primary
4 responsibility for evaluating and responding to the medical aid call; the prioritization of
5 “minimiz[ing] the risk of death or health impairment . . . of those persons exposed to the more
6 serious and immediate risks to life and health;” and the mandate that the public safety agency
7 consult with EMS personnel to determine those risks.

8 24. As discussed in Factual Findings 42 and 51, above, Respondent Klein asserts
9 that he was not acting in the role of a paramedic. However, this is not persuasive in a matter of
10 license discipline regarding an active licensee. (See Factual Finding 1, above.) A licensed
11 paramedic’s statutory scope of practice¹⁷ is not altered by a change in their job title; nor does
12 SCEMSA Document No. 8061.19 include any such exclusion. Furthermore, as the captain on
13 the scene, Respondent Klein ultimately bears responsibility for failing to ensure that applicable
14 SCEMSA medical control protocols, including Document No. 8061.19, were followed.

15 25. Consequently, PDRB finds that the record does include clear and convincing
16 evidence that Respondents initiated but then inappropriately abandoned this policy’s ALS
17 protocol for suspected hypoglycemia, thereby violating SCEMSA policy 8061.19. As such,
18 cause exists to discipline their licenses pursuant to Health and Safety Code section 1798.200,
19 subdivision (c)(10).

20 26. Additionally, Complainant proffered into evidence SCEMSA Document No.
21 8062.08, as the prior version of Document No. 8062.10 asserted to have been in effect as of
22 February 2020. Respondents argue that, for various reasons, the document is not admissible as
23 new evidence at this time. PDRB declines to decide this question, as it is now moot to the
24

25
¹⁷ See California Health and Safety Code, section 1797.84.

1 determination of Respondents' liability for violating Health and Safety Code section 1798.200,
2 subdivision (c)(10).

3 **Disciplinary Action**

4 27. With causes for disciplinary action established, PDRB has discretion to
5 determine the suitable licensure discipline for paramedics, subject to the legislative mandate
6 that PDRB's highest priority should be protection of the public (Health & Saf. Code, §§
7 1797.125, 1797.197(d), 1798.200(b)(2).) Additionally, EMSA has adopted Recommended
8 Guidelines for Disciplinary Orders and Conditions of Probation, dated July 26, 2008
9 (Guidelines). (Cal. Code Regs., tit. 22, § 100111.01, subd. (c).) The Guidelines require
10 consideration of the following factors to determine appropriate discipline: (1) nature and
11 severity of the acts or offenses; (2) actual or potential harm to the public; (3) actual or potential
12 harm to any patient; (4) prior disciplinary record; (5) prior warnings on record or prior
13 remediation; (6) number and/or variety of current violations; (7) aggravating evidence; (8)
14 mitigating evidence; (9) any discipline imposed by the paramedic's employer for the same
15 occurrence of that conduct; (10) rehabilitation evidence; (11) for a criminal conviction,
16 compliance with sentence or probation; (12) overall criminal record; (13) time that has elapsed
17 since the acts or offenses occurred; and (14) evidence of expungement proceedings, if
18 applicable. (See also Cal. Code Regs., tit. 22, § 100111.04.)

19 28. For a violation that involves gross negligence, the Guidelines recommend a
20 stayed revocation, a 60-day suspension, and three years of probation.

21 29. For a violation that involves functioning outside the supervision of medical
22 control in the field care system operating at the local level, except as authorized by any other
23 license or certification, the Guidelines recommend a stayed revocation, 15-day suspension, and
24 one year of probation.

25 30. As discussed in Factual Finding 1 above, Respondent Klein has a prior record of
license discipline. Respondent Klein's gross negligence and deviation from applicable
Decision and Order – Klein, et al.

1 SCEMSA medical control protocols on February 25, 2020, are serious. He departed from the
2 standard of care so significantly that his own proffered expert witnesses readily assessed
3 Respondent Klein was not even acting as a paramedic during SFD's response to this medical
4 emergency. Respondent Klein's gross negligence and deviation from the applicable SCEMSA
5 treatment standard for Decreased Sensorium demonstrate a concerning disregard for the
6 patient's wellbeing, constituting a present or potential unfitness to practice as a paramedic.
7 Respondent Klein was disciplined in relation to the February 25, 2020 incident by his employer
8 as follows: he was suspended without pay for two- hundred and forty hours, i.e. ten 24-hour
9 shifts, his pay was reduced from Step 5 to Step 3 for twenty-six (26) bi-weekly pay periods, and
10 his paramedic sponsorship was revoked for two (2) years, which resulted in his ineligibility to
11 sign up for paramedic assignment and loss of paramedic pay. Respondent Klein offered no
12 evidence of rehabilitation and continued to assert he had no responsibility for overseeing any
13 medical care provided by the paramedics under his command on February 20, 2025, despite
14 visible changes in the patient's presentation and questions from police and the patient's mother
15 as discussed above.

16 31. The board gives great consideration to the disciplinary factors and evidence of
17 prior discipline imposed by Respondent Klein's employer and finds that stayed revocation of
18 his licenses and three years' of probation and relevant educational coursework are sufficient at
19 this juncture to ensure public protection.

20 32. As discussed in Factual Finding 2, above, Respondent Carvalho has no prior
21 record of license discipline or unrelated work discipline. While he committed a single violation
22 of deviating from the applicable SCEMSA treatment standard for Decreased Sensorium, if
23 prompt cardiac monitoring of the patient had been implemented as required by SCEMSA
24 Document No. 8061.19, it may have facilitated earlier intervention and potentially saved this
25 patient's life. However, Respondent Carvalho was not motivated by any improper purpose,
but in good faith attempted to expedite the patient's arrival to a hospital. Respondent Carvalho
Decision and Order – Klein, et al. Page 37 of 48

1 was disciplined in relation to the February 25, 2020 incident by his employer as follows: he
2 was suspended without pay for two- hundred and forty hours, i.e. ten 24-hour shifts, his pay
3 was reduced from Step 5 to Step 3 for twenty-six (26) bi-weekly pay periods, and his
4 paramedic sponsorship was revoked for two (2) years, which resulted in his ineligibility to sign
5 up for paramedic assignment and loss of paramedic pay.

6 33. As discussed in Factual Finding 3, above, Respondent Holleman has no prior
7 record of license discipline or unrelated work discipline. While he committed a single violation
8 of deviating from the applicable SCEMSA treatment standard for Decreased Sensorium, if
9 prompt cardiac monitoring of the patient had been implemented as required by SCEMSA
10 Document No. 8061.19, it may have facilitated earlier intervention and potentially saved this
11 patient's life. However, Respondent Holleman was not motivated by any improper purpose, but
12 in good faith attempted to expedite the patient's arrival to a hospital. Respondent Holleman
13 was disciplined in relation to the February 25, 2020 incident by his employer as follows: he
14 was suspended without pay for two- hundred and forty hours, i.e. ten 24-hour shifts, his pay
15 was reduced from Step 5 to Step 3 for twenty-six (26) bi-weekly pay periods, and his
16 paramedic sponsorship was revoked for two (2) years, which resulted in his ineligibility to sign
17 up for paramedic assignment and loss of paramedic pay.

18 34. As discussed in Factual Finding 4 above, Respondent Simons has no prior
19 record of license discipline or unrelated work discipline. While he committed a single violation
20 of deviating from the applicable SCEMSA treatment standard for Decreased Sensorium, if
21 prompt cardiac monitoring of the patient had been implemented as required by SCEMSA
22 Document No. 8061.19, it may have facilitated earlier intervention and potentially saved this
23 patient's life. However, Respondent Simons was not motivated by any improper purpose, but
24 in good faith attempted to expedite the patient's arrival to a hospital. Respondent Simons was
25 disciplined in relation to the February 25, 2020 incident by his employer as follows: he was
suspended without pay for two- hundred and forty hours, i.e. ten 24-hour shifts, his pay was
Decision and Order – Klein, et al.

1 reduced from Step 5 to Step 3 for twenty-six (26) bi-weekly pay periods, and his paramedic
2 sponsorship was revoked for two (2) years, which resulted in his ineligibility to sign up for
3 paramedic assignment and loss of paramedic pay.

4 35. Respondents Simons, Holleman, and Carvalho all produced letters of support
5 from various fire chiefs, and fire captains. They all provided evidence of good employment
6 reviews, and no history of licensure discipline. Notably Respondent Carvalho submitted
7 recognition of service beyond the call of duty to Station 12 A shift dated November 20, 2012,
8 for saving the life of a police lieutenant who suffered a massive heart attack.

9 36. PDRB gives great consideration to the disciplinary factors and evidence of prior
10 discipline imposed by the employer of Respondents Simons, Holleman, and Carvalho
11 Respondents' employer and finds that stayed revocation of their licenses and one year of
12 probation for each is sufficient at this juncture given the consideration that Respondents
13 Simons, Holleman, and Carvalho continued work in the field, and they kept up with their
14 licensure requirements without any interim disciplinary problems supports the public is
15 sufficiently protected.

16 37. When all the evidence is considered, stayed revocation of Respondent Klein's
17 license and three years' probation is the appropriate discipline. More specifically, further
18 education tailored to the issues that arose in this incident may help Respondent Klein to avoid
19 similar future errors.

20 38. When all the evidence is considered, the appropriate discipline for Respondents
21 Holleman, Simons, and Carvalho is stayed revocation and one year probation for each. More
22 specifically, further education tailored to the issues that arose in this incident may help
23 Respondents Holleman, Simons, and Carvalho to avoid similar future errors.

1 **ORDER**

2 **With respect to Respondent Klein:**

3 License Number P15057 issued to Respondent JEFFREY S. KLEIN is revoked pursuant
4 to legal conclusions 10 and 25, jointly and separately. However, such revocation is stayed and
5 Respondent Klein is placed on probation for three (3) years upon the following terms and
6 conditions:

7 Standard Conditions of Probation

8 It is the responsibility of EMSA to monitor paramedics placed on probation consistent
9 with the terms and conditions of the probationary order.

10 **1. Probation Compliance:** The respondent shall fully comply with all terms and
11 conditions of the probationary order. The respondent shall fully comply with
12 EMSA in its monitoring, investigation, and evaluation of the respondent's
13 compliance with the terms and conditions of their probationary order.

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

16 **2. Personal Appearances:** As directed by EMSA, the respondent shall appear in
17 person for interviews, meetings, and/or evaluations of the respondent's
18 compliance with the terms and conditions of the probationary order. The
19 respondent shall be responsible for all of their costs associated with this
20 requirement.

21 **3. Quarterly Report Requirements:** During the probationary period, the
22 respondent shall submit quarterly reports covering each calendar quarter which
23 shall certify, under penalty of perjury, and document compliance by the
24 respondent with all the terms and conditions of their probation. If the respondent
25 submits their quarterly reports by mail, it shall be sent by certified mail.

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

Additionally, the respondent shall submit proof in writing to 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. The respondent authorizes any EMS employer to submit performance evaluations and other reports which EMSA may request that relate to the qualifications, functions, and duties of prehospital personnel.

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

5. Notification of Termination: The respondent shall notify EMSA within seventy-two (72) hours after termination, for any reason, with their prehospital medical care employer. The respondent must provide a full, detailed written explanation of the reasons for, and circumstances of, their termination.

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

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

If the respondent, during their probationary period, leaves the jurisdiction of California to practice as a paramedic, the respondent must immediately notify 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 EMSA shall be by certified mail.

1 **7. Obey All Related Laws:** The respondent shall obey all federal, state, and local
2 laws, statutes, regulations, written policies, protocols, and rules governing the
3 practice of medical care as a paramedic. The respondent shall not engage in any
4 conduct that is grounds for disciplinary action pursuant to Section 1798.200. To
5 permit monitoring of compliance with this term, if the respondent has not
6 submitted fingerprints to EMSA in the past as a condition of licensure, then the
7 respondent shall submit their fingerprints by Live Scan or by fingerprint cards
8 and pay the appropriate fees within forty-five (45) days of the effective date of
9 this decision.

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

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

17 **8. Completion of Probation:** The respondent's license shall be fully restored upon
18 successful completion of probation.

19 **9. Violation of Probation:** If, during the period of probation, the respondent fails
20 to comply with any term of probation, EMSA may initiate action to terminate
21 probation and implement actual license suspension/revocation. Upon the
22 initiation of such an action, or the giving of a notice to the respondent of the
23 intent to initiate such an action, the period of probation shall remain in effect
24 until such a time as a decision on the matter has been adopted by EMSA. An
25 action to terminate probation and implement actual license suspension/revocation

1 shall be initiated and conducted pursuant to the hearing provisions of the
2 California Administrative Procedure Act.

3 The issues to be resolved at the hearing shall be limited to whether the
4 respondent has violated any term of their probation sufficient to warrant
5 termination of probation and implementation of actual suspension/revocation. At
6 the hearing, the respondent and EMSA shall be bound by the admissions
7 contained in the terms of probation and neither party shall have a right to litigate
8 the validity or invalidity of such admissions.

9 Additional Condition of Probation

10 **5. Educational Course Work:** Within one hundred and twenty (120) days of the
11 effective date of this decision, the respondent shall submit to EMSA proof of
12 completion of four (4) hours of education in areas substantially related to patient
13 restraints, airway management, and behavioral emergencies (preferably including
14 intra-agency collaboration), and an additional four (4) hours of education in areas
15 substantially related to EMS leadership or scene management. Any educational
16 program may include community service to reinforce the learning objectives of
17 the educational program.

18 All courses must be approved by EMSA. Within thirty-five (35) days after
19 completing the course work, the respondent shall submit evidence of competency
20 in the required education. Submittal of a certificate or letter from the instructor
21 attesting to the respondent's competency shall suffice.

22 Any and all notifications to EMSA shall be by certified mail.
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1 **With respect to Respondents Holleman, Simons, and Carvalho:**

2 License Number P27586 issued to Respondent SEAN M. HOLLEMAN is revoked
3 pursuant to legal conclusion 25. However, such revocation is stayed and Respondent
4 Holleman's license is placed on probation for one (1) year upon the following terms and
5 conditions (see below).

6 License Number P29304 issued to Respondent CLINTON R. SIMONS is revoked
7 pursuant to legal conclusion 25. However, such revocation is stayed and Respondent Simons's
8 license is placed on probation for one (1) year upon the following terms and conditions (see
9 below).

10 License Number P21870 issued to Respondent SCOTT W. CARAVALHO is revoked
11 pursuant to legal conclusion 25. However, such revocation is stayed and Respondent
12 Carvalho's license is placed on probation for one (1) year upon the following terms and
13 conditions:

14 Standard Conditions of Probation

15 It is the responsibility of EMSA to monitor paramedics placed on probation consistent
16 with the terms and conditions of the probationary order.

17 **1. Probation Compliance:** The respondent shall fully comply with all terms and
18 conditions of the probationary order. The respondent shall fully comply with
19 EMSA in its monitoring, investigation, and evaluation of the respondent's
20 compliance with the terms and conditions of their probationary order.

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

23 **2. Personal Appearances:** As directed by EMSA, the respondent shall appear in
24 person for interviews, meetings, and/or evaluations of the respondent's
25 compliance with the terms and conditions of the probationary order. The

1 respondent shall be responsible for all of their costs associated with this
2 requirement.

3 **3. Quarterly Report Requirements:** During the probationary period, the
4 respondent shall submit quarterly reports covering each calendar quarter which
5 shall certify, under penalty of perjury, and document compliance by the
6 respondent with all the terms and conditions of their probation. If the respondent
7 submits their quarterly reports by mail, it shall be sent by certified mail.

8 **4. Employment Notification:** During the probationary period, the respondent shall
9 notify EMSA in writing of any EMS employment. The respondent shall inform
10 EMSA in writing of the name and address of any prospective EMS employer
11 prior to accepting employment.

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

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

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

19 **5. Notification of Termination:** The respondent shall notify EMSA within
20 seventy-two (72) hours after termination, for any reason, with their prehospital
21 medical care employer. The respondent must provide a full, detailed written
22 explanation of the reasons for, and circumstances of, their termination.

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

24 **6. Functioning as a Paramedic:** The period of probation shall not run anytime that
25 the respondent is not practicing as a paramedic within the jurisdiction of
 California.

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

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

6 **7. Obey All Related Laws:** The respondent shall obey all federal, state, and local
7 laws, statutes, regulations, written policies, protocols, and rules governing the
8 practice of medical care as a paramedic. The respondent shall not engage in any
9 conduct that is grounds for disciplinary action pursuant to Section 1798.200. To
10 permit monitoring of compliance with this term, if the respondent has not
11 submitted fingerprints to EMSA in the past as a condition of licensure, then the
12 respondent shall submit their fingerprints by Live Scan or by fingerprint cards
13 and pay the appropriate fees within forty-five (45) days of the effective date of
14 this decision.

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

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

22 **8. Completion of Probation:** The respondent's license shall be fully restored upon
23 successful completion of probation.

24 **9. Violation of Probation:** If, during the period of probation, the respondent fails
25 to comply with any term of probation, EMSA may initiate action to terminate

1 probation and implement actual license suspension/revocation. Upon the
2 initiation of such an action, or the giving of a notice to the respondent of the
3 intent to initiate such an action, the period of probation shall remain in effect
4 until such a time as a decision on the matter has been adopted by EMSA. An
5 action to terminate probation and implement actual license suspension/revocation
6 shall be initiated and conducted pursuant to the hearing provisions of the
7 California Administrative Procedure Act.

8 The issues to be resolved at the hearing shall be limited to whether the
9 respondent has violated any term of their probation sufficient to warrant
10 termination of probation and implementation of actual suspension/revocation. At
11 the hearing, the respondent and EMSA shall be bound by the admissions
12 contained in the terms of probation and neither party shall have a right to litigate
13 the validity or invalidity of such admissions.

14 Additional Condition of Probation

15 **5. Educational Course Work:** Within one hundred and twenty (120) days of the
16 effective date of this decision, the respondent shall submit to EMSA proof of
17 completion of four (4) hours of education in areas substantially related to patient
18 restraints, airway management, and behavioral emergencies (preferably including
19 intra-agency collaboration). Any educational program may include community
20 service to reinforce the learning objectives of the educational program.

21 All courses must be approved by EMSA. Within thirty-five (35) days after
22 completing the course work, the respondent shall submit evidence of competency
23 in the required education. Submittal of a certificate or letter from the instructor
24 attesting to the respondent's competency shall suffice.

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

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This Decision shall become effective fifteen (15) days from the date of the signature below.

Dated: July 18, 2025



JANE KANG
Acting Chair, Paramedic Disciplinary Review Board
Emergency Medical Services Authority
State of California

**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. CARVALHO, 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 Carvalho (respondent Carvalho) 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 Carvalho 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 Carvalho renewed his license. Respondent Carvalho 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 Carvalho 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 Carvalho 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 Carvalho 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, Carvalho, Simons, and Munson then lifted the patient onto the gurney. The officers then released the handcuffs, and respondents Holleman and Carvalho immediately turned him onto his back. Respondents Holleman, Carvalho, and Simons then secured the soft restraints to the gurney. Respondents Holleman and Carvalho 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 policies 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 Carvalho 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 Carvalho 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 Carvalho 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 Carvalho 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 Saylor to review the matter and evaluate respondent Klein's actions related to the incident in question. Chief Saylor 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 Saylor reviewed several items, including the police officers' body camera footage and the Sacramento City First Department Manual of Operations. Based thereon, Chief Saylor 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 Saylor 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 Saylor 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 Saylor 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 Saylor 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 Saylor 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 Saylor and Dr. Kazan disagreed with Dr. Stratton. Chief Saylor 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 Saylor 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 Carvalho] 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 Saylor 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 Saylor 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 Saylor 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 Saylor, 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 Carvalho, Sean Holleman, and Clinton Simons, are DISMISSED.

DATE: March 3, 2025



SEAN GAVIN

Administrative Law Judge

Office of Administrative Hearings



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GOVERNMENT CODE - GOV

TITLE 2. GOVERNMENT OF THE STATE OF CALIFORNIA [8000 - 22980] (*Title 2 enacted by Stats. 1943, Ch. 134.*)

DIVISION 3. EXECUTIVE DEPARTMENT [11000 - 15990.3] (*Division 3 added by Stats. 1945, Ch. 111.*)

PART 1. STATE DEPARTMENTS AND AGENCIES [11000 - 11898] (*Part 1 added by Stats. 1945, Ch. 111.*)

CHAPTER 5. Administrative Adjudication: Formal Hearing [11500 - 11529] (*Heading of Chapter 5 amended by Stats. 1995, Ch. 938, Sec. 22.*)

11521. (a) The agency itself may order a reconsideration of all or part of the case on its own motion or on petition of any party. The agency shall notify a petitioner of the time limits for petitioning for reconsideration. The power to order a reconsideration shall expire 30 days after the delivery or mailing of a decision to a respondent, or on the date set by the agency itself as the effective date of the decision if that date occurs prior to the expiration of the 30-day period or at the termination of a stay of not to exceed 30 days which the agency may grant for the purpose of filing an application for reconsideration. If additional time is needed to evaluate a petition for reconsideration filed prior to the expiration of any of the applicable periods, an agency may grant a stay of that expiration for no more than 10 days, solely for the purpose of considering the petition. If no action is taken on a petition within the time allowed for ordering reconsideration, the petition shall be deemed denied.

(b) The case may be reconsidered by the agency itself on all the pertinent parts of the record and such additional evidence and argument as may be permitted, or may be assigned to an administrative law judge. A reconsideration assigned to an administrative law judge shall be subject to the procedure provided in Section 11517. If oral evidence is introduced before the agency itself, no agency member may vote unless he or she heard the evidence.

(*Amended by Stats. 2004, Ch. 865, Sec. 34. Effective January 1, 2005.*)

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GOVERNMENT CODE - GOV**TITLE 2. GOVERNMENT OF THE STATE OF CALIFORNIA [8000 - 22980]** (*Title 2 enacted by Stats. 1943, Ch. 134.*)**DIVISION 3. EXECUTIVE DEPARTMENT [11000 - 15990.3]** (*Division 3 added by Stats. 1945, Ch. 111.*)**PART 1. STATE DEPARTMENTS AND AGENCIES [11000 - 11898]** (*Part 1 added by Stats. 1945, Ch. 111.*)**CHAPTER 5. Administrative Adjudication: Formal Hearing [11500 - 11529]** (*Heading of Chapter 5 amended by Stats. 1995, Ch. 938, Sec. 22.*)

11523. Judicial review may be had by filing a petition for a writ of mandate in accordance with the provisions of the Code of Civil Procedure, subject, however, to the statutes relating to the particular agency. Except as otherwise provided in this section, the petition shall be filed within 30 days after the last day on which reconsideration can be ordered. The right to petition shall not be affected by the failure to seek reconsideration before the agency. On request of the petitioner for a record of the proceedings, the complete record of the proceedings, or the parts thereof as are designated by the petitioner in the request, shall be prepared by the Office of Administrative Hearings or the agency and shall be delivered to the petitioner, within 30 days after the request, which time shall be extended for good cause shown, upon the payment of the cost for the preparation of the transcript, the cost for preparation of other portions of the record and for certification thereof. The complete record includes the pleadings, all notices and orders issued by the agency, any proposed decision by an administrative law judge, the final decision, a transcript of all proceedings, the exhibits admitted or rejected, the written evidence and any other papers in the case. If the petitioner, within 10 days after the last day on which reconsideration can be ordered, requests the agency to prepare all or any part of the record, the time within which a petition may be filed shall be extended until 30 days after its delivery to him or her. The agency may file with the court the original of any document in the record in lieu of a copy thereof. If the petitioner prevails in overturning the administrative decision following judicial review, the agency shall reimburse the petitioner for all costs of transcript preparation, compilation of the record, and certification.

(*Amended by Stats. 2005, Ch. 674, Sec. 23. Effective January 1, 2006. Operative July 1, 1997, by Sec. 98 of Ch. 938.*)



CODE OF CIVIL PROCEDURE - CCP

PART 2. OF CIVIL ACTIONS [307 - 1062.34] (Part 2 enacted 1872.)

TITLE 14. OF MISCELLANEOUS PROVISIONS [989 - 1062.34] (Title 14 enacted 1872.)

CHAPTER 5. Notices, and Filing and Service of Papers [1010 - 1020] (Chapter 5 enacted 1872.)

1013. (a) In case of service by mail, the notice or other paper shall be deposited in a post office, mailbox, subpost office, substation, or mail chute, or other like facility regularly maintained by the United States Postal Service, in a sealed envelope, with postage paid, addressed to the person on whom it is to be served, at the office address as last given by that person on any document filed in the cause and served on the party making service by mail; otherwise at that party's place of residence. Service is complete at the time of the deposit, but any period of notice and any right or duty to do any act or make any response within any period or on a date certain after service of the document, which time period or date is prescribed by statute or rule of court, shall be extended five calendar days, upon service by mail, if the place of address and the place of mailing is within the State of California, 10 calendar days if either the place of mailing or the place of address is outside the State of California but within the United States, 12 calendar days if the place of address is the Secretary of State's address confidentiality program (Chapter 3.1 (commencing with Section 6205) of Division 7 of Title 1 of the Government Code), and 20 calendar days if either the place of mailing or the place of address is outside the United States, but the extension shall not apply to extend the time for filing notice of intention to move for new trial, notice of intention to move to vacate judgment pursuant to Section 663a, or notice of appeal. This extension applies in the absence of a specific exception provided for by this section or other statute or rule of court.

(b) The copy of the notice or other paper served by mail pursuant to this chapter shall bear a notation of the date and place of mailing or be accompanied by an unsigned copy of the affidavit or certificate of mailing.

(c) In case of service by Express Mail, the notice or other paper shall be deposited in a post office, mailbox, subpost office, substation, or mail chute, or other like facility regularly maintained by the United States Postal Service for receipt of Express Mail, in a sealed envelope, with Express Mail postage paid, addressed to the person on whom it is to be served, at the office address as last given by that person on any document filed in the cause and served on the party making service by Express Mail; otherwise at that party's place of residence. In case of service by another method of delivery providing for overnight delivery, the notice or other paper shall be deposited in a box or other facility regularly maintained by the express service carrier, or delivered to an authorized courier or driver authorized by the express service carrier to receive documents, in an envelope or package designated by the express service carrier with delivery fees paid or provided for, addressed to the person on whom it is to be served, at the office address as last given by that person on any document filed in the cause and served on the party making service; otherwise at that party's place of residence. Service is complete at the time of the deposit, but any period of notice and any right or duty to do any act or make any response within any period or on a date certain after service of the document served by Express Mail or other method of delivery providing for overnight delivery shall be extended by two court days. The extension shall not apply to extend the time for filing notice of intention to move for new trial, notice of intention to move to vacate judgment pursuant to Section 663a, or notice of appeal. This extension applies in the absence of a specific exception provided for by this section or other statute or rule of court.

(d) The copy of the notice or other paper served by Express Mail or another means of delivery providing for overnight delivery pursuant to this chapter shall bear a notation of the date and place of deposit or be accompanied by an unsigned copy of the affidavit or certificate of deposit.

(e) Service by facsimile transmission shall be permitted only where the parties agree and a written confirmation of that agreement is made. The Judicial Council may adopt rules implementing the service of documents by facsimile transmission and may provide a form for the confirmation of the agreement required by this subdivision. In case of service by facsimile transmission, the notice or other paper shall be transmitted to a facsimile machine maintained

by the person on whom it is served at the facsimile machine telephone number as last given by that person on any document which they have filed in the cause and served on the party making the service. Service is complete at the time of transmission, but any period of notice and any right or duty to do any act or make any response within any period or on a date certain after service of the document, which time period or date is prescribed by statute or rule of court, shall be extended, after service by facsimile transmission, by two court days, but the extension shall not apply to extend the time for filing notice of intention to move for new trial, notice of intention to move to vacate judgment pursuant to Section 663a, or notice of appeal. This extension applies in the absence of a specific exception provided for by this section or other statute or rule of court.

(f) The copy of the notice or other paper served by facsimile transmission pursuant to this chapter shall bear a notation of the date and place of transmission and the facsimile telephone number to which transmitted, or to be accompanied by an unsigned copy of the affidavit or certificate of transmission which shall contain the facsimile telephone number to which the notice or other paper was transmitted.

(g) Electronic service shall be permitted pursuant to Section 1010.6 and the rules on electronic service in the California Rules of Court.

(h) Subdivisions (b), (d), and (f) are directory.

(Amended by Stats. 2022, Ch. 686, Sec. 2. (AB 1726) Effective January 1, 2023.)