

BEFORE THE  
EMERGENCY MEDICAL SERVICES AUTHORITY  
STATE OF CALIFORNIA

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

JENNIFER HENDERSON,

License No. P 23419

Respondent.

Case No. 07-0403

OAH No. 2009010716

**PROPOSED DECISION**

James Ahler, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter September 8 and 9, 2009, in San Diego, California.

Cynthia L. Curry, Senior Staff Counsel, Emergency Medical Services Authority, represented complainant Nancy Steiner, Chief, EMS Personnel Division, Emergency Medical Services Authority, Health and Human Services Agency, State of California.

David J. Givot, Attorney at Law, represented respondent Jennifer Henderson, who was present throughout the administrative hearing.

The matter was submitted on September 9, 2009.

**FACTUAL FINDINGS**

*Emergency Medical Services Authority*

1. There was no statewide agency responsible for coordinating and integrating emergency medical services and programs in California before 1980. Although many stakeholders involved in the provision of emergency medical services disagreed on many issues, there was a consensus that a unified statewide approach to coordinating emergency and disaster medical services was needed. The Emergency Medical Services System and Prehospital Emergency Care Personnel Act (SB 125) was enacted in 1980. It established a lead agency and centralized resources to oversee emergency and disaster medical services.

The act created the Emergency Medical Services Authority (EMSA),<sup>1</sup> one of 13 departments within California's Health and Human Services Agency.

Among other matters, EMSA operates the State Paramedic Licensure program, which licenses paramedics and conducts disciplinary investigations and actions involving paramedics to ensure that California paramedics provide services that meet our state's high prehospital care standards.<sup>2</sup>

### *Paramedics*

2. To hold a paramedic license in California, an individual must successfully complete an approved paramedic training program;<sup>3</sup> complete a course of training that includes 450 hours of didactic and skills training, 160 hours of hospital and clinical training, and a field internship of 480 hours which must include advanced life support patient contacts; pass the National Registry of EMTs (NREMT) written and practical examinations;<sup>4</sup> submit fingerprints for a criminal history clearance; submit a completed paramedic license application form and documents; and pay required fees.

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<sup>1</sup> Health and Safety Code section 1797.1 sets forth the legislative findings and provides:

"The Legislature finds and declares that it is the intent of this act to provide the state with a statewide system for emergency medical services by establishing within the Health and Welfare Agency the Emergency Medical Services Authority, which is responsible for the coordination and integration of all state activities concerning emergency medical services."

<sup>2</sup> Health and Safety Code section 1797.2 provides:

"It is the intent of the Legislature to maintain and promote the development of EMT-P paramedic programs where appropriate throughout the state and to initiate EMT-II limited advanced life support programs only where geography, population density, and resources would not make the establishment of a paramedic program feasible."

Under Health and Safety Code section 1797.172, subdivision (c), EMSA "shall be the agency solely responsible for licensure and licensure renewal of EMT-Ps who meet the standards and are not precluded from licensure . . . ."

Health and Safety Code section 1797.84 defines "paramedic" as an individual whose scope of practice to provide advanced life support is according to standards prescribed by statute and who has a valid certificate issued pursuant to statute.

<sup>3</sup> To be eligible to enroll in a paramedic training program, an individual must be currently certified as an EMT or have been so certified within the past 12 months.

<sup>4</sup> EMSA uses the NREMT paramedic exam as the state licensing exam. A paramedic certified in another state, territory, or jurisdiction may become a certified California paramedic. Along with a completed application, the applicant must provide documentation that the applicant's National Registration is current; a paramedic training program completion record; documentation of training hours that meet California requirements; and documentation of current or prior state paramedic licensure or certification. A currently licensed California paramedic must complete a minimum of 48 hours of continuing education every two years.

### *Henderson's California License Status*

3. On February 24, 2006, EMSA issued Emergency Medical Technician-Paramedic License No. P 23419 to Jennifer Henderson (Henderson or respondent). The license was issued following Henderson's submission of an "Out-of-State Initial Application" from the State of Washington, where Henderson was licensed. Henderson's California license was in force and effect at all times mentioned herein. That license is current, and it remains in effect until it expires or is renewed, suspended or revoked.

There is no history of any disciplinary action having been imposed against Emergency Medical Technician-Paramedic License No. P 23419.

### *Jurisdictional Matters*

4. On November 5, 2008, complainant Nancy Steiner, Chief, EMS Personnel Division, Emergency Medical Services Authority, signed the Accusation in Case No. 07-0403 in her official capacity. The accusation alleged that on November 3, 2007, Henderson assisted personnel from the Richland Fire Department in providing rapid sequence intubation (RSI) to a patient who was unconscious, unresponsive, and exhibited other symptoms of severe trauma including emesis (vomiting), decorticate posturing, clenched teeth, and a low respiratory rate. The accusation alleged that Henderson delivered two medications necessary to accomplish RSI without medical supervision (third cause for discipline) and exceeded a paramedic's scope of practice (second cause for discipline), and that Henderson submitted a fraudulent patient care report in which she falsely represented that Richland Fire Department personnel had administered all RSI medications (first cause for discipline).

Henderson timely filed a notice of defense after being served with the accusation and other required jurisdictional documents.

On September 8, 2009, the administrative record was opened and jurisdictional documents were presented. Opening statements were waived. On September 8 and 9, documentary evidence was received, sworn testimony was provided, and a stipulation was reached. On September 9, 2009, closing arguments were given, the record was closed, and the matter was submitted.

### *Jennifer Henderson's Background and Training*

5. Henderson received training to become a paramedic in Bismarck, North Dakota. During that training Henderson became familiar with a procedure known as rapid sequence intubation (RSI).<sup>5</sup> After completing her paramedic training, Henderson was

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<sup>5</sup> RSI refers to the sedation and paralysis of the patient before an intubation procedure. The technique is a quicker form of the process that is normally used to "induce" a state of general anesthesia. Medications are utilized to allow the rapid placement of an endotracheal tube between the vocal cords. Neuromuscular blocking agents paralyze the patient's skeletal muscles, most importantly in the oropharynx, larynx, and diaphragm. Once the endotracheal tube has been passed between the vocal cords, the patient is artificially ventilated. The RSI procedure

certified by the National Registry of Emergency Medical Technicians, which required her to pass an examination that included, in part, demonstrated competency in RSI.

Henderson became licensed as a paramedic in the State of Washington. As a Washington paramedic, Henderson was required to know how to perform RSI. Under her Washington paramedic license, Henderson was authorized to perform RSI within the State of Washington.

6. Before November 2007, Henderson observed RSI procedures performed in hospitals and in the field on numerous occasions. She had, herself, performed RSI in the field three or four times, although not in California, both by placing the endotracheal tube and by pushing the medications required to paralyze the patient. In addition to her field experience, Henderson assisted with RSI procedures in nine or ten times in hospitals.

7. Several years ago, Henderson moved to California and obtained licensure as a paramedic. At all times relevant to this disciplinary matter, Henderson was employed by AMR, a nationwide transportation and emergency medical services provider. Henderson was accredited as a paramedic in Riverside County.

California statutes, regulations and local emergency medical service agency protocols set limits on a California paramedic's scope of practice within each local emergency service agency's jurisdiction. Henderson did not enjoy as broad a scope of practice in California as she possessed in Washington. Henderson was not permitted to provide RSI or to administer Lidocaine or Succinylcholine in connection with RSI anywhere in California.

*The Incident Occurring on November 3, 2007*

8. There were numerous wildfires throughout Southern California in fall 2007. Under a Mutual Aid Response request from California, fire departments and paramedics from other jurisdictions came to California to assist in battling those wildfires, including a crew from the Richland Fire Department, based in Richland, Washington.

Under the Mutual Aid Response doctrine, Washington paramedics were authorized to perform any procedure in California which their local license and accreditation allowed them to perform in Washington. Thus, Richland Fire Department paramedics were authorized to perform RSI in California, including the administration of required medications which they carried in the emergency vehicle they drove to California.

9. Around 11:00 p.m. on November 3, 2007, JR, a 37-year-old Cal-Fire employee, was ejected from a golf cart on Buck Tail Drive in Canyon Lakes, Riverside County. JR suffered a very serious closed head injury as a result of that incident. The Riverside County Fire Department (Cal-Fire) responded to an emergency call arising out of the incident. Because Cal-Fire was the first agency to respond to the scene, Cal Fire assumed

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is extremely dangerous because in administering the required medications the clinician removes all ability of the patient to breathe on his own and to maintain a patent airway.

incident command. Shortly after Cal-Fire arrived at the scene, an emergency vehicle and crew from the Richland Fire Department (RFD) arrived. The Richland crew consisted of four persons, two of whom were Washington State paramedics.<sup>6</sup>

10. JR was found facedown on the street. He was unconscious, vomiting, bleeding from the mouth, and nonresponsive to painful and verbal stimuli. There were bruises and lacerations on the side of his head and face.

JR was rolled over, placed on a backboard, and a cervical collar was put in place to provide protection. His pupils were constricted. JR demonstrated decorticate posturing<sup>7</sup> with shallow respirations and a rapid heart rate. Initial responders rated JR as being a 4 on the Glasgow Coma Scale.<sup>8</sup> JR's respirations were ineffective and his SpO<sub>2</sub> (oxygen saturation) readings were low despite the provision of supplemental oxygen. His teeth were tightly clenched and his mouth was full of vomit and blood. An effort to assist ventilation with a bag valve mask (BVM or Ambu bag) was not successful and the patient's respirations did not improve. An IV was established. A Cal-Fire paramedic was unable to establish an airway utilizing basic life support measures.

The emergency personnel at the scene conferred and determined that JR needed to be intubated as quickly as possible. The Richland crew offered to provide RSI since they had the equipment and medications required to carry out that procedure. A Cal-Fire paramedic declined to assist the two Washington State paramedics in performing RSI because he was unfamiliar with the RSI procedure.

11. The AMS unit arrived at the scene at about that time. Henderson observed JR on the backboard. Emergency medical personnel at the scene advised Henderson of JR's status and told her that a decision had been made to provide RSI. Henderson saw paramedic patches on the uniforms of the paramedics who proposed to provide RSI to JR, which led Henderson to believe that they were from the State of Washington. A Cal-Fire responder and a Washington paramedic told Henderson they had permission to provide RSI. Henderson

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<sup>6</sup> As a result of their training, experience, licensure, and the Mutual Aid Response doctrine, the Richland paramedics possessed the medications, equipment and legal authority necessary to provide RSI in California, even though paramedics licensed in California were prohibited from doing so.

<sup>7</sup> Individuals demonstrating decorticate posturing present with the arms flexed, or bent inward on the chest, the hands clenched into fists, and the legs extended and feet turned inward. Abnormal posturing is an involuntary flexion or extension of the arms and legs, and suggests severe brain injury. Since posturing is an important indicator of the amount of damage that has occurred to the brain, it is used by medical professionals to measure the severity of a coma along with the Glasgow Coma Scale. The presence of posturing indicates a severe medical emergency requiring immediate medical attention. Decorticate posturing is strongly associated with poor outcome in a variety of conditions.

<sup>8</sup> The Glasgow Coma Scale or GCS is a neurological scale which seeks to provide a reliable, objective way of recording the conscious state of a person in initial as well as subsequent assessments. A patient is assessed against the criteria of the scale and the resulting points give a patient score between 3 (indicating deep unconsciousness) and either 14 (original scale) or 15 (the more widely used modified or revised scale).

mentioned that she had been licensed in Washington before moving to California, and through the discussion that followed, she confirmed the paramedics were from Washington.

The Washington paramedics asked Henderson if she could help them to provide RSI. Henderson agreed because she was familiar with the RSI procedure and because she thought JR would die without it. She believed permission had been obtained to utilize the procedure. When she agreed to help, Henderson believed that assisting in RSI constituted conduct outside the scope of her paramedic authority in California; however, based on JR's condition and the discussions she had with the initial responders, Henderson believed it was a life or death choice. Washington paramedics asked Henderson to "push" two of the required medications while they positioned JR, monitored his condition and placed the endotracheal tube. Henderson did not call base hospital personnel to seek authority to assist in the RSI procedure before stepping in.

Henderson pushed 100 mg of Lidocaine<sup>9</sup> at approximately 11:13 p.m. A Richland crew paramedic then pushed 20 mg of Etomidate<sup>10</sup> shortly thereafter. Henderson pushed 200 mg of Succinylcholine<sup>11</sup> at 11:15 p.m. After medications were administered intravenously, the endotracheal tube was successfully placed, JR's oxygen saturation level rose, JR was moved to the AMR vehicle, after which JR was transported to the Inland Valley Medical Center in Wildomar, about 11 minutes away.

12. Henderson completed a patient care report on a standard AMR form at the Inland Valley Medical Center. In that form, Henderson indicated that AMR responded to a call involving severe trauma, that AMR received the call at 2301 [11:01 p.m.], that AMR was enroute by 2302, that AMR arrived at the scene at 2310, that AMR encountered the patient around 2311, that medications were administered between 2313 and 2315, that AMR departed the scene with JR onboard around 2331, and that AMR and the patient arrived at the medical center around 2343. The patient care report contained JR's blood pressure readings, pulse rates, respiratory rates, and lung sounds obtained at 2311, 2321, 2331 and 2341.

A portion of the AMR form was entitled "Treatment." The space in which to place information was quite small and it would be nearly impossible to fill in all of the requested data in the limited space provided. With regard to the information at issue in this disciplinary proceeding, Henderson provided the following in part:

TIME	CARE RENDERED	INIT.	I.V.	SIZE/SITE	ROUTE	DOSE	Results	MEDICAL NECESSITY
...								

<sup>9</sup> Lidocaine is a common local anesthetic and antiarrhythmic drug.

<sup>10</sup> Etomidate is a short acting intravenous anesthetic agent used for the induction of general anesthesia and for sedation.

<sup>11</sup> Succinylcholine is a medication used to induce muscle relaxation, usually to make endotracheal intubation. Succinylcholine is sold under the trade names Anectine and Scoline.

2313 100 mg Lidocaine IVP → RFD  
2314 20 mg Etomidate → RFD  
2315 200 mg Succinoclyne [sic] → RFD

In the "Complaints" section of the form, Henderson wrote in part:

"... Assisted ventilations. Pt. given 100 mg Lidocaine, 20 mg Etomidate, 200 mg succinylcholine → Richland WA FD paramedics on scene per their protocols. Pt intubated ..."

Henderson delivered the completed patient care report to her employer at the end of her shift.

13. The patient care report prepared by a Cal-Fire responder stated that 100 mg of Lidocaine was provided intravenously at 2310, that 20 mg of Etomidate was provided at 2310, and that 200 mg of Succinylcholine was provided at 2310. The Cal-Fire patient care report stated that "Wash. State ACS medic unit on scene with RSI capability ..." and "Washington State Paramedic Task Force" adjacent to an area in which medications were listed. The Cal-Fire report did not state who specifically administered the medications.

14. The patient care report prepared by the Richland Fire Department stated that the RFD engine arrived at the scene at 11:07 p.m., that personnel found JR unconscious, unresponsive to stimulus, with labored respirations, that JR was rolled and placed on a backboard, that JR's pupils were constricted, that supplemental oxygen was started but delivery was unsuccessful as a result of the patient's clenched jaw and the presence of blood and vomit in his mouth, that vomit was removed and "pt was RSI with 100 mg Lidocaine IVP, 20 mg Etomidate IVP and 200 mg Anectine IVP with pt. paralyzed, pt. was intubated and ET confirmed by equal breath sounds, end tidal CO2 waveforms, condensation in the tube, and negative gastric sounds." Thereafter, JR was placed in the AMR unit and transported to the medical center according to the RFD report. The RFD patient care report stated that Scott Hansen, a Washington State paramedic, administered the Lidocaine, 20 mg of "Other" [Etomidate], and the Succinylcholine. The RFD patient care report stated that Ronald Duncan, the other Washington State paramedic, was responsible for maintaining immobilization, attempting to clear the airway, observing the patient's oxygen saturation level, providing airway suctioning, observing the cardiac monitor, and capnography (tracking the patient's expelled carbon dioxide).

Henderson's role at the scene was not specifically mentioned, nor was the role of any other emergency responder from any other agency specifically mentioned.

*Review of the Patient Care Reports*

15. AMR reviewed Henderson's report. The provision of RSI was noted and AMR asked Henderson and Julie Timmerek (Timmerek), the other paramedic employed by AMR who responded to the incident involving JR, to provide supplemental statements.

16. Timmerek's supplemental statement to AMR was dated November 7, 2007. It stated in part:

"The medics from Richland, WWA began ventilating the pt . . . Emesis began to come out of his mouth & the medic @ the head suctioned him. They decided they needed to intubate him. The Richland medic @ the head got his intubation equipment ready & the medic ventilating hyperventilated the pt prior to intubating. The medic @ the head attempted intubation & was unsuccessful due to emesis in the airway. The pt was suctioned & bagged again. The decision was made by Richland FD to RSI the pt as it is in their protocols. All of the medics on scene agreed that was best thing for pt. They told us they were advised by their superiors from Cal Fire to act under and follow their own protocols from Washington. They prepared their RSI drugs while the pt was being ventilated via BVM. They pushed the RSI meds & successfully intubated the pt. The tube placement was confirmed by equal bilateral lung sounds. . . ."

17. Henderson's supplemental statement to AMR was dated November 8, 2007. It stated in part:

"Upon our arrival c-spine immobilization had been initiated, pt. had assisted ventilations with BVM and vitals had been taken. An IV was established by FD and AMR placed the pt on their cardiac monitor and provided suction secondary to pt vomiting . . . B/P 140/78. Pt decorticate posturing noted. Pt. had clenched jaw. Unable to nasal assist pt with airway secondary to head trauma. Noted pt gag reflex intact. AMR stated we needed to provide rapid transport to the nearest trauma facility. Per Cal Fire medic on scene stated that the patient was going to be given rapid sequence intubation by Richland WA Fire Dept per their protocols and ability to utilize skills. Assisted Richland WA FD with RSI. Pt given 100 mg Lidocaine, 20 mg Etomidate and 200 mg Succinylcholine all IVP. Pt had SpO2 sats of 86% prior to intubation. Airway had been clear prior to RSI. Pt intubation unsuccessful by Richland FD, second attempt by RFD successful. Placement confirmed . . . Per Cal Fire and Richland WA FD they had permission from their superiors to provide their protocol skills in Riverside County . . . ."

18. Henderson reviewed her patient care report and her supplemental report with a union representative immediately after she completed the supplemental report. In meeting with her union representative, Henderson realized that her reports were not perfectly clear in that she did not directly state in either of them that she was the person who had pushed two of the required RSI medications.

Before there was any suggestion that she had prepared a patient care report that was less than accurate, Henderson sent an email to her AMR supervisor on November 9, 2009, which stated in part:

“I just want to clarify . . . Assisted with skills under direction of Richland Fire Department having been trained in and have previously performed with success, to manage patient airway and provide care in the patients best interest. I was directed and gave 100 mg Lidocaine IVP at which the Richland Fire Department drew up and gave 20 mg. Etomidate and then I was directed by Richland Fire Department to draw up and gave 200 mg of Succinylcholine IVP . . . I followed the orders that were given by Richland Fire Department and Cal Fire who were incident command. . . .”

19. After reviewing the initial reports related to the incident (but not the supplemental reports), Dr. Humberto Ochoa, Riverside County EMS' Medical Director, concluded that the clinical care provided to JR was appropriate, but had questions concerning the “legal issues for prehospital and medical practice of out-of-State mutual aid resources” despite the favorable outcome. By letter dated November 8, 2007, Riverside County EMS sought direction from EMSA to improve communication concerning EMS mutual aid resources.

20. Shortly after November 9, 2007, AMR advised the Riverside County EMS that Henderson had administered Lidocaine and Succinylcholine in the RSI procedure. When that information came to the attention of Karen Petrilla (Petrilla), a Riverside County EMS Specialist, there was concern that Henderson may have acted outside the scope of her practice and that Henderson's initial documentation may have been inadequate or inaccurate.

Petrilla asked AMR and EMSA to investigate.

21. AMR's investigative/improvement plan report was dated November 29, 2007. The report contained background information, an assessment, goals related to an improvement plan, objectives related to the improvement plan, timelines related to the improvement plan, and a summary. The report observed that Henderson's initial patient care report was not clear in describing the manner in which Henderson assisted with RSI, which resulted in the filing of a supplemental report in which Henderson indicated that she drew up and administered the Lidocaine and Succinylcholine.

The report stated that AMR personnel met with Henderson on November 14, 2009, and that Henderson was placed on administrative suspension following that meeting. The report stated that Henderson was permitted to return to work with an improvement plan in place.

The report stated that Henderson had willfully and knowingly acted outside of Riverside County protocol in administering Lidocaine and Succinylcholine, that she had provided substandard/ incomplete documentation in the patient care report creating “false impressions,” and that she lacked understanding of how the incident command system (ICS)

system worked and applied.<sup>12</sup> The report set forth the improvement plan that was imposed. The improvement plan required Henderson to: (1) Shadow Dr. Chua, AMR's medical director, for an six hour shift at Riverside County Regional Medical Center; (2) view a documentation video and study the AMR documentation handbook; (3) pass a test related to documentation with a score of 80 percent or better; (4) write a three to five page paper describe the risks and complications of RSI in the prehospital setting; and (5) write a three to five page paper describing the roles and responsibilities of a paramedic within the ICS system and how to manage conflict.

Henderson completed the performance improvement program within 90 days.

22. The manner in which EMSA investigated the matter and the results of the investigation were not as clear. Ken Bobinski (Investigator Bobinski), an EMSA Senior Investigator, obtained copies of the various patient care reports related to the incident. Investigator Bobinski interviewed Henderson in Riverside sometime in 2007 or 2008. Petrilla was present at that interview, as was a representative from AMR. Petrilla recalled Henderson admitting that she administered Lidocaine and Succinylcholine during the RSI procedure, but Petrilla could not recall any specific statements Henderson made regarding the preparation and contents of her initial patient care report.

Investigator Bobinski provided Eric M. Rudnick, M.D. (Dr. Rudnick) with various materials including the patient care reports, the supplemental reports, and AMR's report that included the plan of correction. Dr. Rudnick authored a report dated May 4, 2009, and testified in this disciplinary matter.

#### *Complainant's Expert Witnesses*

23. Dr. Rudnick received a medical degree from the Medical College of Wisconsin in 1990. He completed a three year residency in Emergency Medicine at Michigan State University, Lansing, in 1993. Dr. Rudnick became a Fellow in the American College of Emergency Physicians in 1994, about the time he moved to California. After arriving in California, Dr. Rudnick worked in an emergency medical setting in the Sacramento area for several years, when he also served as an unpaid clinical professor for the

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<sup>12</sup> AMR's findings are not binding in this proceeding. The AMR meeting was not a judicial-like proceeding in which testimony was taken under oath or in which the parties had the right to subpoena and confront witnesses. There was no established burden or standard of proof. Traditionally, the doctrine of collateral estoppel is applied only if several threshold requirements are fulfilled. First, the issue sought to be precluded from relitigation must be identical to that decided in a former proceeding. Second, this issue must have been actually litigated in the former proceeding. Third, it must have been necessarily decided in the former proceeding. Fourth, the decision in the former proceeding must be final and on the merits. Finally, the party against whom preclusion is sought must be the same as, or in privity with, the party to the former proceeding. Even if these threshold requirements are satisfied, the doctrine will not be applied if such application would not serve its underlying fundamental principles. (*Gikas v. Zolin* (1993) 6 Cal.4th 841, 848-849.)

Even though AMR's factual findings are irrelevant for purposes of this disciplinary proceeding, AMR's disciplinary proceeding itself is relevant in that it imposed an improvement plan that required Henderson to take certain action designed to improve her competence as a paramedic.

University of California, Davis, School of Medicine from 1994-2003. Dr. Rudnick moved out of the Sacramento area in 2003 and has engaged in the practice of emergency medicine in Northern California for approximately five years.

24. By reason of his education, training and experience, Dr. Rudnick was familiar with the rules and regulations pertaining to a paramedic's scope of practice in California. Dr. Rudnick established that relevant California statutes and regulations provide a statewide scope of practice and that the 31 local emergency medical service agencies (LEMSA) have authority to restrict the scope of practice granted by the statutes and regulations through local agency protocols.

Under applicable statutes, regulations and LEMSA protocols, a ground paramedic cannot provide RSI in California. Ground paramedics are permitted to utilize other, less risky methods of endotracheal intubation.

Dr. Rudnick was familiar with the incident involving JR as a result of his review of the patient care reports. Based on those reports, Dr. Rudnick believed that the Washington State paramedics had the authority to perform RSI as a result of their licensure and protocols. He believed that it would have been proper for Henderson to place the endotracheal tube, since that was within the scope of her practice as a paramedic, but that it was improper and outside of her scope of practice to administer Lidocaine and Succinylcholine to patient JR.

25. Dr. Rudnick believed that the "inconsistencies" in Henderson's reports and her failure to specifically state in the initial patient contact that she administered the Lidocaine and Succinylcholine to patient JR constituted dishonesty and fraud. Dr. Rudnick conceded that his opinion was based solely upon his interpretation of the records and that he had no actual knowledge of Henderson's state of mind.

26. Karen Petrilla, a registered nurse with many years of emergency nursing experience, is a Specialist with Riverside County EMS. Petrilla is responsible for the training and certification of emergency medical technicians and paramedics in Riverside County among other matters. She was familiar with local protocols.

Petrilla investigated the incident involving the RSI of patient JR. Petrilla testified that Henderson's administration of Lidocaine and Succinylcholine to JR involved conduct exceeding her scope of practice. Petrilla testified that Henderson failed to contact base hospital concerning the incident and violated local protocol.

27. Petrilla's interpretation of Henderson's initial patient care result led to her personal belief that the report was "falsified," but conceded that the supplemental report and the email "clarified" what was in the initial report.

Petrilla could not recall Henderson stating that she engaged in any dishonest or fraudulent conduct during her interview with the EMSA investigator, and could not recall specific questions being asked about that matter at the interview.

*Riverside County EMS Protocols*

28. Riverside County's EMS Protocols were not provided, although those protocols were discussed by Dr. Rudnick and Petrilla in their testimony. Official notice is taken of Riverside County's EMS Protocol Manual. Section 7000 of that manual sets forth adult protocols. The introduction to the protocols states:

"It is important to note that these policies are intended as a thought process or decision tree, not as an absolute plan. Every situation is unique; a policy could not possibly be written to cover every circumstance. We expect paramedics to use their training and good judgment when treating patients in the field and to document situations that vary from the norm. In the policies, the treatments that appear in the non-shaded areas tend to be the treatments of choice for that set of symptoms. Therefore, it made sense to include those treatments in the 'prior to contact' realm. Paramedics **have the option** to perform procedures or administer drugs in the non-shaded areas on their own counsel, or to contact the base hospital for consultation. Not all treatments need to be done prior to base hospital contact. Treatments in the shaded areas are not necessarily given to every patient who exhibits certain symptoms. Extenuating circumstances sometimes apply. For example, not every patient in cardiogenic shock will receive dopamine. In these cases, physician level judgment is important. Drug and procedure orders in the shaded boxes also **do not** mean that paramedics should **automatically** call the base hospital and request them. Rather, if the patient's condition warrants a medication or procedure, then the paramedic should consult the base hospital. Once base hospital contact is made, all further patient care decisions are under the direction of the base hospital." (Original emphasis.)

29. Under Riverside County EMS protocols, oral endotracheal intubation, stomal endotracheal intubation and naso-tracheal intubation is permitted for all adult patients for whom intubation is indicated. Under the protocols, Lidocaine may be administered in the treatment of cardiac chest discomfort and only then with base hospital orders. Under the protocols related to head, neck and facial trauma, before contacting the base hospital, the paramedics should secure the patient's airway, immobilize the patient's spine, regulate the flow of oxygen as clinically indicated, properly position the patient, and transport the patient to the medical center. An IV access should be established if indicated. The base hospital must be contacted and approval must be obtained to administer morphine.

30. Riverside County EMS protocols do not authorize the administration of Succinylcholine.

31. Henderson admitted that her administration of Lidocaine and Succinylcholine was contrary to Riverside County's EMS' protocols and exceeded her scope of practice.

Henderson admitted that she failed to contact the base hospital before providing the intravenous administration of Lidocaine and Succinylcholine.

*The Allegations of Fraud and Dishonesty*

32. Henderson admitted that the patient care report that she completed at the Inland Valley Medical Center was not as clear as it could have been, but she testified that she did not intend to misstate any information and that she did not intend to engage in any fraudulent or dishonest conduct in completing the report. Henderson testified that in her initial report she used the initials RFD to show that the medications came from the vehicle under RFD's control, since her own vehicle did not carry those medications. On cross-examination, Henderson denied that she wrote the initials "RFD" in an effort to leave an impression that someone from the Richland Fire Department had administered the required RSI medications. This testimony was delivered in a credible fashion.

Henderson stated that within a week after the incident, and before she became aware of concerns about her initial patient care report, so she filed a supplemental statement with her employer in which she wrote in part:

"... Per Cal Fire medic on scene stated that the patient was going to be given rapid sequence intubation by Richland WA Fire Dept per their protocols and ability to utilize skills. Assisted Richland WA FD with RSI. Pt given 100 mg Lidocaine, 20 mg Etomidate and 200 mg Succinylcholine all IVP."

A reasonable interpretation of the supplemental report requires at least consideration of a conclusion that Henderson assisted RFD in administering the RSI medications under their protocols.

The following day, and after determining some confusion regarding her role in the RSI still might exist, Henderson sent an email to her employer that stated in part:

"... I was directed and gave 100 mg Lidocaine IVP at which the Richland Fire Department drew up and gave 20 mg. Etomidate and then I was directed by Richland Fire Department to draw up and gave 200 mg of Succinylcholine IVP . . . I followed the orders that were given by Richland Fire Department and Cal Fire who were incident command. . . ."

Henderson's accounts of her role in providing the medications did not, as Dr. Rudnick asserted, evidence a "change in the story" but was, instead, the result of her appreciation that what she had written was not as complete as it could have been and a sincere desire to make certain that her role in the RSI procedure was known. Henderson's submission of the supplemental report and the e-mail evidenced her desire to tell the truth about what occurred and her role in it.

33. The details provided in the patient care reports provided by Cal-Fire did not include any information about who provided the RSI medications or who administered those medications. To that extent, the Cal-Fire report was less clear and is subject to more criticism than Henderson's initial patient care report.

34. The Richland Fire Department patient care report was sufficiently unclear that a reading of that report might lead one to believe that Washington State Paramedic Scott Hansen actually administered the Lidocaine, Etomidate, and Succinylcholine. To that extent, the RFD report was less clear and is subject to more criticism than Henderson's report.

35. Timmreck's supplemental statement to AMR dated November 7, 2007, did not identify the individual who administered the medications; indeed, the supplemental statement suggested that was done by Washington State personnel.

36. Henderson credibly testified that the emergency medical personnel did not gather together following the incident to get their stories straight and to reach an agreement to draft patient care reports that intentionally failed to identify Henderson as the individual who administered the Lidocaine and Succinylcholine. No credible evidence supported this conspiracy theory. Henderson's testimony concerning the absence of a conspiracy was believable, particularly since personnel from RFD were unknown to AMR personnel.

The conclusion drawn from a review of the several patient care reports prepared immediately after the incident was that identifying who administered what medications in the course of a procedure was not as important to emergency care providers as the patient's identity, the symptoms, a record of the vital signs, a general description of what emergency treatment was provided, the patient's response, the relevant times services were provided and vital signs were obtained, and what happened.

37. The evidence offered to establish that Henderson committed a fraudulent, dishonest or corrupt act in the preparation of the patient care report was neither clear nor convincing, and certainly not as convincing as the opposing evidence. The record supports a finding that although Henderson's initial patient care report was not as clear as possible, any deficiencies were the result of a lack of time and/or writing skills.

#### *Other Matters*

38. JR testified. JR is a Captain with Cal-Fire. JR had no recollection of any of the care he received the evening of November 3, 2007. JR was unfamiliar with Henderson on a personal level, but he was very aware of Henderson's skills, abilities and reputation on a professional level as a result of observing her in the field and as a result of speaking with his colleagues about her professionalism.

JR testified that Henderson was a highly proficient paramedic who was calm under pressure and "very squared away." In the many times he had observed Henderson provide paramedic services, JR never observed Henderson exceed the scope of her practice. He described Henderson as a self-assured individual and a person of integrity. JR's colleagues shared the same opinions about Henderson's character and skills.

39. Following the incident giving rise to this disciplinary matter, Henderson was suspended from work for a period of three days, and was then reinstated to her employment

with AMR under an improvement program. Within 90 days of the implementation of the program, Henderson shadowed Dr. Chua for several hours during his shift at the Riverside County Regional Medical Center, viewed a documentation video and studied the AMR documentation handbook, passed a test related to documentation without any mistakes, wrote an essay describing the risks and complications of RSI in the pre-hospital setting, and wrote an essay describing the roles and responsibilities of a paramedic within the ICS system and how to manage conflict.

Henderson remained employed by AMR through July 2009. Henderson is currently employed as a paramedic with another emergency medical services provider. Henderson's husband is a paramedic employed by Cal-Fire. Henderson is currently studying to become licensed as a Physician's Assistant through a program at the University of Washington.

40. Henderson was a very credible witness. Henderson does not have access in her employment to the medications required to provide RSI.

When asked if she would do the same thing again if she were presented with exactly the same set of circumstances, Henderson replied that she would because she could not live with herself if she was trained and capable of preventing a patient's death and did not do so.

Fortunately for Henderson, the likelihood of the same unique set of circumstances ever occurring again (a patient obviously in need of RSI, the presence of out-of-state paramedics authorized to administer RSI, the existence of the medications and equipment required to provide RSI, and being told by incident command that the RSI procedure was authorized) is highly unlikely, if not statistically impossible.

### *Disciplinary Guidelines*

41. EMSA developed disciplinary guidelines in consultation with EMS constituent groups from across the state. The purpose of the guidelines is to provide consistent and equitable discipline in cases dealing with violations of the Health and Safety Code. EMSA uses the guidelines as a standard in settling disciplinary matters and directs administrative law judge to use them as a guide in fashioning a disciplinary recommendation in a contested matter. The recommended discipline should be imposed in the absence of any aggravating or mitigating evidence. If an administrative law judge recommends discipline that is less than the minimum or which exceeds the maximum, the guidelines require that a full explanation be included to make clear why the case warrants unusual consideration. EMSA's director has the final determination related to administrative discipline.

The guidelines provide that the following factors may be considered in determining the measure of discipline to be imposed. In determining an appropriate suspension period, EMSA or an administrative law judge may give credit for a suspension term imposed by a respondent's employer.

1. Nature and severity of the act(s), offense(s), or crime(s) under consideration;
2. Actual or potential harm to the public;

3. Actual or potential harm to any patient;
4. Prior disciplinary record;
5. Prior warnings on record or prior remediation;
6. Number and/or variety of current violations;
7. Aggravating evidence;
8. Mitigating evidence;
9. Rehabilitation evidence;
10. In case of a criminal conviction, compliance with terms of the sentence and/or court-ordered probation;
11. Overall criminal record;
12. Time that has elapsed since the act(s) or offense(s) occurred;
13. If applicable, evidence of expungement proceedings pursuant to Penal Code 1203.4.

Under EMSA guidelines, the commission of any fraudulent, dishonest, or corrupt act which is substantially related to the qualifications, functions, and duties of prehospital personnel carries a maximum disciplinary recommendation of revocation and a minimum disciplinary recommendation of revocation stayed, with three years probation with terms and conditions.

Under EMSA guidelines, violating or attempting to violate directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this division or the regulations adopted by the authority pertaining to prehospital personnel carries a maximum disciplinary recommendation of revocation and a minimum disciplinary recommendation of revocation stayed, with three years probation with terms and conditions.

Under EMSA guidelines, functioning outside the supervision of medical control in the field care system operating at the local level, except as authorized by any other license or certification, carries a maximum disciplinary recommendation of revocation and a minimum disciplinary recommendation of revocation, stayed, one year probation with minimum terms and conditions of probation and the completion of an Ethics course and the completion of an oral skills examination.

#### *Complainant's Disciplinary Argument*

42. Complainant argued that the record compelled an outright revocation. Complainant observed that Henderson admitted she acted beyond the scope of practice and failed to contact the base hospital in administering the RSI medications, and that these were knowing and willful violations. Complainant argued that Henderson knowingly prepared a false patient care report with the intent of shielding herself from disciplinary action. Complainant asserted that Henderson's admission that she would conduct herself in the future in same manner if she was presented with the same circumstances, that she would chose in essence "to play doctor" and take life and death decisions into her own hands, clearly established that an outright revocation was the only measure of discipline which would protect the public.

### *Respondent's Disciplinary Argument*

43. Respondent admitted that she acted outside the scope of her practice as a paramedic and that her initial documentation could have been clearer. She acknowledged that statutes, regulations and protocols should be followed, but that the extraordinarily unique circumstances occurring the late evening of November 3, 2007, minimized if not excused her conduct. Henderson had been trained to provide RSI. She had successfully provided RSI in the past. Henderson knew that the Washington paramedics were permitted to provide RSI. She was told that RSI had been authorized. Henderson did not volunteer, but her assistance was requested by Washington paramedics with authority to provide RSI. Henderson was forced to make an instant decision and she decided to help. Henderson never claimed to anyone, either in writing or orally, that she did not administer the medications. Under these circumstances, respondent argued that a minimal sanction should be imposed.

### *The Appropriate Measure of Discipline*

44. While there was probable cause for EMSA to investigate and prosecute this disciplinary action, the clear and convincing evidence did not establish grounds to impose an outright revocation or other discipline involving a revocation, stayed, or a suspension. The most troubling allegations related to fraud and dishonest conduct, but those allegations were not established by clear and convincing evidence; indeed, Henderson's initial patient care report was the most complete and accurate of the three reports prepared by initial responders with regard to the provision of the RSI medications. Following Henderson's initial report, Henderson made efforts to clarify what she had written, and she did so with the certain knowledge that doing so might subject her to disciplinary action. There is no basis to impose discipline on the dishonesty and fraud charges (first cause for discipline).

Henderson's failure to call base hospital to seek medical approval (third cause for discipline) was understandable and reasonable; the violation was almost completely mitigated by the fact that Henderson was given to understand by incident command – Cal-Fire – that prior approval had been given to provide RSI in accordance with Washington State protocols. Henderson detailed this understanding in her supplemental statement dated November 8, 2007. Timmreck's report dated November 7, 2007, corroborated what Henderson was told at the scene. Under the circumstances, it was a technical violation.

The conflicting jurisdictional paramedic protocols, JR's grave closed head injury, his unconsciousness, constricted pupils, decorticate posturing, shallow respirations, low oxygen saturation, and Cal-Fire's failure to establish successful ventilation made time of the essence. Exactly what was and was not within Henderson's scope of practice at that moment was not entirely clear, although Henderson knew that she was not personally authorized to provide RSI. Evidence of the lack of clarity about who could do what at the scene was evidenced by Dr. Ochoa's request for direction, as stated in the Riverside County EMS letter dated November 8, 2007, concerning the "legal issues for prehospital and medical practice of out-of-State mutual aid resources." To task Henderson with the responsibility of deciding at that moment that it would be within the scope of a paramedic's practice to place the endotracheal tube (a procedure that is technically far more difficult than pushing medications), but not to

administer the required RSI medications, as Dr. Rudnick suggested, would require a level of legal training and experience far exceeding that enjoyed by most practicing attorneys.

Applying EMSA's disciplinary factors, the clear and convincing evidence established that after a decision had been made by others to provide JR with RSI, and after Henderson was told that doing so was authorized, Henderson assisted the Washington State paramedics in providing RSI in an unauthorized manner. Henderson's assistance resulted in minimal actual and potential harm to the public since the Washington State paramedics would have provided RSI without Henderson's assistance. There was no actual harm to JR, although there was the potential for harm; the RSI procedure may have saved his life, but had it been provided in an incompetent or improper manner, it could have killed him. Henderson has no other disciplinary history. There is no evidence of any previous warnings. There were two, closely related violations, one of which was highly technical. There was no aggravating evidence, and there was considerable mitigating evidence. AMR directed Henderson to complete a comprehensive improvement plan, which Dr. Rudnick endorsed in his written report. Henderson completed that improvement program, which involved significant rehabilitation. In addition, Henderson served a three-day suspension.

Henderson was contrite and remorseful. Henderson's comment that she would do the same thing again under the exact same circumstances must be taken in context – the circumstances will never reoccur. There is no evidence that Henderson is an aggressive paramedic who is prone to take risks or that she has a pattern of acting outside the scope of practice. To the contrary, the credible evidence established that Henderson is a caring, committed, highly competent paramedic, who is a team player.

The purpose of administrative discipline is to protect the public from incompetent or dishonest practitioners. In unusual circumstances and where there is no actual patient harm, such as presented in this matter, it is appropriate to impose an administrative fine and to issue a decision detailing the basis of the imposition of such a fine to serve as a reminder to the licensee that similar conduct in the future will not be tolerated and will result in more serious administrative discipline. The singular facts in this matter, including the evidence in explanation, mitigation and rehabilitation, do not require more to protect the public.

## LEGAL CONCLUSIONS

### *Purpose of Administrative Discipline*

1. Administrative proceedings to revoke, suspend, or impose discipline on a professional license are nonpenal; they are not intended to punish the licensee, but rather to protect the public. (*Griffiths v. Superior Court* (2002) 96 Cal.App.4th 757, 768.)

### *The Standard of Proof*

2. The standard of proof in an administrative action seeking to suspend or revoke a certificate that requires substantial education, training, and testing is "clear and convincing

evidence.” (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.)

3. A preponderance of the evidence standard requires the trier of fact to believe that the existence of a fact is more probable than its nonexistence. Clear and convincing evidence requires a finding of high probability, or evidence so clear as to leave no substantial doubt; sufficiently strong to command the unhesitating assent of every reasonable mind. (*Katie V. v. Superior Court* (2005) 130 Cal.App.4th 586, 594.)

4. Substantial education, training, and experience is required to apply for a paramedic license in California, and the applicant must pass a nationwide written and practical qualifying examination before licensure; a licensee must meet continuing education requirements after licensure. On this basis, the clear and convincing standard of proof applies in this disciplinary proceeding.

*Relevant Statutory Authority*

5. Health and Safety Code section 1798.200 provides in part:

“(b) The authority may . . . suspend, or revoke any EMT-P license issued under this division, or may place any EMT-P license issued under this division, or may place any EMT-P licenseholder on probation upon the finding by the director of the occurrence of any of the actions listed in subdivision (c) . . .

(c) Any of the following actions shall be considered evidence of a threat to the public health and safety and may result in the . . . suspension, or revocation of a certificate or license issued under this division, or in the placement on probation of a certificate or licenseholder under this division:

...

(5) The commission of any fraudulent, dishonest, or corrupt act that is substantially related to the qualifications, functions, and duties of prehospital personnel.

...

(7) Violating or attempting to violate directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this division or the regulations adopted by the authority pertaining to prehospital personnel.

...

(10) Functioning outside the supervision of medical control in the field care system operating at the local level, except as authorized by any other license or certification. . . .”

6. Health and Safety Code section 1798.210 provides in part:

“(a) The authority may impose an administrative fine of up to two thousand five hundred dollars (\$2,500) per violation on any licensed paramedic found to have committed any of the actions described by subdivision (b) of Section 1798.200 that did not result in actual harm to a patient. Fines may not be imposed if a paramedic has previously been disciplined by the authority for any other act committed within the immediately preceding five-year period.

(b) The authority shall adopt regulations establishing an administrative fine structure, taking into account the nature and gravity of the violation.<sup>13</sup> The administrative fine shall not be imposed in conjunction with a suspension for the same violation, but may be imposed in conjunction with probation for the same violation except when the conditions of the probation require a paramedic’s personal time or expense for training, clinical observation, or related corrective instruction.

(c) In assessing the fine, the authority shall give due consideration to the appropriateness of the amount of the fine with respect to factors that include the gravity of the violation, the good faith of the paramedic, the history of previous violations, any discipline imposed by the paramedic’s employer for the same occurrence of that conduct, as reported pursuant to Section 1799.112, and the totality of the discipline to be imposed. The imposition of the fine shall be subject to the administrative adjudication provisions set forth in Chapter 5 (commencing with Section 11500 of Part 1 of Division 3 of Title 2 of the Government Code.

(d) If a paramedic does not pay the administrative fine imposed by the authority and chooses not to renew his or her license, the authority may enforce the order for repayment in any appropriate court. This right of enforcement shall be in addition to any other rights the authority may have to require a paramedic to pay costs.

(e) In any action for collection of an administrative fine, proof of the authority’s decision shall be conclusive proof of the validity of the order of payment and the terms for payment.

(f) (1) Except as provided in paragraph (2), the authority shall not license or renew the license of any paramedic who has failed to pay an administrative fine ordered under this section.

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<sup>13</sup> No regulation pertaining to an administrative fine was found. However, the administrative fine imposed here was specifically based on the nature and gravity of the violations as explained more fully in the Factual Findings.

(2) The authority may, in its discretion, conditionally license or renew for a maximum of one year the license of any paramedic who demonstrates financial hardship and who enters into a formal agreement with the authority to reimburse the authority within that one-year period for the unpaid fine.

(g) All funds recovered under this section shall be deposited into the state General Fund.

(h) Nothing in this section shall preclude the authority from imposing an administrative fine in any stipulated settlement.

(i) For purposes of this section, 'licensed paramedic' includes a paramedic whose license has lapsed or has been surrendered."

7. Health & Safety Code section 1798.211 provides:

"When making a decision regarding a disciplinary action pursuant to Section 1798.200 or Section 1798.210, the authority, and when applicable the administrative law judge, shall give credit for discipline imposed by the employer and for any immediate suspension imposed by the local EMS agency for the same conduct."

*Cause Exists to Impose an Administrative Fine and Issue a Public Reprimand*

8. Cause does not exist to impose any discipline under Health and Safety Code section 1798.200, subdivision (c)(5). The clear and convincing evidence did not establish that Henderson committed any fraudulent, dishonest, or corrupt act that is substantially related to the qualifications, functions, and duties of a paramedic.

This conclusion is based on the Factual Findings and on the Legal Conclusions herein.

9. Cause exists under Health and Safety Code section 1798.200, subdivisions (c)(7) and (c)(10) to impose discipline against Henderson's paramedic license. In the late evening hours of November 3, 2007, Henderson failed to call base hospital to seek medical approval to assist in providing RSI, but that omission was understandable, reasonable, and almost completely mitigated by the fact that Henderson believed that prior approval had been obtained by incident command. Under the circumstances, it was a technical violation. The conflicting jurisdictional paramedic protocols, the patient's grave closed head injury, his unconsciousness, constricted pupils, decorticate posturing, shallow respirations, low oxygen saturation, the failure to establish successful ventilation made time of the essence, and some confusion regarding the appropriateness of the RSI procedure provided some measure of mitigation. There was no actual harm to JR, although there was a risk of harm. There was no aggravating evidence, and there was considerable mitigating evidence. Henderson completed a comprehensive improvement plan and served a three-day suspension. She was contrite and remorseful. Her comment that she would do the same thing again under the

exact same circumstances must be taken in context - the circumstances will never reoccur. In the unusual circumstances in this matter, it is appropriate to impose an administrative fine and to issue a decision detailing the basis of the imposition of such a fine to serve as a reminder to Henderson that similar conduct in the future will not be tolerated and will result in more serious administrative discipline.

This conclusion is based on the Factual Findings and Legal Conclusions herein.

ORDER

Jennifer Henderson shall pay a \$500 fine to Emergency Medical Services Authority, Health and Human Services Agency, State of California, as a result of her violation of Health and Safety Code section 1798.200, subdivisions (c)(7) and (c)(10). The administrative fine shall be paid within 60 days of the effective date of the Decision herein.

DATED: 9/23/09



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JAMES AHLER  
Administrative Law Judge  
Office of Administrative Hearings