

**CAUSE NO. 06-01M**

**NAME: THERESA RINEHART, HOLDER OF PARAMEDIC  
CERTIFICATE #44888**

**ADMINISTRATIVE LAW JUDGE: WILLIAM K. TEEGUARDEN**

**DATE: AUGUST 26, 2008**

**COMMISSION ACTION: AFFIRMED**

**FINDINGS OF FACT**

1. The Commission and the Agency are agencies within the meaning of IC 4-21.5.
2. IC 4-21.5, IC 16-31, and 836 IAC 4 apply to this proceeding.
3. The Commission and the Agency are the state agencies responsible for regulating emergency medical services in Indiana.
4. At all times relevant to this proceeding, Rinehart was the holder of Paramedic certificate 44888 which was issued by the Agency and was employed by the FD.
5. The Commission is the ultimate authority within the meaning of IC 4-21.5 over contested matters involving paramedic certification in Indiana.
6. On September 8, 2005, the FD responded to an emergency call involving the Patient, a choking infant.
7. Rinehart was the paramedic on the ambulance making the run.
8. Rinehart unsealed the infant ventilation unit and commenced its use at the residence.
9. The Patient was blue at this time but color improved somewhat.
10. The mask of the unit worked properly at that time.
11. The equipment used on this run had a "popoff" valve to prevent oxygen from being forced under too much pressure into the lungs.
12. The Patient was placed on a stretcher and moved to the ambulance.
13. In order to get through the residence doorway, the EMTs moving the Patient had to pass control of the mask because of space constraints.
14. The same procedure was used in placing the Patient in the ambulance.
15. After the ambulance pulled away, the EMT holding the bag felt a rush of air and noticed the popoff valve was missing and placed his finger over the hole.<sup>1</sup>
16. Just prior to noticing this problem, the ambulance stopped to pick up another paramedic.
17. Rinehart was concentrating her efforts on starting an IV while the other paramedic took over the breathing apparatus and eventually administered doses of EPI.
18. Shortly after arrival at the hospital, the Patient was pronounced dead.
19. As a result of several follow up investigations by different entities

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<sup>1</sup> One of Rinehart's theories of the case involved a demonstration that the valve was actually still there and could not be knocked off. Given the testimony of all the persons who worked on the Patient at the scene, the trier of fact will assume the valve was missing.

- including the Agency, the Agency issued the Order placing Rinehart's paramedic certification on probation and ordering her to take some continuing education courses.
20. The Agency cited 836 IAC 4-9-3(f)(2) as the rule violated in that Rinehart's failure to observe the absence of the valve endangered the health or safety of the emergency patient.
  21. 836 IAC 4-9-3(f)(2) states "Paramedics shall not act negligently, recklessly, or in such a manner that endangers the health or safety of emergency patients or members of the general public."
  22. The first hearing on this matter was held April 27, 2006.
  23. Subsequently, the administrative law judge wrote a decision concluding that Rinehart's actions, as lead paramedic, of concentrating totally on starting an IV on an infant (difficult to do under the best of circumstances, let alone in the back of a speeding ambulance) justified a finding of negligence as stated in 836 IAC 4-9-3(f)(2).
  24. At the Commission meeting in September of 2006, after extensive argument, Rinehart convinced the Commission that the matter should be remanded for the taking of further evidence.
  25. Upon remand, the administrative judge set formal deadlines for discovery including new exhibits and witnesses.
  26. The administrative law judge also took official notice pursuant to IC 4-21.5-3-26 of the testimony, exhibits, and objections introduced during the April hearing.
  27. The hearing to take additional evidence was held on September 25 and 26, 2007.
  28. The evidence produced at this second hearing shows the wisdom of Rinehart's enthusiastic argument for allowing additional evidence.
  29. A number of witnesses testified at the second hearing.
  30. The trier of fact finds the testimony of Dr. Rutherford, the medical director for the FD at the time the incident occurred, to be highly credible and determinative<sup>2</sup> in this matter.
  31. Dr. Rutherford was not called as a witness at the first hearing and no reference was made to the applicable EMS protocols for Hancock County.
  32. Dr. Rutherford reviewed the protocols in his capacity as medical director and was familiar with them.
  33. Dr. Rutherford read into the record protocol I11E which stated "After making contact with the patient, he or she has a responsibility until you (sic) are released by a higher or equal medical authority, the patient is deemed nonviable, or you receive a signature of release."
  34. In Rinehart's situation, another paramedic entered the ambulance and took charge of the breathing aspect of the treatment while Rinehart worked on the IV.
  35. The other paramedic noted the popoff valve problem and coped with it as best she could.

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<sup>2</sup> Dr. Rutherford left Hancock County for Marion County shortly after this incident and also subsequent to this incident, was appointed to the Commission on which he now serves.

36. Further, Dr. Rutherford also read into the record protocol number B dealing with pediatric patients which stated “Incubate patient and establish IV.”
37. Protocol C was read into the record and involved administering doses of epinephrine.
38. Finally, when asked if anything that was done on this run caused the Patient’s death, he simply responded “no”.
39. When asked about Rinehart’s performance on the day in question, his answer was “My conclusion was that her report had been inadequate”.
40. For the reasons stated in the first decision on this matter, the administrative law judge agrees with Dr. Rutherford that the report was poorly written, however given the fact that the code section violated refers to patient endangerment, an inadequate report is not grounds for a finding of negligent treatment of a patient on site or during transport.
41. The administrative law judge now vacates his decision of July 11, 2006.
42. In trying to start an IV, Rinehart was following her County protocols.
43. Once the other paramedic was in the ambulance and dealing with the mask and the epinephrine, the County protocols relieved her of these responsibilities.
44. Finally, in light of Dr. Rutherford’s conclusion that Rinehart’s actions involving patient care did not contribute to the death of the Patient, the findings and Order of January 24, 2006, should be reversed.

**NONFINAL ORDER**

The Order of the Department of Homeland Security dated January 24, 2006, issued to Theresa Rinehart, holder of paramedic certificate #44888, placing her certification on probation is hereby reversed.