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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

ALAN SAMPSON, et al.,
Plaintiffs,
v.
UKIAH VALLEY MEDICAL CENTER, et
al.,
Defendants.

Case No. [15-cv-00160-WHO](#)

**ORDER GRANTING MOTIONS FOR
SUMMARY JUDGMENT**

Re: Dkt. Nos. 92, 95

The motions for summary judgment of defendants CALSTAR and MEDSTAR raise an important issue: under California law, can emergency medical personnel be found grossly negligent when they have provided some significant amount of care while failing to take other action that might have been more successful? In this sad case, plaintiffs’ son Andrew Sampson died after an automobile accident. While there are differences of opinion on a variety of facts surrounding the care provided by CALSTAR and MEDSTAR personnel, taking the facts in the light most favorable to plaintiffs there was no gross negligence. I GRANT the motions.

BACKGROUND

At approximately 2:20 a.m. on January 11, 2014, plaintiffs’ son Andrew was involved in a single car, rollover incident. Second Amended Complaint (“SAC”) ¶ 12 (Dkt. No. 49). The accident was not discovered until 4:06 a.m. (*id.* ¶¶ 12-13), and at 4:07 a.m. California Highway Patrol (CHP) was dispatched to the scene. The reporting officer arrived at 4:14 a.m. and observed a vehicle on its roof and Andrew lying next to the car. *Id.* ¶ 13.

Ukiah Ambulance Service, operated by defendant MEDSTAR, was dispatched to the scene and arrived at 4:21 a.m. Andrew was assessed and treated by MEDSTAR paramedic Cameron McFadden. There is no dispute that according to the readings taken by McFadden at the scene, Andrew was in distress (although conscious and able to response to simple commands) and his vital signs were deteriorating.

Following initial notification and confirmation from CHP that the road near the accident

1 site would be closed to allow for landing, CALSTAR’s helicopter was dispatched from Ukiah
2 Municipal Airport at 4:38 a.m. The pilot-in-command was Josh Judge and two CALSTAR nurses
3 – Courtney Holbrook Farris and Jaromie Power – were aboard. The CALSTAR helicopter
4 attempted to land, but because of “brown out” conditions was unable to do so. Deposition
5 Transcript of Josh Judge at 24:2-10 (Ex. K to the Declaration of Douglas de Heras [Dkt. No. 92-
6 14]). In light of timing concerns, the decision was made to abort the landing, send Andrew by
7 MEDSTAR ground ambulance to UVMC, and have CALSTAR meet up with the MEDSTAR
8 ambulance at UVMC. Judge Depo. Tr. at 46-52; Declaration of Michael Giannini [Dkt. No. 95-1],
9 ¶¶ 16-17.¹

10 Plaintiffs contend that the decision to abort the helicopter landing (to waive off the
11 helicopter) and transport Andrew to UVMC by ambulance was made by MEDSTAR paramedic
12 McFadden. Declaration of Jon Nevin [Dkt. No. 103], ¶ 10. Plaintiffs assert that McFadden, prior
13 to deciding to transport Andrew by ground transportation to UVMC, failed to follow the Coastal
14 Valleys EMS Agency Protocol 7007.4 by failing to seek guidance as to the plan of transfer with
15 someone with higher level medical credentials. Nevin Decl. ¶ 11. They argue that McFadden did
16 not, but should have, discussed the status of Andrew’s vitals/conditions and the “appropriate”
17 trauma center to direct Andrew to with either the flight nurses then aboard the CALSTAR
18 helicopter that was in flight or with Dr. Marks at UVMC. Nevin Decl. ¶¶ 20-223; Oppo. to
19 MEDSTAR MSJ at 9. MEDSTAR contends, however, that McFadden did discuss Andrew’s
20 condition and vitals with someone at UVMC and received approval to transport Andrew by
21 ground to UVMC. Deposition Testimony of Cameron McFadden at 30:3-13; 30:18-31:2; 31:9-23;
22 31:24-32:11; 49:11-20 (Ex C. to Declaration of Gerald S. Richelson [Dkt. No. 104]; Ex. C to
23 Reply Declaration of Jianlin Song). McFadden argues that he was required to take Andrew to
24 UVMC in light of his unstable vitals and that deciding to “bypass” UVMC was not within his

25
26 ¹ CALSTAR’s expert, Howard Ragsdale, explains that the pilot in command must use “extreme
27 caution” in landing in areas where dust conditions are present and the pilot is given final authority
28 to decide whether it is safe to land. Declaration of Howard Ragsdale [Dkt. No. 92-2], ¶ 12.
Plaintiffs do not present any facts, or argument, in an attempt to show that Judge’s decision not to
land given the brown out conditions was grossly negligent. Plaintiffs do not mention Judge at all
in their Opposition.

1 authority.² *Id.*

2 The MEDSTAR ambulance departed with Andrew at 4:42 a.m. and arrived at Ukiah
3 Valley Medical Center (“UVMC”) at 5:04 a.m. The CALSTAR helicopter also headed to UVMC,
4 and arrived at 5:04 a.m.

5 Andrew was admitted to UVMC and examined by Dr. Marks at UVMC at 5:09 a.m. At
6 UVMC, an X-ray was taken and tests administered, and Andrew was given two units of saline.
7 Following that treatment, Andrew’s blood pressure was normal and his pulse improved. Marks
8 diagnosed Andrew as suffering from multiple fractures, blunt chest trauma, head trauma, resulting
9 in internal bleeding and a hemothorax (bodily fluid collecting between the lung and chest cavity).
10 Expert Report of Karen V. Tomczak [Dkt. No. 99-3] at 3-4; Declaration of Ralph W. Robinson,
11 Ex. G [Dkt. No. 95-9]. Plaintiffs contend that a patient with these injuries should have been
12 intubated to ensure a sufficient supply of oxygen until surgical intervention. Declaration of Dr.
13 Davis Goldschmid [Dkt. No. 104-6] ¶¶ 36, 38. Marks secured approval from a doctor at Santa
14 Rosa Memorial Hospital (“SRMH”), the trauma center destination of choice according to
15 CALSTAR and MEDSTAR, to transfer Andrew there. Marks informed the doctor at SRMH that
16 Andrew had not been intubated. Deposition Transcript of Debbie L. Marks 74, Ex. O to de Heras
17 Decl. [Dkt. No. 92-18].

18 There is a dispute over the time that Andrew was discharged from UVMH into the care of
19 the MEDSTAR and CALSTAR personnel, as different organizations’ records show time of
20 discharge as either 5:22 or 5:28 or 5:37 or 5:43 a.m. There is no dispute that Andrew was
21 discharged for ground transportation via the MEDSTAR ambulance to SRMH.³ CALSTAR flight
22

23 ² MEDSTAR’s expert asserts that there is no protocol for a paramedic on the ground conferring
24 with in-flight nurses above, when the communications channel had to be left open for landing
instructions or other critical safety communications. Reply Declaration of Michael Giannini [Dkt.
25 No. 106-2] ¶ 8.

26 ³ CALSTAR and its expert, Howard Ragsdale, also explain in detail why the CALSTAR
27 helicopter was not used to transport Andrew to SRMH (fog conditions) or to Davis Medical
Center (freezing conditions). And that while transport by air could have been accommodated to
28 SRMH despite the fog, the fog required taking a longer flight pattern and landing away from
SRMH (at the airport, instead of the hospital). Those added issues meant that the flight time
exceeded the ground transportation time. Ragsdale Decl. 13-15. Plaintiffs do not attempt to raise
disputes of fact to undermine the assertions by CALSTAR that air transportation was not a more

1 nurses Farris and Power boarded the ambulance to provide the medical care for Andrew, and
2 MEDSTAR paramedic McFadden was to assist with the care. Nevin Decl. ¶ 15.⁴

3 There is also a dispute as to when the first set of vitals was taken once Andrew was back in
4 the ambulance and to whom those vitals were communicated. Plaintiffs contend that at 5:22 a.m.,
5 Andrew’s vitals were likely taken by McFadden (as shown in the California EMS reports).
6 According to that “reading,” Andrew’s pulse and blood pressure were deteriorating and Andrew
7 was “unstable.” Nevin Decl. ¶ 16; California EMS Report [Dkt. No. 95-12] MAMC 0121.
8 Plaintiffs allege that McFadden failed to “sufficiently and emphatically” inform Farris and Power
9 as to Andrew’s deteriorating condition at that time, as evidenced by the failure of this reading to
10 make it into CALSTAR’s records. Nevin Decl. ¶ 24; Oppo. to MEDSTAR MSJ at 6. Defendants
11 dispute whether these vitals were actually taken, or if they were taken, when they were taken.
12 Giannini Reply Decl. ¶¶ 14-15.⁵ Defendants argue that if these vitals were taken, it would be
13 logical that the CALSTAR nurses would have been aware of them given the small space in the
14 ambulance and the close proximity of McFadden (who may have taken the readings but cannot
15 remember doing so), Farris and Power. *Id.* ¶ 13.

16 Plaintiffs also point out that some of the equipment in the ambulance was not working,
17 forcing paramedic McFadden and nurses Farris and Power to “waste precious time”
18 troubleshooting the equipment problem and McFadden to take manual readings. Tomczak Decl. ¶

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20 reasonable option, much less that the decision to use ground transportation was grossly negligent.
21 As noted above, plaintiffs also do not raise any facts or make any argument that CALSTAR’s
22 failure to land at the accident cite was grossly negligent. Therefore, CALSTAR’s motion is
GRANTED as to the allegations regarding the failure to transport Andrew either from the accident
site or from UVMC to another facility.

23 ⁴ MEDSTAR EMT Bennet Leda was driving the ambulance. Plaintiffs do not discuss Leda or
attempt to show that his conduct was grossly negligent.

24 ⁵ Defendants assert the 5:22 a.m. reading is a mistake, as it is not “attributed” to any set of
25 personnel as all the other readings are, and as it is undisputed that the equipment which would
26 have taken an automatic blood pressure reading was not working at that time. California EMS
Report MAMC 0121. I note that the 5:22 a.m. reading reports *exactly* the same data (pulse, blood
27 pressure, “GCS”, respiratory effort) as the prior reading from 5:04 a.m. taken by McFadden.
Compare MAMC 0117 *with* MAMC 0121. None of the other readings in the California EMS
28 charts have exactly the same data, strongly suggesting that the 5:22 a.m. entry was an accidental
repeat of the 5:04 a.m. reading.

1 8.⁶ Plaintiffs contend that given the 5:22 a.m. reading showing that Andrew was coding and the
2 malfunctioning equipment, it was grossly negligent of McFadden, Farris, and Power to depart
3 UVMC for SRMH rather than inform Dr. Marks and take Andrew back inside UVMC for
4 stabilization.

5 Despite the dispute in the record over whether the 5:22 a.m. readings were taken, the
6 parties agree that the ambulance departed UVMC at 5:28 a.m. Andrew was loaded and secured
7 will “full spinal precautions,” oxygen was administered using a manual mask, warming measures
8 (blankets and headers) were used, and intravenous fluids (saline) were continually administered.
9 Declaration of Robert C. Mackersie [Dkt. No. 92-1], ¶ 19. However, within minutes of the
10 departure, Andrew was having trouble breathing and his pulse was continuing to weaken.
11 Declaration of Karen V. Tomczak [Dkt. No. 99] ¶ 12. Andrew was intubated and, shortly
12 thereafter, had a cardiac arrest. CPR was initiated. CALSTAR nurses administered epinephrine at
13 5:37 a.m. (just nine minutes after departing UVMC). Instead of turning back to UVMC, the
14 closest emergency room, the ambulance continued on and was eventually diverted to Healdsburg
15 District Hospital, where Andrew was pronounced dead at 6:18 a.m.

16 CALSTAR and MEDSTAR move for summary judgment on the remaining claims asserted
17 against them; (i) gross negligence and bad faith (Third Cause of Action); (ii) wrongful death
18 (Fourth Cause of Action); and (iii) survival action (Fifth Cause of Action).

19 LEGAL STANDARD

20 Summary judgment on a claim or defense is appropriate “if the movant shows that there is
21 no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of
22 law.” Fed. R. Civ. P. 56(a). In order to prevail, a party moving for summary judgment must show
23 the absence of a genuine issue of material fact with respect to an essential element of the non-
24 moving party’s claim, or to a defense on which the non-moving party will bear the burden of
25 persuasion at trial. *See Celotex Corp. v. Catrett*, 477 U.S. 317, 323 (1986). Once the movant has

26 _____
27 ⁶ Plaintiffs argue that a 5:24 a.m. blood pressure reading from an automated monitor is
28 “suspect” because the monitor was not working and did not record another reading until 5:43 a.m.
CAL0023. Plaintiffs argue the more accurate blood pressure reading was the one taken by
MEDSTAR by manual cuff at 5:22 a.m. Oppo. to MEDSTAR MSJ at 5.

1 made this showing, the burden then shifts to the party opposing summary judgment to identify
2 “specific facts showing there is a genuine issue for trial.” *Id.* The party opposing summary
3 judgment must then present affirmative evidence from which a jury could return a verdict in that
4 party’s favor. *Anderson v. Liberty Lobby*, 477 U.S. 242, 257 (1986).

5 On summary judgment, the Court draws all reasonable factual inferences in favor of the
6 non-movant. *Id.* at 255. In deciding a motion for summary judgment, “[c]redibility
7 determinations, the weighing of the evidence, and the drawing of legitimate inferences from the
8 facts are jury functions, not those of a judge.” *Id.* However, conclusory and speculative testimony
9 does not raise genuine issues of fact and is insufficient to defeat summary judgment. *See*
10 *Thornhill Publ’g Co., Inc. v. GTE Corp.*, 594 F.2d 730, 738 (9th Cir.1979).

11 Under California law, the standard of care for emergency personnel – including the
12 MEDSTAR and CALSTAR personnel – is gross negligence. *See* Cal. Health & Safety Code
13 1799.106 (providing that emergency medical personnel “who render[] emergency medical services
14 at the scene of an emergency or during an emergency air or ground ambulance transport shall only
15 be liable in civil damages for acts or omissions performed in a grossly negligent manner or acts or
16 omissions not performed in good faith.”). Gross negligence is “the want of even scant care or an
17 extreme departure from the ordinary standard of conduct.” *See, e.g., City of Santa Barbara v.*
18 *Superior Court*, 41 Cal. 4th 747, 754 (2007); *Cooper v. Bd. of Med. Examiners*, 49 Cal. App. 3d
19 931, 941 (Cal. Ct. App. 1975).

20 Generally, where a plaintiff claims negligence in the medical context, the plaintiff must
21 present evidence from an expert that the defendant breached his or her duty to the plaintiff and that
22 the breach caused the injury to the plaintiff. *See, e.g., Sanchez v. Kern Emergency Med.*
23 *Transportation Corp.*, 8 Cal. App. 5th 146, 153 (Cal. Ct. App. 2017), *as modified* (Feb. 16, 2017)
24 (relying on *Powell v. Kleinman* (2007) 151 Cal.App.4th 112, 123 (2007)). Where a moving
25 defendant supports a motion for summary judgment with expert declarations, plaintiff must come
26 forward with conflicting expert evidence. *Id.*

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1 **DISCUSSION**

2 **I. CALSTAR’S MOTION FOR SUMMARY JUDGMENT**

3 CALSTAR relies on the expert declaration of Dr. Robert C. Mackersie [Dkt. No. 92-1], a
4 specialist in trauma surgery, professor of surgery, and certified Advanced Trauma Life Support
5 instructor, to support its motion. After reviewing undisputed facts, he opines that Farris and
6 Power acted in good faith and were not grossly negligent in the provision of care to Andrew.
7 Mackersie Decl. ¶¶ 29 a. – c. He finds that Farris and Power provided significant medical
8 treatment and care to Andrew, including providing oxygen via a non-rebreather mask, full spinal
9 precautions for transportation, warming measures, IV fluids, and intubation. Mackersie Decl. ¶
10 19. When Andrew went into cardiac arrest, the nurses administered “advance cardiac life support
11 medications,” performed CPR, performed bilateral needle thoracostomies, and administered
12 additional IV fluids. *Id.* Based on performing those steps, Mackersie opines that the care
13 provided was not “want of scant care” or a “gross departure” from what a reasonably careful
14 person would do in the same or similar circumstances. *Id.* ¶¶ 27, 29.

15 Plaintiffs counter with the opinion of Karen Tomczak that Farris and Power were grossly
16 negligent in: (i) departing UVMC while Andrew was not stable; (ii) leaving UMVC while the
17 monitoring equipment in the ambulance was still not functioning; (iii) failing to return to UVMC
18 (a level IV trauma center) when Andrew started coding (nine minutes after departure), and instead
19 continuing towards Santa Rosa, which was more than an hour away; (iv) failing to administer any
20 of the blood they were provided by Dr. Marks, and instead administering more saline contrary to
21 normal standards; and (v) failing to provide that saline without the pressure backs.⁷

22 CALSTAR argues that Tomczak failed in her expert report to opine that the treatment
23 provided by Farris and Power was grossly negligent and so failed to create a dispute of fact. In
24 opposition, plaintiffs submitted a declaration from Tomczak that repeats essentially the
25 conclusions from her expert report – that the CALSTAR nurses failed to meet “the applicable
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27 ⁷ As noted above, plaintiffs make no argument or present any evidence regarding whether the
28 CALSTAR pilot in command Josh Judge was grossly negligent. CALSTAR’s motion for
summary judgment is GRANTED with respect to claims regarding Judge’s actions.

1 standard of care” – but expressly identifies the standard of care as gross negligence and opines that
2 the nurses were grossly negligent. Tomczak asserts that each of the five actions identified above
3 shows that “scant care” was provided, identifying as the “most extreme” example the failure of
4 Farris and Power to return Andrew to the care of UVMC either before departing UVMC or soon
5 thereafter because within minutes of their departure they admittedly recognized that Andrew was
6 coding. Tomczak Decl. ¶¶ 8-10, 12-13.

7 CALSTAR contends that even if the new Tomczak declaration is admissible, it is not
8 reliable and not persuasive because nowhere does Tomczak address the care that *was* provided to
9 Andrew – the continued provision of oxygen via a non-rebreather mask, continued full spinal
10 precautions for loading and transportation, warming measures including blankets and heaters,
11 continued IVs and IV fluids, intubation, administration of medicines, and performing CPR after
12 the cardiac arrest – that (according to CALSTAR) establishes as a matter of law that the care
13 provided by Farris and Power was neither scant nor an extreme departure.

14 **A. Admissibility of Tomczak’s Declaration**

15 CALSTAR points out deficiencies in Tomczak’s declaration but none require me to strike
16 it. CALSTAR argues that the declaration contradicts her report – which did not identify the
17 applicable standard of care – by purporting to opine that Farris and Power were grossly negligent.
18 CALSTAR also characterizes Tomczak’s Declaration as an impermissible supplemental expert
19 report, submitted in violation of expert disclosure requirement and agreed-to deadline of March 3,
20 2017. Plaintiffs respond that in her report Tomczak opined that the nurse’s care fell below “the
21 applicable” standard of care and the declaration simply clarifies what that standard is. Plaintiffs
22 also point out that the Tomczak declaration was filed before the April 11, 2017 expert discovery
23 cut-off.

24 CALSTAR also argues that the Tomczak declaration should be rejected because it is based
25 on assumptions without evidentiary support and rests on speculation and conjecture. CALSTAR
26 Reply at 5-6. That argument is based on Tomczak’s failure to acknowledge the care that was
27 given to Andrew and her singular focus on what was not done. A similar accusation could be
28 leveled at CALSTAR’s expert Mackersie, who does not address the alleged failures of care by the

1 CALSTAR nurses identified by plaintiffs and Tomczak in her expert report, but only the care
2 admittedly provided.

3 CALSTAR then contends that Tomczak’s declaration should be struck because she is not
4 qualified to render an opinion as to gross negligence under Cal. Health & Safety Code section
5 1799.106. CALSTAR Reply 6-8. CALSTAR’s argument rests on Tomczak’s description of her
6 opinions as based on her training and practice in the Emergency Room where the gross negligence
7 standard does not apply. Instead, according to CALSTAR, the opinions of Mackersie demonstrate
8 summary judgment should be granted in its favor. While Mackersie is distinguished and
9 eminently experienced in the fields of trauma surgery and advanced trauma life support,
10 CALSTAR does not explain his expertise regarding the gross negligence standard applicable to
11 medical personnel operating at the scene of an accident or in transport, a similar supposed defect
12 that CALSTAR identifies with respect to Tomczak.

13 I will not strike the Tomczak declaration on any of these grounds. Its deficiencies weigh in
14 the resolution discussed below.

15 **B. Want of Scant Care or Extreme Departure from Standard of Care**

16 The issue boils down to whether the provision of some significant amount of care – *e.g.*,
17 the measures of care identified by Mackersie – means as a matter of law that the CALSTAR
18 personnel were not grossly negligent in failing to provide the care identified by Tomczak; *i.e.*,
19 departing in an ambulance with certain pieces of non-functioning equipment, failing to stay or
20 return to UVMC when Andrew coded, and failing at any time to provide blood and/or pressure
21 backed saline. Said another way, did these failures amount to scant care or an extreme departure
22 of care for someone with Andrew’s injuries and symptoms, despite that care was provided?
23 Neither side provides any case law discussing the application of the gross negligence standard in a
24 similar situation. However, the undisputed evidence is that some significant amount of care was
25 provided to Andrew.

26 While Tomczak argues that the CALSTAR nurses were grossly negligent in failing to take
27 certain steps (primarily, returning to UVMC and instead continuing on towards SRMH), she does
28 not address the care that was provided; the intubation, the CPR, the drugs administered while the

1 ambulance was in active transport. Nor does Tomczak contest Mackeris's opinion that the care
2 that was actually provided meant the nurses could not have been grossly negligent. *Cf. Sanchez v.*
3 *Kern Emergency Med. Transportation Corp.*, 8 Cal. App. 5th 146, 162 (Cal. Ct. App. 2017), *as*
4 *modified* (Feb. 16, 2017) ("When the moving papers undermine the assumptions on which the
5 opposing expert's opinion is based, the opposing expert must do more than simply assert those
6 discredited assumptions in order to meet the admissibility requirements of Evidence Code section
7 801, subdivision (b)."). In these circumstances, plaintiffs have failed to raise a material fact
8 showing that the care provided to Andrew was an "extreme departure" from what an emergency
9 nurse should have reasonably provided or was "scant care" given his known injuries and
10 symptoms.

11 The California Legislature has made the determination that emergency medical personnel
12 should not be subjected to liability for their efforts to serve the public unless there is gross
13 negligence – "the want of even scant care or an extreme departure from the ordinary standard of
14 conduct." There is an argument in this case that the nurses should have ordered the ambulance to
15 turn around when Andrew went into cardiac arrest, or done the other things suggested by
16 Tomczak. But the nurses here were undeniably taking steps to try to save Andrew's life in the
17 ambulance, and no reasonable jury could find that their conduct amounted to an extreme departure
18 from the ordinary standard of conduct.

19 **II. MEDSTAR'S MOTION FOR SUMMARY JUDGMENT**

20 Plaintiffs argue MEDSTAR paramedic McFadden failed Andrew in: (i) making no effort
21 to consult with UVMC or the flight nurses regarding the appropriate trauma point of entry, as
22 required by the Coastal Valley EMS Agency protocols; (ii) failing to inform Dr. Marks that
23 Andrew was coding at 5:22 a.m., before the ambulance departed UVMC; and (iii) failing to
24 "sufficiently and emphatically" inform nurses Farris and Power of Andrew's deteriorating
25 condition from the 5:22 a.m. vital readings. Their expert, Jon Nevin (a paramedic with 18 years
26 of experience), identified only two acts of gross negligence.⁸ Nevin Decl. ¶ 1. First, "it was
27

28 ⁸ Also, despite mentioning these issues in passing in their briefing, plaintiffs make no argument or attempt to identify disputes of fact as to whether waiving off the helicopter or failing to consult

1 below the standard of care and incomprehensible” that McFadden “gave no consideration” to
2 bypassing UVMC in favor of SRMH at the accident scene. Nevin Decl. ¶ 23. Second,
3 McFadden’s care for Andrew “grossly fell below the standard of care” when McFadden’s knew of
4 Andrew’s deteriorating vitals at 5:22 a.m. but made no attempt to seek further care from
5 Marks/UVMC and the ambulance was allowed to depart. Nevin Decl. ¶ 25.⁹

6 MEDSTAR relies on the expert declarations of Michael Giannini, a paramedic of over 35
7 years, who argues that McFadden’s conduct was not grossly negligent. Dkt. No. 95-1; *see also*
8 Reply Giannini Decl. [Dkt. No. 106-2]. No reasonable jury could disagree with his conclusion.

9 **A. Decision to Transport to UVMC**

10 As to McFadden’s initial decision to send Andrew to UVMC, Giannini opines that it was
11 in compliance with the Coastal Valleys EMS Policy, which required transportation to the closest
12 emergency department given Andrew’s deteriorating vital signs. Giannini Decl. ¶¶ 18-19; *see also*
13 Policy No. 7007.4 [Dkt No. 106-1]. Giannini also opines that McFadden complied with Policy
14 7007 in that he did consult with a “base station” doctor – someone at UVMC – prior to
15 determining that Andrew should be transported by ground to UVMC. Citing McFadden’s
16 deposition, Giannini asserts that McFadden not only described Andrew’s condition over the radio
17 but also “stipulated” that upon arrival at the UVMC emergency department a decision could be
18 made as to whether Andrew should be immediately be transported elsewhere via helicopter or
19 taken into the UVMC emergency department. Giannini Reply Decl. ¶ 6. Even more significantly,
20 Giannini states there was no duty on McFadden to consider the possibility of direct ground
21 transportation from the scene to SRHC because under the applicable Policy (7007.4) Andrew’s
22 deteriorating vital signs *required* him to be transported to UVMC as the nearest emergency
23

24
25 with the flight nurses constituted gross negligence.

26 ⁹ Plaintiffs also rely on the expert declaration of Dr. David Goldschmid [Dkt. No. 104-6], to
27 discuss why a patient with the injuries and vitals Andrew had meant Andrew should have been
28 intubated at UVMC. Dr. Goldschmid in his declaration opines on the treatment of Andrew by Dr.
Marks at UVMC, but does not mention McFadden, much less address whether McFadden
breached the applicable “grossly negligent” standard of care.

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department. *Id.* ¶ 9.¹⁰

In his deposition, McFadden testified as follows:

Q. With Shane Penland, where the two of you made the decision to transport the patient by ambulance, did you discuss whether to transport him by ambulance to UVMC only or did you consider other hospitals?

A. That's my base hospital. That's the only -- that's where I would transport to. It's the closest facility.

...
Q. In your discussion with Shane Penland regarding whether or not to transport the patient by ambulance, was there any discussion on whether or not UVMC was the appropriate care facility for the patient?

...
A. There was no discussion about if I could go somewhere else. It was my base hospital. It's the place I would take him.

...
Q. There is a note here saying that you were going to transport to UVMC and meet the CALSTAR 4 crew there. Was the -- and did you have any intent to transfer the patient to the CALSTAR 4 crew, as opposed to the E.R. at UVMC, or was it only -- or was it to UVMC, or did you not have an intent either way, at the time of the transfer?

A. I was trying to do what was best for the patient. If they weren't going to be able to land at the scene, for whatever reasons, and they wanted to take the patient to another facility, because they felt they needed another facility, and they would get approval for that, then I wanted to have -- to have them meet me at Ukiah Valley Medical Center, to make that determination for what was best for the patient.

...
Q. Okay. So, the call on whether or not they were going to fly the patient to another facility was going to be left to the CALSTAR 4 crew and presumably the doctors at Ukiah Valley Medical Center?

...
A. I would say yes.

...
Q. Did you make a determination on the morning of the accident of whether or not Santa Rosa Memorial Hospital was within a 60-minute transport time from the scene of the accident?

A. No, I did not. It's my base hospital. I have to contact my base hospital. My base hospital is Ukiah Valley Medical Center. That's where I have to take my patient. I made contact with them. The patient wasn't stable enough to be transported by any other -- or by a ground ambulance to another facility.

¹⁰ Giannini also argues that the Policy guidelines regarding when a local trauma center can be bypassed were not applicable to the incident at issue because they apply only when the local trauma center has put itself on bypass (in other words, unavailable) status and a field paramedic like McFadden has no authority to make that determination. *Id.* ¶ 11.

1 Deposition of Cameron McFadden at 30:3-13; 30:18-31:2; 31:9-23; 31:24-32:11; 49:11-20 (Ex C.
2 to Declaration of Gerald S. Richelson [Dkt. No. 104]; Ex. C to Reply Declaration of Jianlin Song).

3 McFadden also testified that he had an “order” from UVMC to transport Andrew there
4 testifying that in his conversation with UVMC:

5 A. I did not request a divert. I requested – I gave them – in a radio
6 report, I gave [them] a rundown of the patient and his condition, and
7 I said I was coming to rendezvous with the CALSTAR 4 crew, to
8 make a determination if he could go with the CALSTAR 4 crew or
9 come into the E.R.

8 Q. And the doctor signed off on that plan or . . .

9 A. Yeah.

10 *Id.* at 50:20-51:2. Finally, McFadden testified that the decision to bypass and transport a patient
11 directly to a hospital with a higher level of care than available at his base hospital did “not lie”
12 within his power. *Id.* at 56:17-25.

13 Given the language of the Policies under which McFadden was operating and his
14 testimony, plaintiffs have failed to raise a dispute of fact that a jury could rely on to show that
15 McFadden’s failure to consider or request a diversion directly to SRMH was grossly negligent.
16 Under undisputed facts, McFadden was complying with the applicable EMS Policies and could
17 not have been grossly negligent.

18 **B. Impact of Alleged 5:22 a.m. Vital Readings**

19 As an initial matter, Giannini explains that under California law the person ultimately
20 responsible for medical management of a patient is the most medically qualified person on the
21 scene. Giannini Decl. ¶¶ 7-9.¹¹ Therefore, while McFadden was in charge at the accident scene
22 and for the initial transportation to UVMC, once the CALSTAR nurses boarded the ambulance,
23 the care of Andrew was in those nurses’ control. Giannini Reply Decl. ¶ 14.

24 Giannini argues that *if* the vital signs were taken by McFadden at 5:22 am, given they

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26 ¹¹ Cal. Health & Safety Code § 1798.6 provides that “[a]uthority for patient health care
27 management in an emergency shall be vested in that licensed or certified health care professional,
28 which may include any paramedic or other prehospital emergency personnel, at the scene of the
emergency who is most medically qualified specific to the provision of rendering emergency
medical care.”

1 indicated “significant shock” the vitals “would have been conveyed immediately” to the
2 CALSTAR nurses in charge at that time, especially in light of the confined space of the
3 compartment, and any actions based on them was up to the CALSTAR nurses. Giannini Reply
4 Decl. ¶ 13.¹² There is no doubt that this is the only reasonable inference one can take from the
5 facts.

6 Drawing the reasonable inferences in plaintiffs favor, I will assume for ruling on this
7 motion that a blood pressure reading was taken by McFadden at 5:22 a.m. prior to the departure of
8 the ambulance from UVMC. If this occurred, McFadden was still not grossly negligent because
9 the responsibility for making a decision based upon that reading lies with the CALSTAR nurses.
10 Other than speculation of plaintiffs’ expert Nevin, there is no evidence in the record that
11 McFadden *did not* communicate the 5:22 a.m. reading to the CALSTAR nurses. MEDSTAR
12 points out that neither McFadden nor Power was asked at deposition if they communicated
13 regarding the 5:22 a.m. readings. And when asked about the 5:22 a.m. reading in her deposition,
14 nurse Farris simply responded that she did not know who took that “assessment.” Song Reply
15 Decl., Ex, E Farris Depo. Tr. at 34:25 – 36:5.

16 On this record, and after Andrew was in the care of the CALSTAR nurses, McFadden
17 cannot be found to have been “grossly negligent” for either failing to inform Marks at UVMC of
18 the 5:22 a.m. reading or for, as plaintiffs put it, failing to “sufficiently and emphatically” inform
19 nurses Farris and Power of Andrew’s deteriorating condition. MEDSTAR’s motion for summary
20 judgment is GRANTED. There are no material disputed facts that reasonably construed in
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26 ¹² Giannini also contends that given the timing of events which are agreed-to and the fact that
27 vitals are usually not taken until after an ambulance departs and is on the way, it was unlikely that
28 a blood pressure reading was taken at 5:22 a.m. (as apparently recorded in the California EMS
records) and that log entry was more likely triggered by the timing of the notification to dispatch
of the transfer request to SRMH. *Id.* ¶ 15.

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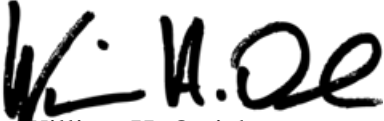
plaintiffs' favor, could lead to a conclusion that McFadden was grossly negligent.

CONCLUSION

CALSTAR's and MEDSTAR's motions for summary judgment are GRANTED in full.

IT IS SO ORDERED.

Dated: May 5, 2017



William H. Orrick
United States District Judge