

2004

# W. Scott Jepson, RN vs. Department of Commerce, Division of Occupational and Professional Licensing : Brief of Appellant

Utah Court of Appeals

Follow this and additional works at: [https://digitalcommons.law.byu.edu/byu\\_ca2](https://digitalcommons.law.byu.edu/byu_ca2)



Part of the [Law Commons](#)

Original Brief Submitted to the Utah Court of Appeals; digitized by the Howard W. Hunter Law Library, J. Reuben Clark Law School, Brigham Young University, Provo, Utah; machine-generated OCR, may contain errors.

Karl Perry; Assistant Attorney General; Attorney for Respondent.

Arron F. Jepson; Attorney for Appellant.

---

## Recommended Citation

Brief of Appellant, *Jepson v. Department of Commerce*, No. 20040808 (Utah Court of Appeals, 2004).  
[https://digitalcommons.law.byu.edu/byu\\_ca2/5223](https://digitalcommons.law.byu.edu/byu_ca2/5223)

This Brief of Appellant is brought to you for free and open access by BYU Law Digital Commons. It has been accepted for inclusion in Utah Court of Appeals Briefs by an authorized administrator of BYU Law Digital Commons. Policies regarding these Utah briefs are available at [http://digitalcommons.law.byu.edu/utah\\_court\\_briefs/policies.html](http://digitalcommons.law.byu.edu/utah_court_briefs/policies.html). Please contact the Repository Manager at [hunterlawlibrary@byu.edu](mailto:hunterlawlibrary@byu.edu) with questions or feedback.

IN THE UTAH COURT OF APPEALS

---0000000---

.A10

DOCKET NO. 20040808-CA

W. SCOTT JEPSON, RN

Appellant,

vs.

DEPARTMENT OF COMMERCE,  
DIVISION OF OCCUPATIONAL AND  
PROFESSIONAL LICENSING (DOPL),  
Respondent

Appeal No. 20040808-CA

DOPL Case No. 2002-151

---0000000---

BRIEF OF APPELLANT

Appeal from a Final Order (June 16, 2003) of The Division of Occupational and Professional Licensing [DOPL], and from an Order on Review (July 30, 2004) of the Department of Commerce upholding DOPL's Order of an illegal post trial change of Utah Controlled Substances Act Rule - R156-37-502(4) made without complying with Utah Administrative Rule Making Act, §63-46a-3(2)(c), (3), (4)(d), (6), (7)(a)(i),(b), (8)(b), and DOPL's retrospective application of its illegal Rule change to Appellant's acts of April 2002, making Appellant's then legal acts illegal and Ordering Appellant to commit future criminal acts.

The Honorable Steven Eklund, ALJ, Presiding at DOPL Trial

The Honorable Mesuda Medcalf, ALJ, Presiding, Dept. of Commerce Review

**ARRON F. JEPSON**(1698)  
10660 South 540 East  
Sandy, Utah 84070  
Telephone: 572-3332  
Attorney for Appellant

Karl Parry  
Assistant Attorney General  
Division of Commercial Enforcement  
160 East 300 South, Fifth floor  
P.O. Box 140872  
Salt Lake City, Utah 84114-0872  
Telephone 801-366-0521  
Attorney for Respondent

Published Decision

FILED  
UTAH APPELLATE COURTS  
DEC 06 2004

**IN THE UTAH COURT OF APPEALS**

---ooo0ooo---

W. SCOTT JEPSON, RN

Appellant,

vs.

DEPARTMENT OF COMMERCE,  
DIVISION OF OCCUPATIONAL AND  
PROFESSIONAL LICENSING (DOPL),  
Respondent

Appeal No. **20040808-CA**

DOPL Case No. 2002-151

---ooo0ooo---

**BRIEF OF APPELLANT**

Appeal from a Final Order (June 16, 2003) of The Division of Occupational and Professional Licensing [DOPL], and from an Order on Review (July 30, 2004) of the Department of Commerce upholding DOPL's Order of an illegal post trial change of Utah Controlled Substances Act Rule - R156-37-502(4) made without complying with Utah Administrative Rule Making Act, §63-46a-3(2)(c), (3), (4)(d), (6), (7)(a)(i),(b), (8)(b), and DOPL's retrospective application of its illegal Rule change to Appellant's acts of April 2002, making Appellant's then legal acts illegal and Ordering Appellant to commit future criminal acts.

The Honorable Steven Eklund, ALJ, Presiding at DOPL Trial

The Honorable Mesuda Medcalf, ALJ, Presiding, Dept. of Commerce Review

**ARRON F. JEPSON(1698)**

10660 South 540 East

Sandy, Utah 84070

Telephone: 572-3332

Attorney for Appellant

Karl Parry

Assistant Attorney General

Division of Commercial Enforcement

160 East 300 South, Fifth floor

P.O. Box 140872

Salt Lake City, Utah 84114-0872

Telephone 801-366-0521

Attorney for Respondent

**Published Decision**

## LIST OF ALL PARTIES

W. Scott Jepson (Jepson)	Appellant
Department of Commerce (Commerce), Division of Occupational and Professional Licensing (DOPL).	Respondent

## TABLE OF CONTENTS

Table of Authorities	iii
Cases	iii -iv
Secondary References	iv
Rules	iv
Statutes and Rules cited in DOPL’s Petition against Appellant	iv
DOPL Petition Count I	iv
DOPL Petition Count II	v
DOPL Petition Count III	v
DOPL Petition Count IV	v
Other Statutes	
Jurisdictional Statement	vi
Statement of Issues and Standards of Review	vi
Constitutional or Statutory Provisions	1
U.S. Constitution, Article 1, §10	1, 38, Exhibit 10
Statement of Case	1
Course of Proceedings	4
Statement of Facts	5
Summary of Argument	8
Argument	10
First Analysis - Delivery	11
Related Issues	20
Second Analysis - Nurse Baker’s Testimony	23
Related Issues	33
Third Analysis - Theft or Taking	35



Related Issues	38
Fourth Analysis - Ex Post Facto Conduct of DOPL	39
Related Issues	39
Fifth Analysis - Utah Administrative Rule Making Act & Usurpation of Exclusive Legislative Authority	40
Related Issues	42
Sixth Analysis - Judge Eklund Excluded Evidence & Gave False Assurance	42
Related Issues	48
Miscellaneous issues	48
Conclusion	48

## TABLE OF AUTHORITIES

### CASES

<i>Anton v Thomas</i> , 806 p.2d 744 (Utah App. 1991)	24,25
<i>Burton v Youngblood</i> , 711 P.2d 245 (Utah 1985);	23,24,25,26
<i>Calder v Bull</i> , 3 U.S. 386, 3 Dall 386, 386, 1 L. Ed. 648(1798).	Exhibit 10
<i>Dikeou v Osborn</i> , 881 P.2d 943 (Utah App. 1994)	25,26
<i>Fussel v. Department of Commerce, Division of Occupational &amp; Professional Licensing</i> , 815 P.2d 250 (Utah App. 1991)	Footnote, 41
<i>Mountain Fuel Supply Co. V Public Service commission</i> , 861 P.2d 414, 222 Utah Adv. Rep. 18 (Utah 1993)	Footnote, 48
<i>Robb v Anderton</i> , 863 P.2d 1322, 920770-CA (Utah App. 1993)	25
<i>Johnson v Simons</i> , 551 P.2d 515 (Utah 1976)	46
<i>Semeco Industries, Inc v. Tax Comm’n</i> , 849 P.2d 1167 Utah correction of error standard	22
<i>State v. Allen</i> ,	Footnote, 37
<i>State v. Chesnut</i> , 621 P.2d 1228 (Utah 1980)	Footnote, 37

<i>State v Dibello</i> , 780 P.2d 1221 (Utah 1989) .....	Footnote, 45
<i>State v Eldredge</i> , 773 P 2d 29 (Utah 1989) .....	47
<i>State v Emmett</i> , 839 P.2d 781 (Utah 1992) .....	47
<i>State v. Gallion</i> , 572 P. 2d 683 (Utah 1977) .....	41
<i>State v. Green</i> , 793 P.2d 912(Utah App. 1990) .....	41
<i>State v. Hollen</i> , 1999 Ut App 123, 982 P.2d 90 .....	37
<i>State v Jensen</i> , 727 P.2d 201 (Utah 1986) .....	45
<i>State v Kazda</i> , 545 P.2d 190 (Utah 1976) .....	37
<i>State v Royball</i> 710 p.2d 168,169 (Utah 1985) .....	45
<i>State v Taylor</i> , 378 P.2d 352, 14 Utah 2d 107 (Utah 1963) .....	36
<i>Utah Ass’n of Counties v Tax Comm’n of the State of Utah</i> , Nos. 930451 .....	48

## SECONDARY REFERENCES

Black’s Law Dictionary, Revised Fourth Ed. 1968, p. 888-889 defines “impossibility” .....	Exhibit 9, p. 3
16A CJS §409 .....	Exhibit 10
16B AM Jur 2d §647, p. 130 .....	Exhibit 10
Jury Instructions given by trial Judge to DOPL Board sitting as Jury regarding:           Ownership of a Narcotic .....	Exhibit 9
Impossibility .....	Exhibit 9
MUJI 6.22 .....	27

## RULES

URE 103 .....	42
401 .....	42
402 .....	42

403	.....	24,27,45
702	.....	23,25,26,27

**Statutes and Rules Cited in DOPL’s Petition**  
**DOPL PETITION COUNT I**

§58-37-8(2)(a)(i), UCA -	.....	12, 17, 19, 21, Exhibits 1 & 1B
§58-37-2(ee) —	.....	21, Exhibit 1B,
§58-31b-502(5), UCA —	.....	12, 32, Exhibit 1B
§58-1-501(2)(a), UCA —	.....	12, Exhibit 1B
§58-1-401(2)(a),(b), UCA	.....	Exhibit 1B, 1C
§58-31b-402(1), UCA —	.....	Exhibit 1B, 1C

**DOPL PETITION COUNT II**

§76-5-111.1(1)(2)(a)(i) —	.....	Exhibit 1C
§58-1-501(2)(g), UCA —	.....	Exhibit 1C

**DOPL PETITION COUNT III**

§58-31b-502(7), UCA —	.....	12,13,17,20,35,41, Exhibit 1B
-----------------------	-------	-------------------------------

**DOPL PETITION COUNT IV**

Rule R156-37-502(4),	....	vii, viii, 3,4,7,8,9,10,13,18,19,20, 22,23,29,32,38,39,40, 41,44, Exhibit 1C
----------------------	------	---

**Other Statutes**

§58-1-502, UCA -	violations of Title 58- class A misdemeanors	....	Exhibit 1
§58-37-8(1)(a)(ii), UCA,	<b>distribute</b>	.....	10,18,20,22,41, Exhibit 1
§58-37-2(1)(n), UCA	<b>“Distribute” means to deliver.</b>	...	10,18,20,22, Exhibit 1

§63-46a-3(2)(c), (3), (4)(d), (6), (7)(a)(i),(b), (8)(b) <i>Utah Administrative Rule Making Act</i> , - provides for the creation of an exception to a Rule .....	19,22,40, Exhibit 1D
§63-46a-2 .....	41
§63-46a-4 UCA, <i>Rule Making Procedure</i> , “ .....	19,40, Exhibit 1D
§63-46b-4(g) .....	7,8,9,47
§63-46b-14 UCA - Notice of Right to Appeal within 30 days .....	41
§63-46b-16, UCA - Notice of Right to Appeal within 30 days .....	6
§63-46b-4(d) .....	6
§63-46b-4(b),(d),(e) .....	7
§63-46b-4(d), (g) .....	6,7
§76-6-404, UCA .....	19, Exhibit 1

## JURISDICTIONAL STATEMENT

This Court has jurisdiction to review this matter pursuant to §63-46b-14 UCA,  
Judicial Review — Exhaustion of administrative remedies, and §63-46b-16 UCA,  
Judicial Review - Formal Adjudicative proceedings.

## STATEMENT OF ISSUES and STANDARD OF REVIEW

1. Whether at all pertinent times Appellant lawfully possessed the liquid morphine?  
Standard of Review: Correction of Error and or Substantial Evidence Test, §63-46b-4(d), (g) - “interpretation” is subject to a correction of error standard of review and is not “merely an exercise of implicitly delegated discretion to interpret or apply the law, reviewed under subsection (4) (h) (i).”  
Stems from post trial DOPL Order
  
2. Whether a traveling home health nurse can temporarily safeguard prescribed but

unnneeded morphine at his home?

Standard of Review: Correction of Error, §63-46b-4(d) - and is not “merely an exercise of implicitly delegated discretion to interpret or apply the law, reviewed under subsection (4) (h) (i).”

Stems from post trial DOPL Order

3. Whether a patient’s daughter and son-in-law have a “right of possession” to a lethal volume of a Schedule II controlled substance - liquid IV morphine - legally in the possession and control of appellant as administering nurse, prescribed by a physician for administration by the appellant nurse to the patient ‘prn’ - on an as needed basis - where the physician ordered appellant nurse “that’s a hell of a lot of morphine” and “be careful with that” and where no need for the morphine existed after the prescription was legally filled?

Standard of Review: Correction of Error, §63-46b-4(d)

Stems from post trial DOPL Order

4. Whether Count I of DOPL’s Petition should be dismissed for lack of evidence?

Standard of Review: Correction of Error and or Substantial Evidence Test, §63-46b-4(d), (g)

Stems from post trial DOPL Order

5. Whether it is error and or illegal for DOPL and Commerce to order “delivery” of physical possession of a lethal volume and concentration of liquid morphine to non-patient family members in violation of statutes and contrary to its own Controlled Substances Act Rule -R156-37-502(4)?

Standard of Review: Correction of Error §63-46b-4(d) -- “interpretation” is subject to a correction of error standard of review and is not “merely an exercise of implicitly delegated discretion to interpret or apply the law, reviewed under subsection (4) (h) (i).”

Stems from post trial DOPL Order

6. Whether DOPL and Commerce have authority to order a nurse to violate a narcotic’s rule and statutes and thereby force him to commit criminal and unethical acts?

Standard of Review: Correction of Error, §63-46b-4(b), (d), (e) —

“interpretation” is subject to a correction of error standard of review and is not “merely an exercise of implicitly delegated discretion to interpret or apply the law, reviewed under subsection (4) (h) (i).”

Stems from post trial DOPL Order

7. Whether Appellant made timely objections to nurse Baker testifying?

Standard of Review: Correction of Error, §63-46b-4(d)

See Exhibit 2 with transcript citations to objections

8. Whether Appellant's 4 objections to nurse Baker's lack of qualifications as expert witness should have been sustained and the testimony disallowed or disregarded?

Standard of Review: Correction of Error, §63-46b-4(d)

See Exhibit 2 with transcript citations to objections

9. Whether Baker's testimony is "personal opinion" not expert testimony - as admitted by DOPL?

Standard of Review: Correction of Error, §63-46b-4(d)

See Exhibit 2 with transcript citations to objections

10. Whether nurse Baker's incompetent testimony failed to establish a standard of care requiring "delivery" of schedule II controlled substances to a patient's family? morphine?

Standard of Review: Correction of Error §63-46b-4(d); (possibly also Substantial Evidence Test, under §63-46b-4(g)

See Exhibit 2 with transcript citations to objections

11. Whether nurse Baker's testimony constitutes substantial evidence?

Standard of Review: Substantial Evidence Test, §63-46b-4(g)

See Exhibit 2 with transcript citations to objections

12. Whether all Department of Commerce's findings and conclusions are in error which rely on the finding and conclusion that nurse Baker's testimony established a nursing standard of care for handling of a lethal quantity of liquid morphine?

Standard of Review: Correction of Error and Substantial Evidence Test, §63-46b-4(d), (g)

See Exhibit 2 with transcript citations to objections

13. Whether Jepson committed theft or a taking and whether Count III should be dismissed?

Standard of Review: Correction of Error and or Substantial Evidence Test, §63-46b-4(d)

Stems from post trial DOPL Order

14. Whether the prosecution met its burden of proof at trial on Counts I and III , filed against Appellant?

**Standard of Review:** Correction of Error, §63-46b-4(d)

Written Motion to Dismiss, Record p. 248-260

15. Whether DOPL's post trial substantive change to Utah Controlled Substance Act

Rule R156-37-502(4) and its retrospective application to appellant, making, without warning, his lawful legal possession of a controlled substance ipso facto unlawful, illegal, and unprofessional, and DOPL's application of the change to a "class of persons" (e.g. home health nurses) without compliance with the Utah Administrative Rule Making Act, is error and illegal, is beyond the jurisdiction conferred by statute, is an unlawful procedure or decision-making process, or fails to follow prescribed procedure, or is not supported by substantial evidence, or is contrary to the evidence?

Standard of Review: Correction of Error and possibly in part Substantial Evidence Test, §63-46b-4((a), (b), (d), (e) (g?)) - "interpretation" is subject to a correction of error standard of review and is not "merely an exercise of implicitly delegated discretion to interpret or apply the law, reviewed under subsection (4) (h) (i)." Stems from post trial DOPL Order

16. Whether DOPL's actions constitute illegal, unconstitutional or ex post facto conduct?

Standard of Review: Correction of Error, §63-46b-4(a), (d), (e)  
Stems from post trial DOPL Order

17. ISSUE: Whether DOPL must comply with the Utah Administrative Rulemaking Act in making substantive changes to Controlled Substances Act Rules, and whether failure to do so is a usurpation of exclusive legislative authority?

Standard of Review: Correction of Error, §63-46b-4(a), (d), (e)  
Stems from post trial DOPL Order

18. Whether DOPL's trial judge wrongfully excluded relevant evidence affecting the right of appellant to present the national standard for the security of Schedule II narcotics in home health care of the Joint Commission on Accreditation of Healthcare organizations, "having any tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence?"

Standard of Review: Correction of Error, §63-46b-4(d)  
Presented Exhibit before 2<sup>nd</sup> day of Trial, see trial discussion - MT 52:16-56:17

19. Whether the trial Judge's false assurance to defense counsel that Board would not find a "taking" or "theft" caused failure to object?

Standard of Review: Correction of Error, §63-46b-4(d); Substantial Evidence Test, §63-46b-4 (g)  
Plain Error-Manifest Injustice - Objections made out of hearing of Jury and off the record - and Judge made an assurance and a curative Jury Instruction

20. Whether the ordered reprimand should be vacated?

Standard of Review: Correction of Error, §63-46b-4 (d)

Stems from post trial DOPL Order

21. Whether the requirement of disclosure regarding a “Private reprimand” is reasonable or appropriate?

Standard of Review: Substantial Evidence Test, §63-46b-4 (g)

Stems from post trial, Dept Of Commerce Order on Review

## **CONSTITUTIONAL OR STATUTORY PROVISIONS**

U.S. Constitution, Article 1, §10 states: *No State shall...pass any Bill of Attainder, ex post facto Law ...*

**Statement of the Case** Citation are to April Transcript (AT), May Transcript (MT)

### **1. The Nature of the Case** (including facts and citations to trial transcript)

Appellant, Scott Jepson, RN, (“Jepson”), was an “A” student in nursing school, had the highest ACT score in his entering class, “was an excellent excellent student,” “an excellent nurse,” and had “above average” patient assessment skills (Dr. Roger Badger, MD [Dr. Badger] AT 180: 21-181:9; Nursing Professor Instructor Teemant [Teemant]: MT 130:19-131:6). He is a specialized and very experienced nationally certified critical care nurse (CCRN) (MT 45: 11-20). He has an unblemished record (DOPL Order, p. 13, lines 2-3). He has experience in hospital neo-natal intensive care (ICU), and pediatric nursing, and extensive experience in adult ICU and coronary care (CCU) nursing. While working for First Choice Home Health many cardiovascular patients were referred from the Hospital Cardiology Unit because Jepson was an employee there. (Jepson: AT 222:20-225:2; Dr. Badger AT 148:14-15). He has years of specialized training in federal DEA and state statutes, rules, regulations, and patient advocacy (MT 24:19-25:17; 53:15-



16; 54:8-12; 81:23-25; AT 148:12-15; 191:12-192:8) As an ICU, CCU, and CCRN he has extensive specialized experience in the handling, control, and administration of liquid intravenous morphine. In April 2002 he was temporarily working as a traveling home health care nurse (AT 223:18-19). He has since returned to work as a hospital ICU CCU nurse.

This entire case centers around Jepson's proper and legal handling and control of a \$26.00 single-multi-use vial containing a "shocking" (Dr . Badger AT 150:25) and "lethal"(see Addendum Exhibit 12 for 37 references) amount of 300 mg of liquid intravenous morphine, highly concentrated in a 20 ml solution [15 mg/ml] (hereafter "Morphine" or "IV Morphine")(MT 14:21-15:22), prescribed and requiring complex administration (Dr. Badger AT 178:6-7) "as needed" for a very debilitated 89 year old patient (Mortensen). This was the only Morphine available on the evening of April 11, 2002, when a valid prescription was issued to Scott Jepson (herein after "Jepson") (with a warning from the Doctor "be careful with this") for administration to the patient on a "prn" basis, which means, "only as needed." Complex administration means the administration of this concentration of Morphine requires skill and experience beyond that of the average nurse, and far beyond a lay patient or family member. If wrongfully administered it is fatal. This quantity of morphine is 75-150 times the average dose of 2-4 mg. It is also 10 times the total amount of 30 mg of Morphine, originally prescribed by the same Doctor's office earlier the same evening but which prescription could not be filled. The average dose of morphine is 2-4 mg (Teemant: MT 105:23; Jepson AT 231:6-

7; MT 11:4-6), an amount difficult or impossible for the average nurse, lacking specialized experience and training (let alone for a lay person), to calculate and draw from the above described multi-use vial, since syringes are marked in milliliters, not milligrams (Dr. Badger AT 151:11-13; Jepson: MT 80:6-10; Teemant: 105:7 - 106:23) . This explains why one of the most common mistakes in medicine is the mis-administration of liquid morphine (Dr. Badger: AT 151:11-16; Dr. John Frischknecht, MD [Dr. Frischknecht]: AT 194: 24-195:11; Jepson: MT 33:3-6; Dr Eric Hogensen [Dr. Hogensen]: MT 158:8-11).

The uncontested evidence showed the morphine was never needed nor administered due to the immediate and miraculous recovery of the patient (AT 31:1-8; 247:8-18). (Conclusions, 10:13-14). After it was determined that the morphine was not needed, and after obtaining a required witness, Jepson wasted the morphine in accord with standard nursing practice and in accord with the standard 72 hour narcotic discontinuance rule (Teemant: MT 112:8-113:16; Jepson: MT 63:10-66:4). (Findings, 5:14-15). The violation of any “unlawful conduct” provision of Title 58 is a crime (Class “A” misdemeanor - §58-1-502 UCA). Jepson was familiar with these statutes and Rule 502(4) and obeyed and followed them.

The Judge/Board post-trial illegally and “substantively changed” Utah Controlled Substances Act Rule (UCSAR) **R-156-37-502(4)**(hereafter “**502(4)**” or “**Rule**”) without compliance with the Utah Administrative Rulemaking Act and unconstitutionally imposed the changed Rule **Ex Post Facto** against Jepson’s actions of a year prior. The rule

requires the administering nurse to maintain effective control of the morphine. Jepson obeyed the Rule and the Board concluded he should have violated it, based on their change, so they concluded his non-violation was a theft. The Judge also allowed a prosecution witness, Nurse Baker, to testify over six (6) defense objections to her qualification. Admissible exhibit evidence was wrongfully excluded by Judge Eklund.

## **2. The Course of Proceedings and Disposition at Trial before DOPL (with citations)**

A Petition (Exhibit 17, Record, p. 348) was filed against Jepson with DOPL on or about July 5, 2002. Trial was held before DOPL on April 25, 2003 and again on May 30, 2003. Administrative Law Judge Steve Eklund sat as trial Judge (hereafter “Judge”) and 8 female members of the Utah State Nursing Board sat as a jury (hereafter “Board”). The Judge sat with the Board in deliberations following trial - part two, and drafted the Findings, Conclusions, and Recommended Order (hereafter and heretofore called “Findings” or “Conclusions” or “Order” - Exhibit 18). The Petition charged Jepson with violations of seven statutes and one Rule as set forth in **Exhibits 1b and 1c**.

The prosecution failed to prove any violation of Rule 502(4) or Counts II & IV, resulting in the **dismissal of Counts II and IV** and in the Conclusion that Jepson fully complied with Rule R156-37-502(4) UCSAR (hereafter “Rule 502(4) or “Rule”) (i.e. he maintained effective control of the Morphine)(See Conclusions: 11:11-13, 24-26; 10:13-27; 11:1-4;). The dismissal of Counts II and IV dismissed all allegations against Jepson for wasting the Morphine without a witness and without documentation and of violating

Rule 502(4).

Despite the dismissal aforesaid, antithetic conclusions were reached and included by DOPL in its final Order concerning the 1) the wasting witness's competency , 2) documentation, and 3) possession-at-home issues of Counts II and IV.

**3. Statement of Facts:** All facts cited above and below are incorporated herein by this reference. The facts relevant to Counts I and III are stated here. The facts relative to the three challenged conclusions are stated in the discussion of them below. Jepson was working for First Choice Home Health as a traveling home nurse. On Thursday, April 11, 2002 Jepson was assigned to fill in for another nurse in visiting and caring for Mortensen, who was living with Beckstroms (AT 225:3-226:9). He visited the patient three times in three days, 300% more than any prior nurse (MT 145:14-24), from April 11, through 13. Upon examination, Jepson found this extremely debilitated patient with a decreased level of consciousness.<sup>1</sup> After lengthy conference with Beckstroms, and their declination to move Mortensen to the hospital, Jepson called Dr. Hogensen, the patient's primary care physician (AT 228:13-229:21). Dr Hogensen prescribed a Duragesic Patchs and liquid morphine (30mg - 3x10 unit dose vials) (AT 229:22-231:2; 234:20-235:14). Jepson went

---

<sup>1</sup> obtunded, had significant gargling, wasn't swallowing, and had lost gag reflex, with significant right sided hemiparesis with paralysis of the upper right arm and paresis of the lower extremity. He also knew that she suffered with multiple compression fractures in her spine, multiple meaning most of them had fractures in them, severe osteoporosis, pain in her shoulder and her right arm. He knew she had a real reason to have real significant pain if her level of consciousness started to increase. (AT 225:3-228:12; 234:20-235:14).

with Garth Beckstrom (Garth), in Garth's car and picked up the two prescriptions from Dr. Hogenson's office and then went to a Shopko pharmacy. The pharmacy filled the prescription for the patches and gave the patches directly to Garth. The pharmacy did not have the unit-dose vials. Jepson then called numerous pharmacies and the morphine prescription could not be filled. C&S and B&H Pharmacies only had a multi-dose vial contained 300 milligrams of morphine in a 20 milliliter solution - 15 milligrams per milliliter. It was ten times the amount Dr. Hogenson originally prescribed (MT 11:18-12:4; AT 231:4-240:25; MT 134:11-137:22).

Garth asked and Jepson inquired and determined the cost to be \$26.00. Then Garth drove home, kept the patches, and gave Jepson \$26.00 to pay for the morphine and supplies (AT 239:14-240:3). Jepson got out of Garth's vehicle and went back to Dr. Hogenson's office. He was gone. Dr. Rose was covering for Hogenson. Dr. Rose came out, wrote a prescription for the available larger 300mg multi-dose vial and handed it to Jepson, saying, **"that's a hell of a lot of morphine."** As Jepson started to walk away, Dr. Rose said to him, **"be careful with that."** These two statement were Dr. Rose's orders to Jepson concerning the morphine. Jepson went to B&H Pharmacy where Jeff Fisher the pharmacist filled the prescription. He arrived about 7 pm.(AT 236:18-238:20). Jepson left the pharmacy about 8 o'clock p.m. He called Garth (AT 240:25-245:9). Mortensen's condition had improved. Garth told Jepson he had been trying to call him and said, "if you haven't filled the prescription, don't" and "We don't think we want the morphine anymore. We don't think she needs the morphine" (Jepson: AT 241:5-8; 243:12-17;

MT 92:10-25; Garth: MT 144:14-15; Karen: AT 31:9-16; 35:16-17). Jepson checked his cell phone and found that Garth had made no calls to him (AT 241:18). Garth testified that he could not remember (MT 138:15-16). Before the second day of trial, Jepson obtained a copy of his cell phone records and verified that he had called and spoken with Garth (MT 168:8-169:12). Jepson affirmatively testified at trial about his call to and conversation with Garth and Garth's lack of memory does not negate Jepson's testimony. Therefore, Jepson's testimony was undisputed at trial. Jepson emphasized to Garth that if Mortensen woke up in the night and was having pain, please call him on his cell phone and he would come right over and set up the IV and administer the liquid intravenous morphine to Mortensen, no matter what time of the night. He made sure Beckstroms knew that he and the morphine were available, that he was keeping control of the morphine, and that they could call him at any time. He gave Beckstroms his cell phone and beeper numbers (AT 241:4-242:10; 243:6-244:10; 245:13-246:1). Jepson then drove to his home where the morphine was secured in his home under lock and key, according to Jepson's understanding and training and in compliance with Rule 502(4). This was the only location where Jepson could secure and safeguard the morphine through the night and still keep it available to administer if the need arose (MT50:18-51:10)

The need never arose. The Duragesic patches were never administered (AT 29:19-21). No call from the patient or Beckstroms came during the night (AT 246:3-9). As of the first day of trial (Apr 25, 2003) a year later, there had been no need for the morphine

because Mortensen had “stayed pretty much the same” (Karen: AT 37:10-15). The next morning, Friday, April 12, Jepson called Beckstroms to check on Mortensen. He was told by Karen, “It’s almost a miracle, She just seems like a miracle to us. She is up. She is eating. She has already had breakfast” and had taken her oral pain pills. Jepson asked specifically about what medications she had taken. He went by the Beckstrom home late morning to verify what Beckstroms had told him (AT 246:9-248:2; MT 6-7:14). He had no reason to disbelieve Beckstroms’ report (AT 248:3-8). He had no reason to believe the morphine was needed and hence left it secured at his home. Jepson concluded the IV morphine order/prescription was no longer relevant and was held or rescinded at that time to be wasted, since it could not be administered without need, nor in addition to the oral medication. Jepson took time to educate Beckstroms about the fact, he was not allowed to distribute the 300mgs of liquid morphine which was in his control for the sole purpose of administration to Karen’s mother, Mortensen. Jepson came again on Saturday the 13<sup>th</sup>. Mortensen continued to be improved (AT 221-248:11; MT 6-93:13). Jepson proceeded that day or the next day to waste the morphine, as soon as he could obtain a witness, which was Jack Branin, who came to Jepson’s home (MT 49:8-50:9).

#### **4. Summary of the Argument**

The Petition contained poorly drafted antithetic allegations - which means, in this case, Jepson was charged with opposites. Reduced to its simplest but accurate factual form, Jepson was charged on one hand with failing to maintain effective control of the lethal quantity of Morphine (in violation of Rule 502(4) - Count IV) — an allegation

proven false at trial — and on the other hand with failing to relinquish control by way of failing to “distribute” and “deliver” (criminal acts) the Morphine to Beckstroms.

The following may seem like a play on words, but it is not. It is factual. DOPL charged Jepson with violating Rule 502(4), then found him not guilty, then substantively changed the Rule, post trial, and found him guilty for being not guilty. Stated differently, they charged him with a violation, found he committed no violation, then changed the Rule and found he should have committed the violation with which they originally charged him. And, because he didn't commit the violation, they labeled his non-violation an unlawful possession and a theft or taking. All of this DOPL did, even though they dismissed both Counts II and IV, which contained the underlying charging language and Rule 502(4), and even though it presented no evidence, let alone substantial evidence, to prove any of the charges or elements of the 7 statutes or Rule pleaded in the petition against Jepson. A summary of the prosecution's case-in-chief is attached as Exhibit 7 and shows there was no proof of violation by Jepson of any statute or Rule. The prosecution witnesses didn't even mention the charging language under any Count, nor the elements of any of the Statutes or Rule, cited in the petition. Not only did the prosecution utterly fail in its burden of proof, but Jepson affirmatively proved , charge by charge, element by element, with typed copies in the hands of each Board/Jury member, and overwhelming evidence, that he did not violate, but rather meticulously adhered to and obeyed every statute and rule he was charged with violating. The four defense medical witnesses were all expert in the handling, control and administration of liquid IV morphine, whereas the



prosecution's only (case-in-chief) medical witness admitted she had no "exposure" to nor "experience" with liquid IV morphine. She was no expert at all.

Stated differently, DOPL changed Jepson's legal lawfully-compliant patient/family-protective acts of maintaining effective control under Rule 502(4) and refusing to unlawfully and criminally "distribute" by "delivering" the morphine to Beckstroms (in violation of 58-1-502, 58-37-8(1)(a)(ii), and 58-37-2(1)(n), UCA) into unlawful and unprofessional conduct by substantively changing Rule 502(4) so as to suspend the duty to maintain control, ordered "delivery" of the morphine, applied it retrospectively, and concluded that since Jepson kept control of, rather than "delivering," the morphine to Beckstroms, he unlawfully possessed the morphine and was guilty of theft or a legal taking. In short, Jepson obeyed the law and DOPL concluded he should have broken the law. A Bizarre conclusion.

DOPL had no authority to substantively change the Rule (limiting it to institutions and suspending its application to a class of persons - home health nurses), without following the legal procedure mandated by the Utah Administrative Rulemaking Act. Even if it had such authority under any analysis, it cannot change statutes that prohibit "distribution" and "delivery" of controlled substances.

## **A R G U M E N T**

### **INTRODUCTION**

This entire case can and should be disposed of in favor of Appellant Jepson based on any one or more of five (5) different analyses set out below. The related issues will be

set forth and answered at the end of each Analysis. Jepson seeks dismissal of DOPL Petition Counts I and III and vacation of reprimand and several findings/conclusions.

**FIRST ANALYSIS**  
**Statutorily Prohibited “Delivery” vs. DOPL Ordered “Delivery”**  
**of schedule II controlled substances**

This analysis begins with a careful reading of six statutes and one rule. These statutes and rule are or should be dispositive of this case. Please turn to Addendum Exhibit 1 and read them before continuing. Other statutes and cases are cited hereafter.

DOPL found and concluded that Jepson should have “delivered” the morphine to Beckstroms, and then Ordered Jepson to “deliver” physical possession of all Controlled Substances into patient’s homes in the future. Said findings and conclusions regarding “delivery” are illegal and the Order to do so in the future is also illegal and requires Jepson, and perhaps other administering home nurses, to unlawfully “distribute” and “deliver” - which is a crime. Let’s analyze this.

**The DOPL Petition** (Addendum Exhibit 14) **Counts I, III, and IV** are related. Count I charges unlawfully possessing the morphine, Count III charges “failed to produce<sup>2</sup> a medication ... for a patient,” and Count IV charges failing to maintain effective control of it after legal possession was obtained. The uncontested evidence proves Jepson obtained legal possession of the morphine, produced and kept it available<sup>3</sup>,

---

<sup>2</sup> See Addendum Exhibit 13 - Definitions

<sup>3</sup> See Addendum Exhibit 13 - Definitions

and maintained effective control of it. The word “produce” is not in the statutes cited under Count III.

**Count I:** DOPL found Jepson lawfully obtained the morphine (Conclusions 9:24). The uncontested evidence support this. He complied with every element of §58-37-8(2)(a)(i) (Addendum Exhibit 1; MT 7:17-12:20). The other two statutes cited (§58-31b-502(5) & §58-1-501(2)(a)) (see Exhibit 1B) do not stand alone but rise or fall with proof of §58-37-8(2)(a)(i). Nevertheless, Petition Count I, which alleges violation of §58-37-8(2)(a)(i) was not dismissed. The prosecution presented no evidence to support Count I (see Exhibit 7-summary of Prosecution’s case-in-chief with transcript citations). Jepson’s testimony was uncontested, undisputed, and unimpeached. There was no evidence, certainly no substantial evidence supporting Count I. It should be dismissed.

**Count III:** Compliance with §58-37-8(2)(a)(i) constitutes “producing” a medication “for a patient.” By the aforesaid actions, Jepson did “produce” (Exhibit 13) the morphine for the patient and kept it constantly under lock and key, but “available” (Exhibit 13) for administration to Mortensen, even for a couple of days after it was determined the morphine was unneeded. DOPL through its prosecutors chose and pleaded the word “produce” and based it upon §58-31b-502(7) - the “taking” statute, but utterly and totally failed to present any evidence or prove any of the elements of theft or of a legal taking (Addendum Exhibit 7 and Analysis 3 below). The evidence proved just the opposite, that Jepson lawfully **obtained** and exercised **authorized control** over the

property not belonging to another<sup>4</sup> without a purpose to deprive<sup>5</sup> Mortensen of it, but rather with the very purpose or intent to “administer” it to Mortensen “as needed” in strict accord with the Doctor Rose’s orders and instructions (see Facts) and the law. Neither Karen, Tiernan, nor Baker testified about any of the elements of theft. However, the prosecution’s pleading of the “taking” statute (§58-31b-502(7), *Unprofessional conduct includes (7) unauthorized taking or personal use of a patient’s personal property*) intended “theft” as evidenced by Prosecutor Cheryl Luke’s closing argument, “...was that a theft...” (MT 190: 5; and Exhibit 7 - summary). Jepson affirmatively proved, element by element, that he complied strictly and completely with all legal requirements and practice standards (MT 8:13-93:16 -Count I p 8; Count II p 14; Count III p 36; Count IV p 45). There was no evidence, certainly no substantial evidence, supporting Count III. It should be dismissed.

**Count IV:** After obtaining legal possession, Jepson maintained effective control of the morphine as required by Rule 502(4). In order to have proven a violation of Rule 502(4), DOPL/Prosecution had to prove that Jepson’s actions were not effective against “diversion, theft, or shortage.” The prosecution presented no evidence that there was any “diversion, theft, or shortage” of the morphine(Exhibit 7), hence Jepson’s actions were effective, and DOPL/Board found Jepson did not violate Rule 502(4) (conclusions

---

<sup>4</sup> See Addendum Exhibit 9 - Jury Instruction given to Board/Jury regarding ownership of a narcotic.

<sup>5</sup> See Addendum Exhibit 14 - DOPL & Commerce findings as to Jepson’s “intent”

11:14-15). Therefore DOPL dismissed Petition Count IV.

**Count II & IV:** Count II alleged failure to administer, failed to report suspicion. Counts II & IV both alleged - disposed of narcotic without a proper witness, or witness, and maintained narcotic at home. DOPL/Board concluded Jepson “inappropriately” and without “good judgment” **maintained morphine at his home**. Having the morphine in his home was not in itself a violation by Jepson of any statute, rule, or order, as found and concluded by DOPL.<sup>6</sup> It was only a violation in the mind of the DOPL Board because taking it home to maintain effective control was not “delivery” to Beckstroms, hence the wording: *Respondent violated the applicable standard of care BECAUSE he failed to duly deliver that medication to the Beckstroms* (p. 10, ¶ 1, lines 4-5) [emphasis added]. Since Counts II and IV were dismissed, so too should the conclusion, based thereon, be dismissed and not remain to support a reprimand. This result was argued by DOPL and adopted by ALJ Medcalf on appeal to Commerce on two other conclusions - see next paragraph. It should apply here.

**Count II & IV:** Both these counts alleged Jepson wasted morphine without a “witness” or “competent witness.” Neither count pleaded, nor did any statute cited therein mention, “documentation.” Nevertheless, Prosecution at trial questioned about documentation of the wasting of the morphine. Jepson testified, and Prosecutor Luke

---

<sup>6</sup> “ Respondent inappropriately kept the morphine sulphate at his home. . . .However, the Board finds and concludes that such conduct - standing alone - fails to establish a violation of §58-1-502(2)(g) . . . (Order, 11:5-9; Record, p. 191:5-9)

admitted, that Jepson's employer never supplied a narcotic waste sheet for documentation by witness signature (undisputed fact)(MT 24:18-28:2; 46:20-47:4; 129:12-130:3).

Baker testified she hadn't reviewed and "didn't know" whether Jepson documented the wasting on the Oasis 485 medication sheet (AT 120:2-121:2). Neither Prosecution nor Baker produced that sheet, although they were mysteriously able to produce the rest of the Oasis recertification. Strange, huh? The only crucial evidentiary sheet missing (Record pp 208-230)? Jepson testified he did document the wasting on the Oasis medication sheet. His testimony was thus undisputed. In sustaining Jepson's objection about that line of questioning, the Judge ruled that "documentation" "is not an issue before the Board" (AT 106:19-20). Both counts II and IV were dismissed. Despite that, DOPL/Board concluded Jepson wasted the morphine "without a competent witness and any documentation" (Conclusions p 11:6-7). There was no evidence, let alone substantial evidence to support that conclusion. How could there be a conclusion on a point that was ruled "not an issue" before the Board? Jepson challenged both conclusions on appeal to Commerce (Record p 113-118). DOPL argued in response that both conclusions were "totally irrelevant at this point in time, because Count IV of the Petition ...was dismissed" (DOPL Response Brief 18:1-5, dated Feb. 13, 2003; Record p 90:1-5). ALJ Medcalf agreed with DOPL's argument and ruled that the Board's aforesaid two conclusions were "not relevant" and "harmless error" (Order, 18:11-21, at 17, 21). Jepson requests now that the aforesaid three conclusions be stricken and vacated since they are not supported by any, let alone, substantial evidence.

**Delivery:** There is no evidence for and Jepson did not “distribute” nor “deliver.” He did not “agree, consent, offer, arrange” nor “intend” to “distribute” or “deliver” the morphine. He did not “**produce**, manufacture, or dispense,” nor “**possess with intent to produce**, manufacture, or dispense, a controlled or counterfeit substance” all in the sense meant by **58-37-8(1)(a)(i)**. Now let’s compare the law to the actions of DOPL and Commerce.

**DOPL’s Conduct:** DOPL’s and Commerce’s allegations, findings, conclusions, and Order are so disparate and incommensurable with the narcotic’s statutory and rule framework (Exhibit 1) as to constitute its antithesis. “Produce” does not mean “deliver” (Exhibit 13) by any stretch of the imagination. Neither is “deliver” a synonym for “produce,” yet, bear in mind, Jepson was charged with “failed to **produce**...for a patient.” DOPL concluded, post trial, that the Petition wording “possessed outside his responsibilities,” and “failed to produce...for a patient” (Counts I & III, respectively) both mean Jepson “failed to deliver” physical possession of the morphine to the Beckstroms (see quotes below) (Conclusions, 10:4-5). They then transmuted that conclusion into a conclusion that he stole the morphine because he did not “deliver.” Their wording was that he “took” it (see 3<sup>rd</sup> Analysis below).

An examination of DOPL’s language (DOPL Order (Exhibit 18, Record pp 180-194) leads to the inescapable conclusion that it failed to understand and therefore failed to follow statutory law and Rules passed by our Legislature. Please look at DOPL’s

language. As you will see, DOPL's entire focus was on "delivery:"

*failed to duly **deliver** that medication to the Beckstroms (Conclusions, p. 10, line 5); rather than **deliver** that medication to the Beckstroms. (Conclusions p. 12, lines 2-3); ...medication should have been available at the Beckstrom's home...(Conclusions P. 12, lines 4-5); should have **delivered** that medication to the Beckstroms... (see Conclusions p. 12, lines 13-14); [emphasis added]*

***Respondent [Jepson] lawfully obtained the morphine...**(Conclusions p. 9 line 24) ...he unlawfully possessed that prescribed controlled substance in his home and he **failed to deliver** that medication to the Beckstrom's home (p. 9, last paragraph, last three lines). Respondent also engaged in unprofessional conduct -- violative of §58-31b-502(7) -- when he took<sup>7</sup> Ms. Mortensen's prescribed medication and possessed the morphine sulphate in his home. Respondent violated the applicable standard of care **BECAUSE** he **failed to duly deliver** that medication to the Beckstroms (p. 10, ¶ 1, lines 4-5); Respondent failed to exercise good judgment when he elected to retain the morphine sulphate in his home **rather than deliver** that medication to the Beckstroms (p. 12, lines 1-3); ...**he should have delivered** that medication to the Beckstroms and Respondent **failed to do so** in his zealous attempts to obtain and then exclusively control access to that medication (p. 12, ¶ 2, lines 13-16) . [emphasis added] (Exhibit 18, Record pp 180-194)*

Another problem with DOPL's conclusions about "delivery" is the glaring fact that the prosecution never even mentioned, let alone proved, any standard of care (see Exhibits 5 & 7), especially not about "delivery." They couldn't, because "delivery" is illegal and it's criminal.

Please don't be misled by DOPL's misuse of the words "took" and "available" in the above quotes (see 3<sup>rd</sup> analysis below). Jepson had legal possession from the pharmacist in accord with §58-37-8(2)(a)(i). He never "took," "stole," or "removed"

---

<sup>7</sup> Addendum Exhibit 13 - Definitions of Took, Take, & Taking



anything from the possession of the patient or patient's family. As the reader can see, the entire thought process of DOPL was so narrowly, even fanatically (albeit illegally), focused on "delivery" they overlooked the fact that "delivery" of IV morphine by an administering nurse is a crime. It is prohibited by statute. Jepson knew this and he obeyed the law and did not "deliver" but kept the morphine "available" for administration - which never became necessary (see 3<sup>rd</sup> Analysis below). Nevertheless, DOPL Ordered Jepson:

**Respondent shall abstain from such conduct in the future and assure that medications prescribed for any of his patients in a home health care setting are maintained in their home for administration to the patient as may be warranted. [emphasis added]**

"Maintained in their home" means Jepson, and other home health nurses, charged with administration of schedule II narcotics, cannot obey the statutes and rules by maintaining effective control required by Rule 502(4), §58-37-8(1)(a)(ii), and §58-37-2(1)(n) but rather shall break the law and commit crimes by "delivering" narcotics to the patient's home, relinquishing effective control of them, and leaving them with the family, consistent with DOPL's Order. This meaning is clear from the findings and conclusions that precede the Order(quoted above). The only problem with such an Order is that it is illegal, contrary to statutes, and requires Jepson, and perhaps other administering home nurses, to commit future crimes. This Order of DOPL creates a new crime or class of crimes which "creation" is an illegal usurpation of **exclusive legislative power** (Exhibit 1D).

**DOPL Changed Rule 502(4) without authority so it could Order Delivery: On**

appeal to Commerce, Jepson argued that DOPL changed Rule 502(4) when it declared, “R156-37-502(4) does not apply strictly in a home health care setting. . .” and “Wherefore, it is ordered that Respondent be publicly reprimanded. . .” [emphasis added]

He argued the change was illegal and creates a precedent at DOPL and sets the stage for the nursing Board to illegally impose this illegal standard upon all administering home health nurses in Utah, thus requiring every one of them to commit crimes as well. ALJ Medcalf therefore changed the ordered public reprimand to a private reprimand with a requirement for Jepson to publish it, in a transparent effort to avoid the “precedent” Jepson argued. Her effort fails because it did not remedy DOPL’s illegal conduct of changing the Rule without compliance with the **Utah Administrative Rulemaking Act** (§63-46a-3, 4) nor does it remedy the illegal order requiring Jepson to commit future crimes by “distributing” through “delivery” of narcotics. It also fails to prohibit DOPL from using this case as a precedent by making it into an exception to Rule 502(4) (§63-46a-3 (8)(b)). That would mean that every wasting of unneeded or unused morphine (and other schedule II drugs) by every administering home nurse every day in Utah is a crime because of failure to “deliver” the morphine to the patient or patient’s family in accord with DOPL’s Order and its change to Rule 502(4). DOPL’s Rule change is a dramatic, and unwarranted departure from the intent of the legislature in passing the aforementioned controlled substances statutes and rules. Now, the Related Issues and answers.

**1. ISSUE: Whether at all pertinent times Appellant lawfully possessed the liquid morphine?**

**Ans:** Yes. He complied with every element of §58-37-8(2)(a)(i) and thereafter with every element of Rule 502(4), as written, and did not violate 76-6-404 (theft) nor 58-31b-502(7) (taking). DOPL illegally changed Rule 502(4) and concluded “delivery” was what they required. “Delivery” is an unlawful “distribution under §58-37-8(1)(a)(ii) and §58-37-2(1)(n). By its conduct DOPL created a new class of crimes - an illegal usurpation of exclusive legislative authority. Prosecution presented no evidence to the contrary. Count I and III should be dismissed and the reprimand based thereon vacated.

**2. ISSUE: Whether a traveling home health nurse can temporarily safeguard prescribed but unneeded morphine at his home?**

**Ans:** Yes. The prosecution offered no competent testimony, statute, rule, nor order prohibiting such conduct. Jepson was required by Rule 502(4) to maintain control and all the expert testimony at trial by all medical witnesses, except Baker, demonstrated that the standard of practice and care for a lethal volume of liquid IV morphine was to never deliver it into the possession of the patient.

**3. ISSUE: Whether a patient’s daughter and son-in-law have a “right of possession” to a lethal volume of a Schedule II controlled substance - liquid IV morphine - legally in the possession and control of appellant as administering nurse, prescribed by a physician for administration by the appellant nurse to the patient ‘prn’ - on an as needed basis - where the physician ordered appellant nurse “that’s a hell of a lot of morphine” and “be careful with that” and where no need for the morphine existed after the prescription was legally filled?**

**Ans:** No. Beckstrom’s name was not on the morphine prescription. They had no

intent nor training to administer it. It was a lethal volume and concentration. It was illegal for Jepson to have “delivered” it into their physical possession. It was illegal for the pharmacist to have dispensed it to them since its quantity (300 mg) exceeded by ten times the original prescription (30 mg) intended for the patient, and exceeded the amount needed for a 72 hour period (MT 85:18-86:3; 86:25-87:4; 106:19-20). Last, the Jury instruction given by the trial Judge set the demarcation line between ownership and non-ownership of a schedule II controlled substance by a patient as “possession” (Exhibit 9; Jury Instruction supported by expert testimony - MT 116:3-24). There is no “right of possession” since the framework of the narcotic’s laws and rules requires of administering nurses strict controls of narcotics and wasting of unneeded narcotics. The nurse is not allowed to just hand the narcotic over to the patient concerning which the nurse is charged with administering. It is easy to understand. The patient can pick up any narcotic directly from the pharmacist (not 300 mg of morphine), but if it’s an IV narcotic, then the nurse cannot administer it or take it (MT 81:25-83:3; 116:3-24). The administering nurse must obtain the IV narcotic direct from the pharmacist and maintain control of it (please read §58-37-8(2)(a)(i) carefully and notice the wording “directly from a practitioner.”) Practitioner is defined in §58-37-2(ee) as a “physician, dentist, veterinarian, pharmacist...” If the patient picks it up from the pharmacist, then the nurse cannot ‘take’ it from the patient’s possession, cannot administer it, and therefore cannot maintain effective control of it. Neither can the nurse leave it with the patient or family and maintain effective control of it. The nurse must obtain it direct from the pharmacist,

administer it as needed, maintain control of it until it is unneeded, then waste it. The defense evidence was overwhelming, the prosecution evidence nil (Exhibit 7).

**4. ISSUE: Whether Count I of DOPL's Petition should be dismissed for lack of evidence?**

**Ans:** Yes. Not only did the prosecution fail to prove Count I, but Jepson overwhelmingly disproved it. Jepson was in legal possession at all times.

**5. ISSUE: Whether it is error and or illegal for DOPL and Commerce to order "delivery" of physical possession of a lethal volume and concentration of liquid morphine to non-patient family members in violation of statutes and contrary to its own Controlled Substances Act Rule -R156-37-502(4)?**

**Ans:** Yes. It is reversible error and illegal for DOPL to order a nurse to "deliver" schedule II controlled substances into the physical possession of non-patient family members. Even if DOPL could change Rule 502(4) without complying with the Utah Administrative Rulemaking Act (§63-46a-3(2)(c), (3), (4)(d), (6), (7)(a)(i),(b), (8)(b)), which it cannot, it cannot change statutes (§58-1-502, §58-37-8(1)(a)(ii), and 58-37-2(1)(n)) which make "delivery" of a controlled substance unlawful and criminal. Such an Order is not "merely an exercise of implicitly delegated discretion to interpret or apply the law (*Semeco Industries, Inc v. Tax Comm'n*, 849 P.2d 1167).

**6. ISSUE: Whether DOPL and Commerce have authority to order a nurse to violate a narcotic's rule and statutes and thereby force him to commit criminal and unethical acts?**

**Ans:** No. No one has authority to order another to commit a crime. Doing so is itself a crime. DOPL's order requires Jepson and perhaps other nurses to commit future

crimes by unlawfully distributing and delivering controlled substances to non-patient family members. DOPL has no such authority and certainly nothing to support such claimed authority was presented by the prosecution at trial (Exhibit 7).

**SECOND ANALYSIS**  
**Nurse Baker's Testimony Should be Stricken**  
**due to Lack of Foundation & Qualifications, Timely Objections,**  
**Incompetence, and because It Advocates Illegal and Criminal Conduct**  
**and is Insubstantial in Light of the Whole Record**

In its case in chief DOPL called Nurse Baker as its only medical witness. Baker did not interview Jepson. The prosecution failed to show Baker had any *knowledge, skill, experience, training, education* (702 URE) or specialization (*Burton Rule*, *infra*) in the handling, control and administration of liquid morphine - the central issue of this case and the area of Jepson's specialty and experience. Neither did she have knowledge of the applicable Controlled Substances Act and Rules or Title 58 statutes, as evidenced by the testimony she gave which advocated illegal and criminal conduct contrary to statutes and Rule 502(4) (e.g. "distribution" and "delivery" to non-patients of controlled substances in the legal possession of the administering nurse). Baker only read through some medical records and testified. No foundation was laid for, and Baker was not qualified by the prosecution as (1) one of two possible forms of a lay witness,<sup>8</sup> or (2) as an expert witness under Rule 702, URE, concerning handling and control of liquid morphine. Rather the

---

<sup>8</sup> *Evidentiary Foundations*, 3 ed., Imwinkelried, Edward J., The Michie Co. Law Publishers, Charlottesville, Virginia, 1995, pp. 241-246; See Addendum Exhibit 6

opposite - She testified that she had no “exposure” to nor “experience” “in administration or control of IV morphine” (see Addendum, Exhibit 3; see also AT 118:25-119:17). She disqualified herself as an expert for this trial. She was allowed to testify over five (5) initial objections and one final objection by the defense as to her lack of qualifications (see Addendum, exhibit 2; AT 98:24-100:17; 136:3-5). She testified only by way of her personal opinion as to what she would have done or thought Jepson should have done - i.e. “delivered” the morphine to the Beckstroms (see Addendum, Exhibit 4). She advocated “delivery” of a controlled substance by an administering nurse. She testified about handling liquid IV morphine, something she knew nothing about — her testimony was pure guesswork, misled the Board/Jury, caused confusion of the issues, and created unfair prejudice to Jepson, all in violation of Rule 403 URE.

Baker’s testimony did not meet the standard for an expert medical witness as set and required by the Utah Supreme Court in the case of *Burton v Youngblood*, 711 P.2d 245 (Utah 1985). The Burton Court held that one specialized Plastic Surgeon witness could not testify against another General Plastic Surgeon defendant who performed a specialized procedure within the area of practice of the witness doctor , unless the proper foundation was first laid, even though the witness was otherwise qualified. The foundation must be laid. The Burton Court said, “this rule makes good sense. . . we follow it here.” In contrast, Baker was not qualified nor was the required foundation laid for her testimony - and on top of that, she disqualified herself (see below).

The **Burton Rule** was affirmed by this Utah Appellate Court in *Anton v. Thomas*,

806 P 2d 744 (Utah App. 1991) wherein the Court upheld the trial court's exclusion of an expert witness stating, "Admission of expert testimony requires proper foundation to qualify the witness."

Again in the case of *Robb v. Anderton* 863 P 2d 1322, 920770-CA (Ut. App. 1993) this Court upheld the Burton Rule and the trial court's allowance of an out-of-state Doctor being qualified as an expert because the proper foundation was laid at trial showing he had written books and articles about the subject, had practiced in that area, and had "personally administered anesthesia to thousands of children." The case involved a question about the administration of anesthesia to a child. The *Anton* and *Robb* Courts reviewed trial Judges' rulings which followed the Burton rule.

In *Dikeou v Osborn*, 881 P2d 943 (Utah App. 1994) this Court held:

The trial court is given discretion under Rule 702 of the Utah Rules of Evidence 'to determine the admissibility of expert testimony, and to determine if the [expert] witness is qualified to give an opinion on a particular matter.' " *Robb v. Anderton*, 863 P 2d 1322, 1326 (Utah App. 1993) (quoting *Anton v. Thomas*, 806 P. 2d 744, 746 (Utah App. 1991)) **In exercising that discretion, we believe a trial court should require a medical expert witness to demonstrate familiarity with the applicable standard of care based on more than just a review of the documents in the particular case.** See *Arnold*, 846 P. 2d at 1310; *Youngblood*, 711 P.2d at 248. By definition, an expert is one who possesses a significant depth and breadth of knowledge on a given subject. To allow a doctor in one specialty, retained as an expert witness, to become an "expert" on the standard of care in a different medical specialty by merely reading and studying the documents in a given case invites confusion, error, and **a trial fraught with unreliable testimony.** See *Nielsen*, 763 p.2d at 822 ("[W]e think it is sound policy to limit expert testimony in medical malpractice cases to that which is within the doctor's specific field of practice."). [emphasis added]



It appears to us that the Utah Supreme court's **rationale** underlying the Youngblood and Arnold decisions...**is to assure that relevant expert medical testimony given to establish the applicable standard of care maintains a high degree of reliability, thereby avoiding confusion for a jury.** [emphasis added]

This *Dikeou* rule applies, or should apply, to a nursing case like this one, where unprofessional conduct is alleged, not unlike in a malpractice case. It should apply to nurse testifying against nurse, where Jepson has specialized *knowledge, skill, experience, training, education, specialization, expertise, experience, and practice* and is involved in an *unusual circumstance*<sup>9</sup> with a lethal volume and concentration of liquid IV morphine, and the adverse witness (Baker) has no such *knowledge, skill, experience, training, education, specialization, expertise, experience, or practice*, by her own admission. The trial Judge in the instant case violated the *Burton rule* and this *Dikeou rule*. Judge Eklund ruled Nurse Baker could testify and then the basis of her testimony could be examined, and “then he would allow” the testimony. He never ruled she was accepted by the Court as an Expert Witness (Exhibit 2 and AT 100:6-8), as he did with the defense witnesses. At the end of her testimony there was a 6<sup>th</sup> Objection which the Judge ignored. He failed to make his promised ruling or any ruling on 1) the Objections, 2) whether the testimony was being allowed and 3) whether Baker was accepted as an Expert Witness, even though the basis of her testimony had been examined and found to be glaringly

---

<sup>9</sup> Order, “isolated incident” 12:24; “rather unique facts of this case” 13:6; Jepson, AT 129:6; MT 91:12-92:2; Frischknecht, AT 191:12-192:6; 194:13-15; 194:20-195:23; Teemant MT 125:4-6;

wanting and not in conformity with the *Burton* rule. Judge Eklund violated the Burton Rule, and Rules 403 and 702 URE. He abused his discretion. He allowed the Board/Jury to hear Baker, which was, or should be, reversible error, and Baker's testimony should be disallowed and stricken.

DOPL, through Karl Perry (Perry), admitted in its Memo, p. 17 lines 11-14, Record p 89), that Baker offered only her own **personal opinion** and that such was all that was elicited from her. This personal opinion testimony does not meet the standards of Rule 702 UR,E nor does it meet the generally accepted standard for expert testimony, nor does it meet the Utah-adopted *Frye* standards for expert opinion testimony. The ultimate issue in this case goes to the area of Jepson's specialized knowledge, skill, experience, training, and education - the handling, control, and administration of liquid IV morphine.

Furthermore, MUJI 6.22 states in pertinent part [emphasis added]:

The amount of caution and attention required in the exercise of a nurse's duty is measured by the *patient's condition, the danger involved in the treatment. . .the information and instructions given the nurse by the attending physician or surgeon*, and other surrounding circumstances.

Prosecution witness, Dr. Rose, told Jepson, "**That's a hell of a lot of morphine,**" and "**Be careful with that**" (AT 237:12-238:20; MT 12 5-15; 121:23-122:9)." Although Prosecution witness, Dr Hogenson, testified that he regularly prescribes morphine "pills" which he thought ought to be kept in the patient's home, he also testified that he never prescribes for use in home health a lethal 300 mg / 20 ml high-concentration single-multidose vial because it is different than pills from "**an administration standpoint, risk**

**standpoint” and is “usually kept elsewhere... it’s not convenient... and a nurse has to administer it” (MT 156:7-157:19).** Isn’t that something? Jepson obeyed the instructions from Dr. Rose to “be careful” with the morphine, and also acted like Dr. Hogenson testified, by “keeping” the lethal volume of morphine “elsewhere,” other than at the patient’s home. Neither of these prosecution witnesses refuted anything Jepson or other defense witnesses testified to during trial, even though, as prosecution rebuttal witnesses, they had every opportunity to do so. Now let’s compare Baker’s testimony to the testimony of the four defense medical witnesses, for substantiality, in light of the whole record. There is no way to put into this brief the full content nor overwhelming import of the Defense witnesses’ testimonies. But the reader can get a feel for it, as follows.

The **first crucial comparison** is that the Court never ruled that Baker was an expert. Dr. Badger, Dr. Frischknecht, and Nursing Professor Teemant were all offered by Jepson as, and each was accepted by the Trial Court and the prosecution as, an “Expert Witness” as to all the issues at trial. All, except Baker, testified they had extensive experience with liquid IV morphine (Badger - AT 146:17-147:12; Frischknecht - AT 190:1-19; Teemant: MT 94:9-104:5, see esp. pp. 103:22 and 104:3-5).

Nurse Baker was never “offered” by the prosecution as an “Expert Witness” (see AT 90-98:24) but was “offered” as an Expert by the Trial Judge (see AT 99:3-14), after defense objections, under the condition precedent that the basis of her testimony could be examined, and then he would allow her testimony (AT 100:6-8; see also Exhibit 2, for 6

identified objections and transcript citations).

A **second comparison** examines whether the witnesses' testimonies referred to the elements of the charging language and supporting citations in the petition, which the prosecution had to prove with a preponderance of the evidence. Baker's testimony did not contain one word, not one scintilla, of evidence about the required elements of proof and the handling of liquid morphine (Exhibits 7 & 8). Baker never so much as mentioned Petition Counts I or III's charging language or citations (trial testimony AT pp 90-142; summary of her testimony Exhibit 7; List of Elements and Prosecution's Burden of Proof, Exhibit 8).

Baker did talk about:

her background; charting concerns by nurses; duty to educate patient and caregiver; wasting of narcotics; documenting (which the Judge ruled was not an issue at trial - AT p 106, lines 19-21); Oasis recertification medication sheets; that "if a medication is ordered for a patient it should be left in their home;" but that "you wouldn't leave it there if it wasn't a safe situation;" that she had no exposure to nor experience with liquid IV morphine; she didn't know whether Jepson documented the morphine on the Oasis medication sheet; testified opposite to the wording of the reporting statute, the language of which was read by her; that if the morphine were left in a home the administering nurse would have no way to control the theft of the morphine; couldn't answer any questions about unit dose vials of morphine; answered numerous speculative questions put to her by the prosecution; that there should be a witness to a wasting; that a witness cannot sign a non-existent wasting form; and that she had not reviewed any material from First Choice. (See summary, Exhibit 7)

None of her testimony proved any of the required elements of the seven (7) statutes or of a violation of Rule 502(4) under which Jepson had been charged, let alone the 3 statutes under Count I or the one statute under Count III (Exhibit 8).

**Dr. Badger**, on the other hand testified about his expertise with and the handling of liquid morphine. (Apr Tran pp 142-186; see esp p 143, lines 14-25; p 146, lines 7-23; p 147, lines 1-10). Dr. Bager testified that the 300 mg/20 ml lethal IV Morphine quantity was a shocking amount and should not have been left in the patient's home and that Jepson did the correct thing by maintaining effective control of it. He even said he would forbid it. (AT 147-158; 152:9-10; 165:11-167:10; 168:6-12; 169:13-17; 170:7-10, 20-24; 171:21-173:1; 176:15-177:12; 178:5-8).

**Dr . Frischknecht** testified that nurses are under obligation, the same as doctors, to "do no harm" to patients (AT 192:7-19). He also testified that there is increased risk to patients if a 300 mg vial is left with untrained persons (AT 195:21-23). He also testified about the dangers of leaving such a quantity of Morphine in a family home (AT 196:14-198:20; 199:14-18). Finally he testified that *it would create an unreasonable risk of potential harm or even death, to leave such a volume in a concentrated dosage in a family home* (AT 202:19-25).

The defense expert, nursing instructor Teemant, with 33 years experience (MT 95:3-4) and familiarity with the "standards of nursing" (MT 102:20-24) who taught both Jepson and Baker in nursing school, testified what the state and national standards were and that Jepson's conduct complied with the law and nursing standards regarding the lethal volume and concentration of liquid IV morphine, that IV narcotics are never delivered to a patient according to state and national nursing standards, and that, having

reviewed Baker's trial testimony, Baker was incompetent to testify in this trial (MT 107:10-110:18; 112:8-113:16). She testified that, in the case of Mortensen, she had read over Jepson's April Trial Transcript and listened to his in-court May testimony and found Jepson complied with the appropriate standards of nursing practice and care and "did the right thing" (MT 104: 18-25). Further, she testified there was nothing that led her to believe to a reasonable degree of nursing certainty that Jepson did not act, at all times and in all matters and with regard to the issues surrounding Hazel Mortensen's care, in a professional manner as a prudent practitioner (MT 109:9-17). She described the difficulties of Morphine and older patients and the difficulties of administering the correct dose from a 300 mg/20ml vial of Morphine, especially for family members, and even for nurses untrained and inexperienced with IV Morphine administration (MT 105:7-106:23). She testified to the unreasonable risk of harm presented to a family and patient and the nurse by bringing into a home and delivering into the possession of the patient or family the "toxic, lethal dose" in this case; the required assessment skills that family members and even non-ICU-trained nurses lack; and to the requirement of wasting the IV Morphine if not used (MT 109:23-112:22; 114:3-116:2).

She also testified to the **72 hour discontinuance rule** for narcotics, and that **a narcotic is not kept for future needs** and that this nursing practice standard is accepted throughout Utah and the Nation (MT 112: 4-114:1) This uncontested testimony disproved the illegal theory of the prosecution and the Board about keeping liquid Morphine for future needs. She testified about Count III and the "taking" allegation and

that Jepson did not “take” the Morphine but rather complied with accepted nursing practice of maintaining effective control and not delivering it to the patient or family (MT 116:3-24).

Jepson’s testimony dealt in agonizing detail with every single element of every single statute and Rule 502(4) as well as with the very wording of the charging language in Counts I and III (MT 8:13-93:16 -Count I p 8; Count II p 14; Count III p 36; Count IV p 45). None of his testimony was rebutted, contested, or disputed in any way (see AT 221:-end; MT pp 6-93) . Furthermore, the testimonies of Dr. Badger, Dr. Frischknecht, and Nursing professor Teemant all supported Jepson’s and countered Baker’s testimony. Even the three prosecution rebuttal witnesses, Garth, Dr. Hogensen, and Dr. Rose supported Jepson’s testimony.

For the above reasons, Jepson’s six (6) trial Objections should be sustained, the Judge’s rulings on them reversed, Nurse Baker’s entire testimony stricken and disregarded as unqualified non-expert lay-personal-opinion - not expert opinion - testimony inadmissible at trial. This Court should also hold that Baker’s testimony did not constitute “substantial evidence” in light of the whole record and that the findings and conclusions of DOPL’s nursing Board/Jury, which are based exclusively on the Baker testimony, should be reversed, Counts I and III dismissed, and Jepson’s record cleared.

**In summary as to Count I:**, There is no competent evidence in support of Count I, let alone, substantial evidence. Failure by the prosecution to prove the required elements of §58-37-8(2)(a) (i), §58-31b-502(5), and §58-1-501(2) UCA prevents the

conclusion that Jepson “possessed controlled substances outside of his responsibilities as a nurse” and requires, under the correction of error standard of review, the dismissal of Count I.

**In summary as to Count III:** Not only did the prosecution fail its burden of proof that a theft or legal taking happened, let alone present substantial evidence, but the actual evidence at trial, including the Jury instruction on narcotic ownership, proved there was no theft or taking and that Jepson’s conduct was legal from start to finish. Count III should be dismissed and Jepson’s record ordered cleared. Let’s look at the issues.

**7. ISSUE: Whether Appellant made timely objections to nurse Baker testifying?**

**Ans:** Yes. 6 Objections. See Exhibit 2

**8. ISSUE: Whether Appellant’s 4 objections to nurse Baker’s lack of qualifications as expert witness should have been sustained and the testimony disallowed or disregarded?**

**Ans:** Yes. For all of the reasons set out in the first and second analyses.

**9. ISSUE: Whether Baker’s testimony is “personal opinion” not expert testimony - as admitted by DOPL?**

**Ans:** Yes. Admitted by DOPL. See Exhibit 4. No foundation laid. Not questions asked about any specific standard or standards of care. None identified. No testimony about nursing industry-wide acceptance or practice on any point. (Exhibit 7 - summary)

**10. ISSUE: Whether nurse Baker’s incompetent testimony failed to establish a standard of care requiring “delivery” of schedule II controlled substances to a patient’s family?**

**Ans:** Yes. Baker’s testimony failed to establish any standard, let alone a standard



requiring “delivery” to a patient’s family. There were only 4 “standards” questions put to her (see Exhibit 5). She never answered the first, and the other three were her personal opinion about wasting narcotics.

**11. ISSUE: Whether nurse Baker’s testimony constitutes substantial evidence?**

**Ans:** No it does not. She is not an expert on liquid morphine and was not accepted by the Court as an Expert and was objected to by the defense. Her personal opinion testimony advocated illegal and criminal “distribution” and “delivery” of schedule II controlled substances contrary to Utah Statutes and Rule. Her testimony was incompetent and unqualified. She disqualified herself. Therefore her personal opinions cannot constitute substantial evidence. Four other medical witnesses testified just the opposite from her and all were qualified and three of them were expressly accepted by the Court and prosecution as experts as to all issues at trial.

**12. ISSUE: Whether all Department of Commerce’s findings and conclusions are in error which rely on the finding and conclusion that nurse Baker’s testimony established a nursing standard of care for handling of a lethal quantity of liquid morphine?**

**Ans:** Yes. For all the reasons above.

**Third Analysis - Theft or Taking**

“Produce” “Took,” “taking,” and “available” have been defined above. The elements of theft are set out in Exhibit 1.

With respect to element 1, DOPL concluded Jepson “obtained” the morphine lawfully (Exhibit 18; Conclusions 9:24; Record p. 189:24). With respect to element 4, it

also found and concluded that Jepson had “good intent” and Commerce concluded that his intent was to obey the law (Exhibit 14). This leaves only elements 2 and 3. Neither Karen, nor Tiernan or Baker testified Jepson exercised “unauthorized control” or that the morphine “belonged to another” - i.e. Mortensen, rather DOPL found Jepson *lawfully obtained the morphine...*(Conclusions p. 9 line 24) . In this quasi-criminal case, Jepson was charged with “failed to Produce...for a patient” based upon §58-31b-502(7) (Exhibit 1). A violation of this section is a crime. Jepson “produced” the morphine as shown in Analysis One above. There was no proof offered by the prosecution of personal use by Jepson nor does the Petition allege such. The only part of the statutory language left is “unauthorized taking ...of a patient’s personal property”

Nowhere in the trial transcript can be found even one scintilla of evidence that the morphine was owned by or belonged to Mortensen. To the contrary, Judge Eklund gave a Jury Instruction to the Board to the opposite effect,<sup>10</sup> that ownership by the patient does not exist until it is in the patient’s physical possession. There is nothing in the DOPL Order that mentions any basis for or that it disregarded that instruction, which was given based upon the defense evidence presented during trial.<sup>11</sup> DOPL never filed a cross-

---

<sup>10</sup> See Addendum Exhibit 9

<sup>11</sup> **Judge Eklund:** *First of all, there have been cases in the past where instruction have been provided to boards as a consequence of the evidence offered during the hearing. Because there is precedence for doing it, it could be done in this case.* (M T, p.197, lines 1-5) [emphasis added] The clear implication is that the Judge thought there was ample evidence offered by the Defense during the trial to supported the Instruction, and there was.

appeal challenging that instruction. The instruction is therefore controlling in this case.

Mortensen was never in physical possession of the morphine. A prescription, like the one in the instant case, for administration by a nurse “as needed,” is not a bill of sale or conveyance of title nor order to “deliver” physical possession of the drug and its container to the patient. It is nothing more than a medical order to a nurse to administer the prescribed drug to the patient - if and as needed. The Utah Supreme Court has

declared: *And the State must prove substantially as charged the offense it relies upon for conviction. The judgment must stand or fall upon the proof, or lack thereof, of the crime with which the State charged the defendant, essayed to prove, and of which he stands convicted... State v. Taylor, 378 P.2d 352, 14 Utah 2<sup>nd</sup> 107 (Utah 1963).*

There was no evidence presented by the prosecution to support a conclusion of “unauthorized taking” by Jepson, nor to support a conclusion that the morphine was the “patient’s personal property.” I challenge DOPL to point out such evidence in its response brief, if exists. Not only is there no substantial evidence to support DOPL’s findings and conclusions of a taking and hence of unlawful possession, but there is no evidence at all (see Addendum Exhibit 7). Jepson has marshaled the evidence, summarized the Prosecution case in chief and found no evidence in support of DOPL’s errant-illegal conclusion. Therefore, DOPL and Commerce should have concluded, and this Court should now conclude and rule that DOPL did not meet its burden of proof of theft or a taking, and there is no evidence, and certainly no substantial evidence, in light of the whole record, to support a conclusion of theft or taking, or of Count III, and Count III should therefore be dismissed, together with all findings and conclusions contrary to

this Courts ruling.

Both DOPL and Commerce specifically found, respectively, that Jepson had “good intentions” and “At all times, his intentions were to comply with the law and the standard of care for home health nurses, not to violate them” (Exhibit 14). Our Supreme Court declared about intent:

*There is, of course, no question about the proposition: if the defendant took the property under an honest but mistaken belief that he was entitled to do so, that would negative his intent to steal; and he would not be guilty of theft; State v Kazda, 545 P.2d 190 (Utah 1976)*

It is clear from the facts as testified to by Beckstroms and Jepson that from April 11, 2002 forward , Jepson has claimed he was bound by law not to make an illegal distribution and delivery of controlled substances. Right or wrong, although he was right, this belief negatives any intent to steal and he cannot be found guilty of theft or taking. This coupled with the fact that Jepson never “took” any thing, is the final nail in the “unlawful conduct”/theft conclusion’s coffin. Count III must be dismissed. Furthermore, Case law on theft reveals that proof of theft requires more than an administrative substantive rule change applied retrospectively.<sup>12</sup> Now the related issues:

**13. Whether Jepson committed a theft or taking and whether Count III should be**

---

<sup>12</sup> *State v. Allen*, it is necessary to find intent to steal; *State v. Chesnut*, 621 P.2d 1228 (Utah 1980) - theft requires evidence that the property was taken from the possession of the owner; *State v. Hollen*, 1999 Ut App 123, 982 P.2d 90 removal of money was a taking;

**dismissed?**

**Ans:** No. Jepson committed no theft or taking. There was no prosecution evidence whatsoever to prove the elements of theft. Yes, Count III should be dismissed.

**14. ISSUE: Whether the prosecution met its burden of proof at trial on Counts I and III , filed against Appellant?**

**Ans:** No. The prosecution proved none of the Petition allegations and none of the elements of the statutes and Rule cited in the petition. None of the prosecution witnesses even discussed the petition allegations or the required elements of proof. The only thing that was discussed by the prosecution that was tangible was Jepson's failure to "deliver" the morphine to Beckstroms, which of course would have been illegal.

#### **Fourth Analysis - Ex Post Facto Conduct of DOPL**

The United States Constitution Article 1 Section 10, states: *No State shall...pass any Bill of Attainder, ex post facto Law ...*(see Addendum Exhibit 10).

DOPL is a creation of the legislature of the State of Utah, and as such cannot violate ex post facto principles, as it did in this instant case. Neither the Petition against Jepson nor DOPL's actions gave Jepson "fair notice" of this new rule (changed Rule 502(4) or of the punishments which would flow from it's violation, which violation is ipso facto a violation of Title 58 and hence a crime. DOPL 's new rule and its Order makes that criminal which was not so at the time the action was performed in April, 2002. DOPL'S actions are punitive in nature, conclude that Jepson's conduct was "unlawful," thus,

criminal under Title 58, and are, in this case, ex post facto, and should be reversed and vacated.

**15. ISSUE: Whether DOPL's post trial substantive change to Utah Controlled Substance Act Rule R156-37-502(4) and its retrospective application to appellant, making, without warning, his lawful legal possession of a controlled substance ipso facto unlawful, illegal, and unprofessional, and DOPL's application of the change to a "class of persons" (e.g. home health nurses) without compliance with the Utah Administrative Rule Making Act, is error and illegal, is beyond the jurisdiction conferred by statute, is an unlawful procedure or decision-making process, or fails to follow prescribed procedure, or is not supported by substantial evidence, or is contrary to the evidence?**

**Ans:** Yes. DOPL's actions are beyond statutory jurisdiction, are , error, illegal, unlawful procedure, fail to follow the Utah Administrative Rule Making Act, are not supported by substantial evidence, and are contrary to the evidence.

**16. ISSUE: Whether DOPL's actions constitute illegal, unconstitutional or ex post facto conduct?**

**Ans:** Yes. DOPL applied its aforesaid Rule change retrospectively over one year to Jepson's conduct, and made his then legal conduct illegal. It couldn't have done this without substantively changing Rule 502(4), because without that change, the Rule required Jepson to maintain control of the morphine, not relinquish control by "delivery" to Beckstroms. Thus DOPL's actions are illegal and ex post facto, which is then unconstitutional. Even if not held unconstitutional/ex post facto by this Court, DOPL's conduct is nevertheless illegal, since it contravenes statutory prohibitions against "delivery" and was totally unsupported by any competent evidence at trial (Exhibit 7).

### **Fifth Analysis - Utah Administrative Rule Making Act &**

## Usurpation of Exclusive Legislative Authority

DOPL did not follow its own Rule 502(4). Please note, the rule language contains no exceptions and exempts no group of persons. It applies to all persons equally who are licensed to handle narcotics in Utah - Doctors, Nurses, Dentists, Veterinarians, Pharmacists, etc. The aforesaid Rule change was made by way of two Conclusions of Law issued by DOPL:

1. . . . *R156-37-502(4). That rule governs a failure of a practitioner to maintain controls over controlled substances **in an institutional setting** as to effectively prevent the diversion, theft or shortage of such substances.* (see Conclusions, p. 11, lines 15-19)
2. *R156-37-502(4) does not strictly apply in a home health care setting.* . . . (see Conclusions, p. 11, lines 20-21) [emphasis added]

By the first Conclusion, the ALJ/Board purportedly substantively changed **Rule 502(4)** by restricting its application to an “institutional setting,” which restrictive language appears nowhere in the Rule. By the second Conclusion they purportedly amend **Rule 502(4)** by suspending the Rule from applying to home health nurses, including Jepson, which suspending language appears nowhere in the actual **Rule**. **These Conclusions are not announcing a nurse practice standard - they are changing a Controlled Substances Act Rule.** DOPL has enacted no exceptions to Rule 502(4)(which it is required to do by following rule making procedures and which it could

have done.<sup>13</sup> under §63-46-3 et seq., UCA. Neither has it complied with the mandatory language of §63-46a-3, UCA, requiring it to enact rules within 120 days of a decision, e.g. as in this case. It has made a “substantive change” in Rule 502(4) (§63-46a-2(18)) without following “procedural requirements of chapter 46a (63-46a-14, UCA). Defendant challenges on basis of non-compliance.

DOPL has created three new crimes:

If Jepson obeyed Rule 502(4) and maintained control of a controlled substance, which he did, then (1) he is guilty of violating this new rule requiring him [retroactively] (a) to not obey Rule 502(4) and (b) to relinquish control of the controlled substance; (2) he is required [retroactively] to have made an illegal distribution of a controlled substance by “delivering” it to Beckstroms, persons for whom it was not prescribed, in violation of §58-37-8(1)(a)(ii), UCA, Prohibited Acts, and (3) he is allegedly guilty of a theft or taking under §58-31b-502(7), UCA, for failing to “deliver” the controlled substance as required in (2) above. Remember also, the Board said Jepson acted “unlawfully” (Conclusions, 9:27; 13:9).

Therefore, each of these new crimes is a misdemeanor, with a penalty affixed by statute. Only the legislature can define a crime, not DOPL. DOPL’s conclusions in the instant case are not only unconscionable and incoherent, but are an illegal usurpation of exclusive legislative authority and must be vacated. (See *State v. Gallion*, 572 p. 2d 683 (Utah 1977), confirmed by *State v. Green*, 793 p. 2d 912 (Utah App. 1990).

---

<sup>13</sup> §63-46a-3(2)(c), (3), (4)(d), (6), (7)(a)(i),(b), (8)(b) - *Utah Administrative Rule Making Act*, - provides for the creation of an exception to a Rule and requires adherence to the Act when making any substantive change to a Rule, especially, and the Act is specific, if it applies to a “class of persons” -- such as home health care nurses; §63-46a-4 UCA, *Rule Making Procedure*, “...when... amending... a rule agencies shall comply with (a) the requirements of this section” [emphasis added];



Even if this Court finds that DOPL's conduct was an interpretation rather than a substantive change to Rule 502(4), the interpretation must be consistent with statute, which it is not.<sup>14</sup>

**17. ISSUE: Whether DOPL must comply with the Utah Administrative Rulemaking Act in making substantive changes to Controlled Substances Act Rules, and whether failure to do so is a usurpation of exclusive legislative authority?**

### **Sixth Analysis - Judge Eklund Excluded Evidence & Gave False Assurance**

Rule 402 URE states: *All relevant evidence is admissible...* Rule 401 URE states:

*'Relevant evidence' means evidence having any tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence.*

Rule 103 URE provides that, *Error may not be predicated upon a ruling which ...excludes evidence unless a substantial right of the party is affected. . . or is plain error*

Jepson offered into evidence a written national standard for the security of Schedule II Controlled substances published by and listed on the web site of the Joint Commission on Accreditation of Healthcare Organizations (hereafter "JCAHO"), attached hereto as Exhibit 16 and incorporated herein. It specifically stated it was based upon DEA regulations. The prosecution made a frivolous objection that the exhibit - a large chart - didn't include all three pages of the web site printout and they couldn't tell

---

<sup>14</sup> In *Fussel v. Department of Commerce, Division of Occupational & Professional Licensing*, 815 P. 2d 250 (Utah App. 1991), this Court ruled that DOPL's interpretation of administrative rules must be consistent with governing statutes.

whether it was about home health care. I replied that the prosecution was free to introduce the other two pages into evidence if they wished and that on the face of the exhibit the words “Home Care,” “Home Care,” “Home Care Page,” and “Home Care” appeared at least four times and were clearly visible and legible. Some of this discussion occurred in the hall out of the hearing of the Board. In the hearing Ms. Luke said the exhibit was “off the beam” was “irrelevant” and “We would have to go into a lot of studying...” and she thought it was “prejudicial. It’s off the beam? Really? Is that a real competent objection? What it is, is incompetent nonsensical noise because she was unprepared and doesn’t know the rules of evidence. The objections were baseless and frivolous. Based on that frivolous objection alone Judge Eklund went along and excluded the exhibit, admitting the exhibit says “Home Care Home Page” (MT 52:16-56:18, esp. 54:22-23). He claimed he didn’t find anything in the language that addresses a home health setting.. Well I had circled the language, quoted immediately below, in yellow on the exhibit. However, the language the Judge was reading was the next paragraph below that.(see) . The language of the exhibit which Jepson offered into in evidence states:

Q. Do all prescription and non-prescription drugs need to be secure? A: Yes. How secure depends on the classification of the medication as a “controlled substance” or not. Certainly all Schedule II controlled substances (narcotics) need to be secure under lock and key based on DEA laws and regulations (standard TX.3.4). Although most states no longer require a “double-lock” system, these products must be stored in a “substantially constructed locked cabinet”. In addition, these drugs must be tightly controlled and accounted for, under law and regulation.

This evidence went directly to ultimate issues in this home health care case. The

Judge castrated Jepson's substantial right and his attempt to defend himself on these issues and to present evidence which would probably have radically changed the outcome of the verdict. Jepson would have and should have been acquitted on all Counts.

The wrongful exclusion of the above evidence allowed the Judge/Board to rule that: all Schedule II controlled substances (narcotics) need NOT be secure under lock and key based on DEA laws and regulations (standard TX.3.4) and that these drugs must NOT be tightly controlled and accounted for, under law and regulation — diametrically opposite from the above proffered evidence and “standard” for home health care, based upon federal law.

Furthermore, this JCAHO standard was “evidence having any tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence. What facts and ultimate issues were affected? What defense was affected? Several. It would have:

(1) directly impacted the determination of this action; (2) confirmed the correctness of Jepson's action in taking a lethal quantity of Morphine home and locking it up under a double lock; (3) tended to support the defense position that Jepson acted professionally and lawfully in following Rule 502(4) and in electing not to “deliver” the lethal Morphine to the Beckstroms; (4) confirmed that Rule 502(4) applies in home health care and must be followed by home health nurses; (5) tended to prevent the Judge/Board from restricting Rule 502(4) to institutions and suspending the application of Rule 502(4) to home health nursing, retroactively and ex post facto, and specifically to Jepson's April 2002 actions, (6) prevented a conclusion that Jepson acted unlawfully or criminally, (7) prevented a conclusion that Jepson acted unprofessionally; (8) prevented a conclusion that Jepson's election not to “deliver” the Morphine constituted, absent other evidence, theft or a “taking,” and last but not least, (8) tended to have caused the Judge/Board to acquit Jepson on all Counts, which would have

kept Jepson's nursing record meticulously clean and spotless.

Judge Eklund examined the exhibit and knew its content. By the exclusion of this evidence, Judge Eklund intentionally and knowingly adversely influenced the outcome of this case for Jepson, especially where, in light of the whole record, the exhibit agreed with all of the competent testimony from four competent experienced medical witnesses. In other words, Judge Eklund excluded exculpatory evidence which he knew would both help Jepson and destroy the prosecution's case. Judge Eklund's exclusionary ruling should be reversed. The Judge's exclusion of this evidence was harmful error<sup>15</sup> and directly affected the outcome of the trial. The Judge did not rule that the evidence offered would be unfair, prejudicial, confusing or misleading, nor that it would cause delay, waste of time, or needless cumulative evidence under URE 403. He simply excluded it on a frivolous objection by the prosecutor. This prejudiced the Defense. (See *State v Royball* 710 p.2d 168,169, that the Trial Court so abused its discretion as to create a likelihood that injustice resulted; *State v Jensen*, 727 P 2d 201 (Utah 1986), confirmed)

In closing argument prosecutor Cheryl Luke, in a shocking display of misconduct, asked the Board, "...was that a theft...?" (MT 190: 5), when the "whole record" proves no evidence of theft had been presented by prosecution, and theft had been disproved by the defense, and she knew it. Defense counsel asked for a conference outside the hearing of the Board/Jury (MT 195: 16-17). Strenuous objection was made off the record by

---

<sup>15</sup> "To constitute an abuse of discretion, the ruling must have been harmful error." *State v Dibello*, 780 P,2d 1221 (Utah 1989)

Jepson as to the prosecutor's misconduct in alleging theft, when none of the elements of theft had been proven during trial. Objection was also made for the reason that the prosecutor was DOPL's attorney and the Board would believe what she said even without any proof - which the result proves - the Board bought it lock stock and barrel with no supporting prosecution evidence and contrary to clear defense evidence of no theft/taking. The Judge assured defense counsel that no finding of theft or taking would be made by the board. When reconvened, the Judge gave a defense requested jury instruction to the effect that a schedule II narcotic becomes the property of a patient at that point in time when it is "delivered" into the physical possession of the patient (MT 197:6-20; Exhibit 9, Record p 233). The standard of care supporting that Instruction had been profusely adduced by the defense during trial and the Board was therefore not allowed to disregard it. Since no delivery had taken place, defense counsel was content to believe the Judge's off-record assurances, buttressed by his giving of the aforesaid jury instruction to correct the misconduct. No objection was therefore made in front of the jury since the misconduct problem seemed to have been corrected and defense counsel was, thereby lulled in to a feeling of security.<sup>16</sup> Notwithstanding, the Judge's assurances, and the Instruction, DOPL through its Board, as drafted by the Judge, who gave the assurances and issued the Jury Instruction, found theft or taking (Exhibit 18 at 10:1-4; Record, p 191:1-4), without mention of disregard of the Instruction and without identifying any

---

<sup>16</sup> ... "the judge had lulled counsel into a feeling of security by promising to give the substance of a particular instruction." *Johnson v Simons*, 551 P.2d 515 (Utah 1976)

standard of care, other than by simply stating in two places, “The standard of care in nursing...requires...a competent witness...” (Conclusions 5:16-17, Record, p 186:16-17), and “Respondent violated the applicable standard of care because he failed to duly deliver that medication..” (Conclusions, 10:4-5; Record, p 191:4-5). Therefore, although there was a contemporaneous objection out side the hearing of the Jury, there was no objection on the record, under the circumstances, but:

...the premise of rule 103(d) [URE] is that the ends of justice must not be lost sight of in the pursuit of procedural regularity and that when an error is plain, the trial court can legitimately be said to have had a reasonable opportunity to address and correct it, even in the absence of an objection. *State v Eldredge*, 773 P.2d 29 (Utah 1989)

Jepson has here shown:

that the prosecutor’s remarks were obviously improper and harmful and that his failure to object did not lead the court into error. *State v Emmett*, 839 P.2d 781 (Utah 1992)

Since the Instruction had been given based upon defense evidence during trial, and to correct misconduct, and there is no indication that the Board knowingly and intentionally disregarded it, it should be enforced, the prosecutor’s misconduct identified for what it was - misconduct - and the aforesaid conclusion of theft/taking stricken, reversed, and vacated.

**18. ISSUE: Whether DOPL’s trial judge wrongfully excluded relevant evidence affecting the right of appellant to present the national standard for the security of Schedule II narcotics in home health care of the Joint Commission on Accreditation of Healthcare organizations, “having any tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence?”**

**Ans:** Yes.

**19. ISSUE: Whether the trial Judge's false assurance to defense counsel that Board would not find a "taking" or "theft" caused failure to object?**

**Ans:** Yes. Can be reviewed under Manifest Injustice; Substantial Evidence Test, §63-46b-4 (g)

### **MISCELLANEOUS ISSUES**

**20. ISSUE: Whether the ordered reprimand should be vacated?**

**Ans:** Of course. It is not supported by substantial evidence.

There is no basis for the three conclusions challenged herein above nor for Counts I and III. They should all be vacated and dismissed. No basis left for a reprimand.

**21. ISSUE: Whether the requirement of disclosure regarding a "Private reprimand" is reasonable or appropriate?**

**Ans:** It is probably a moot point given the answer to the last preceding issue.

However, a private reprimand is not private if it requires "disclosure to even one other person or organization (e.g. Jepson's employer). Private means private, "not shared with others in any way, secret, hidden from others."

### **CONCLUSION**

Jepson has marshaled the trial evidence and shown that the prosecution failed to meet its burden of proof, creating a trial record devoid of evidence, let alone substantial

evidence<sup>17</sup>, in support of Counts I and III of DOPL's Petition, or in support of the three challenged conclusions. The only medical evidence offered by the prosecution was Baker's testimony, who was incompetent to testify in this trial. Even if ruled a competent Expert by this Court, she only gave personal opinions, not expert, established no standard of care or practice about anything, disqualified herself about liquid morphine, the central issue, and failed to testify about any of the charging language or about any of the elements of the statutes and Rule cited in the petition, or about how Jepson violated any of them. She testified and advocated illegal criminal conduct of "distribution" and "delivery" of controlled substances. Baker was never accepted by the Court nor defense as Expert. She testified over six (6) defense objections.

The defense thoroughly proved Jepson violated neither the charging language nor any of the cited statutes in Counts I and III. The findings and conclusions adverse to Jepson, challenged herein above, are contrary to the evidence adduced at trial and they, together with Counts I and III should be reversed, dismissed, and vacated, and Jepson's prior unblemished record restored, including an Order that no record nor reference to this disciplinary action be maintained in his file. If attorney's fees and costs are appropriate to be awarded to Jepson, please award them based on a Petition not brought or asserted in


---

<sup>17</sup> *Mountain Fuel Supply Co. V Public Service Commission*, 861 P.2d 414 222 Utah Adv. Rep. 18 (Utah 1993) - "viewed in light of the whole record;" *Utah Ass'n of Counties v Tax Comm'n of the State of Utah* Nos. 930451, 930 (Utah 1995) "We have defined 'substantial evidence' as 'that quantum and quality of relevant evidence that is adequate to convince a reasonable mind to support a conclusion'"



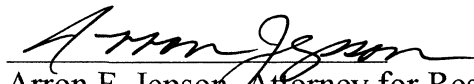
good faith and in violation of Rule 11. Thank you.

Dated this 6 day of December, 2004.

  
Arron F. Jepson  
Attorney for Scott Jepson

**Certificate of Delivery**

The undersigned hereby certifies that a true and correct copy of the above Brief of Appellant has been hand delivered to Judge Mesuda Medcalt, Heber M. Wells Building, 160 East 300 South, Salt Lake City, Utah, 84114, and to Karl Perry, Assistant Attorney General, Division of Commercial Enforcement, 160 East 300 South, Fifth floor, Salt Lake City, Utah, 84114, this 6<sup>th</sup> day of December, 2004.

  
Arron F. Jepson, Attorney for Respondent / Appellant

**Tab 1**

**ADDENDUM**  
6 Statutes & 1 Rule

**EXHIBIT 1**

A Crime Defined by the Legislature

**58-1-502. Unlawful conduct -- Penalty.** Unless otherwise specified in this title, any person who **violates the unlawful conduct provisions** defined in this title is guilty of a **class A misdemeanor**. [emphasis added]

Title 58-37 - Controlled Substances Act - Crimes Defined by Legislature

**58-37-8(1)(a)(ii). Prohibited Acts — Penalties.** (1) Except as authorized by this Chapter it is **unlawful** for any person to knowingly and intentionally: (a)(ii) **distribute** a controlled or counterfeit substance . . . [emphasis added]

**58-37-2(1)(n). Definitions.** (n) “**Distribute**” means to **deliver other than by administering** or dispensing a controlled substance or a listed chemical. [emphasis added]

**58-37-8(1)(a)(i),(ii),(iii). Prohibited acts -- Penalties.**

(1) Prohibited acts A -- Penalties:

(a) Except as authorized by this chapter, it is **unlawful** for any person to knowingly and intentionally:

- (i) **produce**, manufacture, or dispense, or to **possess with intent to produce**, manufacture, or dispense, a controlled or counterfeit substance;
- (ii) **distribute** a controlled or counterfeit substance, **or to agree, consent, offer, or arrange to distribute** a controlled or counterfeit substance;
- (iii) **possess** a controlled or counterfeit substance **with intent to distribute**; or... [emphasis added]

**§ 58-37-8(2)(a)(i). Prohibited Acts — Penalties** It is **unlawful** for any person knowingly and intentionally **to possess** or use a controlled substance, **unless** it was **obtained** under a **valid prescription** or order, **directly from a practitioner while acting in the course of his professional practice** or as otherwise authorized by this chapter; [emphasis added]

Rule R156-37 -- Utah Controlled Substances Act Rule - Passed by the Legislature

**Utah Controlled Substances Act Rule - R156-37-502(4) [Rule 502(4)].**  
“**Unprofessional conduct**” means (4) **failing** to **maintain controls** over controlled substances which would be considered by a prudent practitioner

to be **effective** against diversion, theft, or shortage of controlled substances;  
[emphasis added]

Criminal Code - Passed by the Legislature

**76-6-404. Theft -- Elements.**

A person commits theft if he **obtains** or exercises **unauthorized control**  
over the **property of another** with a **purpose to deprive** him thereof.

Enacted by Chapter 196, 1973 General Session [emphasis added]

## ADDUNDUM

## EXHIBIT 1B

### Charging Language & Statutes under Counts I & III

**Count I** - Jepson possessed controlled substances outside of his responsibilities as a nurse;

This allegation was based upon three (3) conduct statutes and two (2) penalty statutes, referred to in the petition (see Petition, page 5, Count I) the text of which provide [with emphasis added]:

a. **58-37-8(2)(a)(i)** UCA - Prohibited Acts - Penalties (2) It is **unlawful**: for any person knowingly and intentionally to **possess** or use a controlled substance, **UNLESS** it was **obtained** under a **valid prescription** or order, **directly from** a practitioner while acting **in the course** of his professional practice or as otherwise authorized by this chapter;

(**58-37-2(ee)**UCA - “**Practitioner**” means a physician, dentist, veterinarian, **pharmacist . . .**)

b. **58-31b-502 (5)**, UCA - Unprofessional conduct includes (5) **unlawfully** obtaining, **possessing**, or using a **prescription drug** or illicit drug;

c. **58-1-501(2)(a)** UCA - Unlawful & Unprofessional Conduct - (2) Unprofessional conduct means conduct by a licensee that is defined as unprofessional conduct under **this title (58) or** under **any rule** adopted under this title and includes:

(a) **violating**, or aiding, or abetting any other person to violate **any statute, rule, or order** regulating an occupation or profession under this title;

Two penalty provisions were also included:

d. **58-1-401(2)(a)(b)** UCA: The division may refuse to issue a license to an applicant and may refuse to renew or may revoke, suspend, restrict, place on probation, issue a public or private reprimand to, or otherwise act upon the license of any licensee in any of the following cases:

(a) the applicant or licensee has engaged in **unprofessional conduct**, as defined by statute or rule under this title;

(b) the applicant or licensee has engaged in **unlawful conduct** as defined by statute under this title;

e. **58-31b-402(1)** UCA: After a proceeding pursuant to Title 63, Chapter

46b, Administrative Procedures Act, and Title 58, Chapter 1, Division of Occupational and Professional Licensing Act, the division may impose an administrative penalty of up to \$10,000 for unprofessional or unlawful conduct under this chapter in accordance with a fine schedule established by rule.

**Count III** - Jepson failed to produce a medication . . . for a patient. [emphasis added]

This allegation was based solely upon one (1) conduct statute 58-31b-502(7) and two (2) penalty statutes, set forth under Count I above. (see Petition, page 6, Count III).

a. **§58-31b-502(7)**, UCA provides: Unprofessional conduct includes . . . (7) unauthorized **taking** or personal use of a patient's personal property.

b. **58-1-401(2)(a)** UCA: The division may refuse to issue a license to an applicant and may refuse to renew or may revoke, suspend, restrict, place on probation, issue a public or private reprimand to, or otherwise act upon the license of any licensee in any of the following cases:

(a) the applicant or licensee has engaged in **unprofessional conduct**, as defined by statute or rule under this title;

c. **58-31b-402(1)** UCA: After a proceeding pursuant to Title 63, Chapter 46b, Administrative Procedures Act, and Title 58, Chapter 1, Division of Occupational and Professional Licensing Act, the division may impose an administrative penalty of up to \$10,000 for unprofessional or unlawful conduct under this chapter in accordance with a fine schedule established by rule.

## ADDENDUM

## EXHIBIT 1C

### Charging Language and Statutes/Rule of Counts II & IV

**Count II** - Was dismissed after trial for lack of evidence. (See Conclusions: p. 11, ¶ 1, lines 11-13; see also p. 10, ¶ 3, lines 13-27, and p.11 lines 1-4). This Count II alleged: Jepson (1) failed to administer medication to his patient as prescribed; and (2) maintained a patient's narcotics medication at his residence and (3) disposed of the same without a proper witness; and (4) failed to report his suspicion that the patient was a victim of abuse; [emphasis and numbers added]

This allegation was based upon two (2) conduct statutes and two (2) penalty statutes, referred to in the petition (see Petition, page 6, Count I) the text of which provide [with emphasis added]:

a. § 76-5-111.1(1)(2)(a)(i) UCA: Any person, including but not limited to, a social worker, physician, phschologist, nurse, teacher, or employee of a private or public facility serving adults, who has reason to believe that any disabled or elder adult has been the subject of abuse, emotional or phychological abuse, neglect, or exploitation shall immediately notify the nearest peace officer, law enforcement agency, or local office of Adult Protective Services within the Department of Human Services, Division of Aging and Adult Services.

b. §58-1-501(2)(g) UCA: **Unprofessional conduct** means conduct by a licensee that is defined as unprofessional conduct under this title or under any rule adopted under this title and includes: (g) practicing or attempting to practice on occupation or profession regulated under this title **through gross incompetence, gross negligence, or a pattern of incompetency or negligence**:

c. 58-1-401(2)(a) UCA: The division may refuse to issue a license to an applicant and may refuse to renew or may revoke, suspend, restrict, place on probation, issue a public or private reprimand to, or otherwise act upon the license of any licensee in any of the following cases:

(a) the applicant or licensee has engaged in **unprofessional conduct**, as defined by statute or rule under this title;

d. 58-31b-402(1) UCA: After a proceeding pursuant to Title 63, Chapter 46b, Administrative Procedures Act, and Title 58, Chapter 1, Division of Occupational and Professional Licensing Act, the division may impose an administrative penalty of up to \$10,000 for unprofessional or unlawful conduct under this chapter in accordance with a fine schedule established by rule.

**Count IV** - Was also dismissed after trial for lack of evidence. (See Conclusions: p. 11, ¶ 3, lines 24-26). It alleged that Jepson maintained a controlled substance at his home and destroyed the same without a witness, and engaged in unprofessional conduct defined in Rule R156-37-502(4), Utah Controlled Substances Act Rules, (hereafter “Rule” or “Rule 156”) [emphasis added]

This Count is based upon one Rule: Utah Controlled Substances Act Rule R156-37-502(4) (herein after “Rule” or “Rule 156”) and upon essentially the same two penalty statutes cited under Count I above. Rule 156 states:

- a. Rule - **R156-37-502(4)**, UCA: “**unprofessional conduct**” means: ...**(4) failing to maintain controls** over controlled substances which would be considered by a prudent practitioner to be **effective** against diversion, theft, or shortage of controlled substances; (see Petition, Count IV, p. 6), on file. [emphasis added]
- b. **58-1-401(2)(a)** UCA: The division may refuse to issue a license to an applicant and may refuse to renew or may revoke, suspend, restrict, place on probation, issue a public or private reprimand to, or otherwise act upon the license of any licensee in any of the following cases:
  - (a) the applicant or licensee has engaged in **unprofessional conduct**, as defined by statute or rule under this title;
- c. **58-31b-402(1)** UCA: After a proceeding pursuant to Title 63, Chapter 46b, Administrative Procedures Act, and Title 58, Chapter 1, Division of Occupational and Professional Licensing Act, the division may impose an administrative penalty of up to \$10,000 for unprofessional or unlawful conduct under this chapter in accordance with a fine schedule established by rule.



## ADDENDUM

## EXHIBIT 1D

### Utah Administrative Rulemaking Act

#### **63-46a-3. When rulemaking is required.**

(1) Each agency shall:

- (a) maintain a current version of its rules; and
- (b) make it available to the public for inspection during its regular business hours.

**(2) In addition to other rulemaking required by law, each agency shall make rules when agency action:**

- (a) authorizes, requires, or prohibits an action;
- (b) provides or prohibits a material benefit;
- (c) applies to a class of persons or another agency; and**
- (d) is explicitly or implicitly authorized by statute.

**(3) Rulemaking is also required when an agency issues a written interpretation of a state or federal legal mandate.**

**(4) Rulemaking is not required when:**

- (a) agency action applies only to internal agency management, inmates or residents of a state correctional, diagnostic, or detention facility, persons under state legal custody, patients admitted to a state hospital, members of the state retirement system, or students enrolled in a state education institution;
- (b) a standardized agency manual applies only to internal fiscal or administrative details of governmental entities supervised under statute;
- (c) an agency issues policy or other statements that are advisory, informative, or descriptive, and do not conform to the requirements of Subsections (2) and (3); or
- (d) an agency makes nonsubstantive changes in a rule, except that the agency shall file all nonsubstantive changes in a rule with the division.**

(5) A rule shall enumerate any penalty authorized by statute that may result from its violation.

(6) Each agency shall enact rules incorporating the principles of law not already in its rules that are established by final adjudicative decisions within 120 days after the decision is announced in its cases.

**(7) (a) Each agency may enact a rule that incorporates by reference:**

- (i) all or any part of another code, rule, or regulation that has been adopted by a federal agency, an agency or political subdivision of this state, an agency of another state, or by a nationally recognized organization or association;**
- (ii) state agency implementation plans mandated by the federal government for participation in the federal program;
- (iii) lists, tables, illustrations, or similar materials that are subject to frequent change, fully described in the rule, and are available for public inspection; or
- (iv) lists, tables, illustrations, or similar materials that the director determines are too expensive to reproduce in the administrative code.

**(b) Rules incorporating materials by reference shall:**

- (i) be enacted according to the procedures outlined in this chapter;

- (ii) state that the referenced material is incorporated by reference;
  - (iii) state the date, issue, or version of the material being incorporated; and
  - (iv) define specifically what material is incorporated by reference and identify any agency deviations from it.
- (c) The agency shall identify any substantive changes in the material incorporated by reference by following the rulemaking procedures of this chapter.
- (d) The agency shall maintain a complete and current copy of the referenced material available for public review at the agency and at the division.
- (8) (a) This chapter is not intended to inhibit the exercise of agency discretion within the limits prescribed by statute or agency rule.**
- (b) An agency may enact a rule creating a justified exception to a rule.**
- (9) An agency may obtain assistance from the attorney general to ensure that its rules meet legal and constitutional requirements.

Amended by Chapter 138, 2001 General Session

**63-46a-4. Rulemaking procedure.**

- (1) Except as provided in Sections 63-46a-6 and 63-46a-7, when making, amending, or repealing a rule agencies shall comply with:
- (a) the requirements of this section;**
  - (b) consistent procedures required by other statutes;
  - (c) applicable federal mandates; and
  - (d) rules made by the division to implement this chapter
- (2) Subject to the requirements of this chapter, each agency shall develop and use flexible approaches in drafting rules that meet the needs of the agency and that involve persons affected by the agency's rules.
- (3) (a) Each agency shall file its proposed rule and rule analysis with the division.
- (b) Rule amendments shall be marked with new language underlined and deleted language struck out.
- (c) (i) The division shall publish the information required under Subsection (3) on the rule analysis and the text of the proposed rule in the next issue of the bulletin.
- (ii) For rule amendments, only the section or subsection of the rule being amended need be printed.
- (iii) If the director determines that the rule is too long to publish, the director shall publish the rule analysis and shall publish the rule by reference to a copy on file with the division.
- (4) Prior to filing a rule with the division, the department head shall consider and comment on the fiscal impact a rule may have on businesses.
- (5) The rule analysis shall contain:
- (a) a summary of the rule or change;
  - (b) the purpose of the rule or reason for the change;

- (c) the statutory authority or federal requirement for the rule;
- (d) the anticipated cost or savings to:
  - (i) the state budget;
  - (ii) local governments; and
  - (iii) other persons;
- (e) the compliance cost for affected persons;
- (f) how interested persons may review the full text of the rule;
- (g) how interested persons may present their views on the rule;
- (h) the time and place of any scheduled public hearing;
- (i) the name and telephone number of an agency employee who may be contacted about the rule;
- (j) the name of the agency head or designee who authorized the rule;
- (k) the date on which the rule may become effective following the public comment period; and
- (l) comments by the department head on the fiscal impact the rule may have on businesses.

(6) (a) For a rule being repealed and reenacted, the rule analysis shall contain a summary that generally includes the following:

- (i) a summary of substantive provisions in the repealed rule which are eliminated from the enacted rule; and
- (ii) a summary of new substantive provisions appearing only in the enacted rule.

(b) The summary required under this Subsection (6) is to aid in review and may not be used to contest any rule on the ground of noncompliance with the procedural requirements of this chapter.

(7) A copy of the rule analysis shall be mailed to all persons who have made timely request of the agency for advance notice of its rulemaking proceedings and to any other person who, by statutory or federal mandate or in the judgment of the agency, should also receive notice.

(8) Following the publication date, the agency shall allow at least 30 days for public comment on the rule.

(9) (a) Except as provided in Sections 63-46a-6 and 63-46a-7, a proposed rule becomes effective on any date specified by the agency that is no fewer than 30 nor more than 120 days after the publication date.

(b) The agency shall provide notice of the rule's effective date to the division in the form required by the division.

(c) The notice of effective date may not provide for an effective date prior to the date it is received by the division.

(d) The division shall publish notice of the effective date of the rule in the next issue of the bulletin.

(e) A proposed rule lapses if a notice of effective date or a change to a proposed rule is not filed with the division within 120 days of publication. Amended by Chapter 138,

Tab 2

ADDENDUM

EXHIBIT 2

**6 Objections to Nurse Baker's Testimony**  
(April 25, 2004 - Transcript (AT) pp. 98-100, 136)

**Lima:** Once a controlled substance prescription is issued to a patient, does the home health nurse determine if and when the medication can either be physically delivered to the patient or the caregivers or be retained by the patient or the caregivers? . . . . . P 98, lines 19-23

**1<sup>st</sup> Objection** - "I am going to object. I think that's a Legal question. Depends upon what the statute says and the rules say. It's not subject to an opinion on that point" . . . . . P 98 line 24 thru P 99 line 2

**Judge** replied: "I think the question was put to the witness in the capacity as an Expert Witness and I think she can answer to the extent she understands the question." . . . . . P 99, lines 3-6

**2<sup>nd</sup> Objection** - "Then I object because she has not been qualified in that area" . . . . . P 99, lines 7-8

**Judge** replied "I think she was being offered as one, is she not, Miss Lima?" . . . . . P 99, lines 9-10

**Lima** says: "She is" . . . . . P 99, line 11

**3<sup>rd</sup> Objection** - "I beg your pardon, Judge. She was offered"["?"] - "she was not offered, but I guess she is now" [being offered] "as a qualified expert on home health nurs[ing]." [editing added to clarify Atty Jepson's shock and surprise and reply to Judge's action of offering the witness himself as

an expert since the prosecution had not done so]

**Judge** replied, "I think that's what she is here to testify - . . . . . p 99, lines 15-16

**Further Objection** - "Yeah. The question here is where the legal duty lies

as to who makes what determination and I think we can - " P 99, lines 17-19

**Judge** replies: "The question was put in the context of a home health nurse and the question, as I recall it, was does the home health care nurse have the authority to decide when or how to administer controlled substances." . . . . P 99, lines 20-24

**4<sup>th</sup> Objection** - "Exactly. And the word authority means nurses are controlled by statute and regulations and so the proper question should be, if it's asked, what is the statute or where is the regulation and what does it say, not do you have an opinion about what the law is, so **I maintain my objection.** . . . . . P 99, line 25 thru P 100, line5

**Judge** replied: I think the witness can answer the question and the source and the basis for her answer can then be explored and then I'll allow it. . P 100, lines 6-8

**Witness:** If I understand the question correctly, are you asking me if a pharmacist prescribes - or if a physician prescribes a medication for a patient is there any reason why I don't think that patient should have that medication?P 100, lines 9-13

**Ms. Lima:** Yes. . . . . P 100, line 14

**5<sup>th</sup> Objection** - "**Objection.** That is not what the question was. The question was a determination of authority to act, not what her opinion is." . . . . . P 100, lines 15-17

**6<sup>th</sup> Objection: Mr. Scott Jepson:** Objection. She has already clearly stated that she doesn't have the background in administering narcotics to have any expert testimony. . . . . P. 136, lines 3-5

(Note: No ruling by the Judge on this last objection. No ruling ever made whether Baker is accepted by the court as an expert witness or whether her testimony is being allowed.)

Tab 3



## ADDENDUM

## EXHIBIT 3

### **Nurse Baker Disqualifies Herself** (April Transcript p. 118, line 25 through p. 119, line 17)

Q: Okay. So you have had some experience administering morphine?

A: At the time I was an L.P.N., so **very little**.

Q: Rarely?

A: And usually it was I.M.

Q: Did you ever administer I.V. morphine?

A: **No**.

Q: Okay. And then since then, you have not had positions or — you haven't had any kind of position where you would have exposure to being required to administer I.V. morphine, correct?

A: **Nope**.

Q: So your testimony is that you have no experience in administration or control of I.V. morphine?

A: **No**.

Q: Thank you.

Mr. Arron Jepson: **No, means no experience?**

The Witness: **Right**

Tab 4

## ADDENDUM

## EXHIBIT 4

### Examples of Nurse Baker's Personal-Opinion-Non-Expert Testimony April 25, 2003 Transcript (AT)

"If I were going ... (P. 98, lines 1-2

"I would recommend..." (98, line 2)

"I think it's important..." (p 98, line 4

What is the standard of care...?" (P 100 line 20). "I felt like...if I was concerned... I would..." (p 101, lines 3, 7-8).

"If I felt like it was a safe situation..." P 101, line 3

"My job would be ..." P 101, line 6

"If I was concerned and felt like..." P 101, line 7

"I would involve ..." P 101, line 8

"...who I was working ..." P 101, line 9

"I think it would be up to the nurse and the family." P 101, line 14

"You would like to have somebody watch you ..." P 101, line 18

"I think as a nurse I would want to record that just to cover myself..." P 102, lines 20-21

"Probably in the patient's record and perhaps in a log..." P 103, lines 1-2

"I would report..." (P 117, line 5);

"My understanding is... I don't believe so." (P 123. Lines 5, 21);

"I understand as a nurse..." (P 124, line 3);

"If it wasn't a safe situation I wouldn't be in there taking care of the patient." P 127, line 13 thru P 128, line 7

"I would write down...because I care for my license...I would probably...When I recorded...I would do it right there..." . . . . . (P 137, lines 5,9,14,20,22)

"I wouldn't want...No I would want...I don't believe so." . . . . (P 138, lines 5,7,11)

Note: DOPL, through its Attorney Karl Parry, has admitted that Nurse Baker gave only personal opinion answers: "as to how she would act or handle different situations as posed to her..." (See DOPL Memo to Department of Commerce on Review, p. 17, lines 11-14; Record, p. 89:11-14)

Tab 5

## ADDENDUM

## EXHIBIT 5

### Nurse Baker's Only Testimony Regarding "Standard of Care"

#### 1) April 25, 2003 Transcript - P 100, line 20 through p. 101 line 15

Q: What is the standard of care when — in a situation where a patient is issued controlled substances by his or her physician? Is the nurse — does the nurse have any say as to whether or not the family can **retain the drug**?

A: Well, the nurse — the person probably wouldn't be accepted for home health unless it was a safe situation and a workable situation, because you have to have a caregiver there, especially for a patient like this. If I felt like it was a safe situation and they were giving her her medications correctly and she has a new one ordered that was a controlled substance, it would be — you know, my job would be to make sure they understood how to use it safely and — if I was concerned and felt like that wasn't going to work, then, again I would involve a social worker or someone else in my — who I was working with and maybe get some interventions going and find a more workable situation.

#### 2) April 25, 2003 Transcript - P 101, line 16 through p. 102 line 1

Q: What is the standard of care regarding the **wasting** of controlled substances in a home health setting?

A: You would like to have somebody watch you waste it, if that's what you were going to do. I am thinking — say you had a medication order and you didn't need it at the time. You would, you know, keep it in the refrigerator or just store it. It's — you know, it's got the patient's name on it, not the nurse. My duty would be to make sure they understood about the medication and you know, ongoing teaching and then evaluation of the patient and her medications and what was and what was working and what wasn't.

#### 3) April 25, 2003 Transcript - P 102, line 2 through p. 102 line 17

Q: If the decision was made to **waste** the medication, could you walk me through the process of how that waste would actually occur, according to your interpretation or understanding of the standard of care as it applies to a nurse in a home health setting?

A: If it was a controlled substance I would have the family watch me and we would waste it together. I did a lot of hospice nursing and when we have to change

a morphine cassette you would bring out the new morphine cassette to put in and the old one to take out. And maybe there was a few cc's of morphine left. The family would watch you cut the bag and waste it and put in the new one. Again, you know, narcotics in a home health situation, you are involved in that when it's a safe situation. You don't take people off the service it's not safe so it's never been an issue.

**4) April 25, 2003 Transcript - P 102, line 2 through p. 102 line 17**

Q: If you worked for a facility that had no separate **wasting forms** or procedure in place, what would be the nursing practice that you think meets minimum standard of care in handling a wasting situation?

A: Well I would have a competent witness.

Mr. Arron Jepson: Excuse me. I'm sorry. I have to object. The question phrased says Minimum standard of care. There is only one standard of care. Is there a minimum and maximum? And if there is then the question assumes facts not in evidence.

Administrative Law Judge: Tell the witness to not relate her answer on the basis of any minimum; just as to the standard of care.

Q: (My Ms. Luke) Just as to the standard of care.

A: I would write down the medication that I was wasting and the amount. I would have the person who was witnessing me make sure that they understood the magnitude of what we were doing. I would write it down and record it, because I care for my license.

Tab 6



## ADDENDUM

## EXHIBIT 6

### Lay Witnesses - Foundation Elements

*Evidentiary Foundations*, 3 ed., Imwinkelried, Edward J., The Michie Co. Law Publishers, Charlottesville, Virginia, 1995, pp. 241-246;

**Collective Fact or Shorthand Rendition Witness** 1) The Witness was in a position to observe; 2) the witness in fact observed; 3) the witness observed enough data to form a reliable opinion; and 4) the witness states the opinion. "... the opinion is the type of inference that lay persons commonly and reliably draw; and — the key to the doctrine — the lay witness cannot verbalize all the underlying sensory data supporting the opinion." Ibid, p 242 "The Judge will assume that the witness has enough common, human experience to be able to estimate distance, time, or height." Ibid p 243;

**Skilled Lay Observer Witness** 1) The witness is familiar with the person or his or her voice or handwriting style; 2) The witness explains how he or she became familiar; and 3) The witness states his or her opinion. "In each of these situations, if the witness has had repeated, prior opportunities for observation, the witness qualifies as a skilled lay observer." Ibid p 243

Tab 7

**Summary of Prosecution's Case-in-Chief**  
April 25, 2003 Transcript (AT) — Events of April, 2002

**KAREN BECKSTROM - Mortensen's Daughter, - begins at p. 16**

Described Mother's condition and living arrangements . . . . . pp 16-22

**Apr 11** Described Jepson's April 11 visit to home and his call to Dr. Hogensen pp 23-26

Described medications Mortensen was on . . . . . p 23-p 25

Described Dr Hogensen prescribed Patches and 30mg liquid morphine . . . . . p 26

Described Jepson and husband, Garth, went together to get prescriptions and to Shopco pharmacy and returned home with only patches . . . . . p 26

Described her concern that Dr. Hogensen didn't work on Fri or Mon and "it would be a length of time without any increase in the medication for pain" . . . . . p 27

Described where she lives . . . . . p 27

Described husband's and Jepson's conversation on way back from pharmacy and and Jepson's unsuccessful attempts to find unit dose vials of morphine p 27 - p 28

*Described Jepson left to get new prescription for morphine . . . . . p 28*

Claimed she did not hear back from Jepson that evening (Apr 11; contradicted by Jepson's testimony; Husband couldn't remember ) . . . . . p 28 - p 29

Claimed Jepson did not explain patches to her (contradicted by Husband) . . . P 29

Jepson talked about Morphine with them . . . . . p 29

Claimed she was not going to administer the morphine herself . . . . . p 29

No one ever administered the Duragesic Patches . . . . . p 29

She administered 4 Lortab to Mortensen on April 11 . . . . . p 29 --p 30

Jepson did not administer Duragesic Patches on April 11 . . . . . p 30

Jepson did not come into house on way back from Pharmacy . . . . . p 30

She got no direct instruction on where to place patches (Jepson & Husband contradict) . . . . . P 30

**Apr 12** Described Mother (Mortensen) as "much better" next day - on 12<sup>th</sup> . . . . . P 31

Said Garth called Scott and left message "if prescription for Morphine was not filled, please do not do so . . . . . p 31

"The more she got thinking about it she thought she didn't know for sure if her mother really did need the morphine" . . . . . P 31

"We didn't feel we really wanted it" . . . . . P 31

"My mother probably did not need it" . . . . . P 31

Jepson came, said he did not have morphine, . . . . . p 31

Then she said she didn't know if she actually asked about the morphine . . . p 32

She said there were different days they discussed the morphine after

the 12 <sup>th</sup>	p 32
Jepson did not take vitals because Mother was sitting at table	p 33
The 12 <sup>th</sup> was a Friday	p 32
Jepson said he though Mortensen's recovery was remarkable	p 32
Claims Garth asked Jepson on 12 <sup>th</sup> about cost of Morphine and paid him (this was contradicted by Garth)	P 33
<b>Apr 13</b> Claims they asked Jepson about morphine - he said it would be an illegal distribution of drugs to give it to them and he had destroyed it	p 34 - 35
Karen said she wondered why ... <b>"But then I thought well, I was the one too that said I didn't want the morphine"</b>	P 35
Said she reported concern 1 week later	p 35
<b>Apr 24</b> Another substitute nurse came, she had reported to nursing director at First Choice	p 37
 <b>Apr 25, 2003 - One year later —</b>	
Said they were still caring for Mother, Mortensen. (Note: no subsequent need for liquid Morphine arose in over 1 year!)	P 37

#### X-Examination:

Nothing negative to report about Jepson	p 39
Next substitute nurse was Andrea Swenson an LPN	p 40
Dr. Hogensen wanted to make sure Mortensen had adequate pain medication because he wouldn't be back in office for several days	p 40
Reviewed conversation about morphine - she claimed again that Jepson claimed it would be illegal distribution of drugs to give her the morphine	p 43 - 44
Neither LPN Swenson nor Director of Nursing Mark Francis told Karen about the Standard of Practice set out in Rule R-156-37-502(4)	P 48 — 49
Said she was aware of several calls to different pharmacies by Jepson because her husband told her.	P 49
Said she did not know what original prescription was - never saw it	p 49
Said she knew original prescription got changed	p 49
Said she knew change was because quantity was not available	p 49 - 50

#### Re-direct Examination

Said Jepson left her in control of Lortabs already in her possession	p 50
--	------

#### Re-Cross Examination:

Said she took responsibility of administering the Lortabs ..... p 50  
 Said she felt nurse would have responsibility for administering liquid  
 Morphine ..... p 51  
 Said she had responsibility for other medications ..... p 51

Board Questions:

Said Duragesic Patches were never used ..... p 51-52  
 Asked if Morphine was ever used (no answer recorded) ..... p 52

**SHANE TIERNAN - INVESTIGATOR**

Testimony begins p 53

Gave general background information about himself, work history, etc. . P 53-55  
 Interviewed Jepson April 30, 2002 ..... p 55  
 Described receiving complaint from Mark Francis at First Choice ..... p 55  
 Said Jepson never took the morphine to Mortensen's family house ..... p 56  
 Described prescription filling problems ..... p 55 - 56  
 Said one of the reasons Jepson did not bring Morphine was he was suspicious that family was trying to get him to play a part in a murder or assisted suicide plot (Jepson contests this as a misrepresentation of their conversation) .... P 57 - 58  
 Said Jepson got prescription filled late and he **called Beckstroms evening of April 11** and told them he was not coming by and took it home and put it in his refrigerator ..... P 58  
**Apr 12** Said Jepson returned to Beckstroms house on April 12 ..... p 58  
 Said Jepson said Mortensen was up eating breakfast; Karen Beckstroms made comments to him about it being God's will, etc. and some discussion about the morphine ..... p 59  
 Said Jepson said he told Beckstroms he had a moral and legal obligation to keep the morphine ..... p 59  
 Tiernan said he "believed" Jepson was paid for the morphine on the 12<sup>th</sup> (this was disputed by both Jepson and Garth Beckstrom) . .... P 59  
 Tiernan read from his report notes: Jepson informed family on Sunday or Monday (April 14 or 15) he disposed of morphine because Mortensen no longer needed it. Karen Beckstrom told Jepson that he could pay for the morphine next time Mortensen needed it. Jepson was upset over the payment situation ..... p 60  
 Tiernan gave his own interpretation - that Beckstroms were upset because they had to pay for something they couldn't see ..... p 61  
**Judge said:** Don't think "we" are asking - included himself as a prosecutor . p 61  
 Said Jepson kept the morphine because he felt the family was trying to kill

Mortensen - and he did not want the liability - felt it was his ethical obligation to keep morphine . . . . . p 62 - 63  
Claimed Jepson made decision to dump morphine down sink and did not have anybody witness that . . . . . p 63 - 64

X-Examination by Arron Jepson:

Tiernan was asked if most companies provide a narcotics waste sheet? . . P 64-65  
He answered "They can" . . . . . P 65  
He was asked if that was normal practice and he replied it depends on the kind of setting . . . . . p 65  
He was asked if he was aware of the standards that require a witness documentation to a wasting - he said "I am" . . . . . P 65  
Said that where Jepson picked up the prescription for someone else "**that changes the standard**" . . . . . P 65  
Question: "So you are saying in this particular situation with Mr. Jepson there is no requirement for a narcotic waste sheet and a signature by a witness?" He answered, "In somebody's private home, no." . . . . . P 65  
Discussion about what Jepson meant by "no witness" and whether he could have meant he had "no witness signature" on a waste sheet - i.e. no witness. Tiernan finally agreed Jepson could have meant that.- "sure" . . . . . P 65 - 68, line 13

X-Examination by Scott Jepson:

Scott and Tiernan discussed and argued about some of the things from their April 30, 2002 interview that Scott claimed were missing from Tiernan's report -  
Tiernan claimed that a nurse could only be in possession of a narcotic long enough to pick it up and transport it to the patient . . . . . p 68 - 69  
Tiernan was questioned about Scott's assertion that a nurse who has responsibility for administering a narcotic also has responsibility to keep the narcotic safe from theft and diversion Tiernan answered that as he understood Scott's position it was that Scott had to maintain possession . . . . . p 69-71  
Then Tiernan changed his testimony to be, "the problem I had was the time that you maintained possession." . . . . . P 72  
Scott questioned Tiernan about waste sheet requirement and Tiernan answered and said he did not know where in the law there was anything about waste sheets 73-74  
Jepson asked, "You previously said that it wasn't required to have a witness waste in a home health setting." Tiernan answered, "Because it's somebody's prescription." . . . . . P 74  
Discussion about payment of \$26.00 for the morphine and where it was in Tiernan's report . . . . . P 74-75

#### Re-Direct Examination - Ms. Lima

Asked about what Jepson said in initial interview about wasting morphine . . . p 75  
Tiernan said Jepson said he didn't want family to have it, he didn't think they should have it. Said he **didn't have anybody witness the waste** and that it was his legal, moral and ethical obligation and responsibility to get rid of it . . . . P 75  
Discussion with Judge re testimony of lay witness about a legal conclusion p 76-77  
Asked about a Family's responsibility about possession of a controlled substance and the wasting of a drug Ans: no obligation to maintain a record . . . . . P 77  
Asked if that same obligation or lack of obligation apply to a licensed health care professional? Ans: "I don't know that it's required in the law. . . . . P 77  
Tiernan gave his personal opinion that there is a responsibility to account - to have someone elwse say yes I say morphine go down the sink and to write it down p 78

#### Re-X-Examination - Arron Jepson:

Questioned about his contradictory testimony. He answered that the nurse would "want that to be witnessed because - for him to maintain that possession." p 78 - 79  
Testified he had no knowledge of the " what the Procedures and policies and forms availability are from First Choice" . . . . . P 79

#### Re-X-Examination - Scott Jepson

Discussed initial interview again on point of who could witness a wasting and that Tiernan said he recalled telling Jepson that "security guards" can witness a narcotics wasting and it doesn't have to be another licensed professional . . . p 80

#### Board Examination

Ms. Price - asked about the initial interview and reason Jepson said he wasted the morphine - Tiernan said Jepson reported in the initial interview that he felt they were giving her too much pain medication but that he didn't know if Jepson felt that way at the time that he got - obtained the prescription . . . . . P 81

Questioned about location in Tiernan's report - Scott and Arron Jepson . . . . . p 82-83

#### Board Examination continued

Ms. Bittner asked who Mark Francis was - Tiernan answered "Supervisor" P 84  
Also asked who Jeff Fisher was - Ans: Pharmacist . . . . . p 84

#### Continued Re-X-Examination - Arron Jepson

Arron Jepson asked Tiernan to read from his report - the reading disclosed that Jepson had actually said he thought perhaps the daughter had given Mortensen too much pain medication - the report did not say anything about a murder/suicide comment by Jepson which is contrary to Tiernan's prior testimony . . . . P 84-85

Scott Jepson refreshed Tiernan's memory about a hypothetical he had posed to Tiernan during the initial interview on Apr 30, 2002 about the handling of 300mg/20ml solution of liquid morphine and the possibility that the family might have succumbed to administering the liquid morphine at 2:00 o'clock a.m. because of severe pain and accidentally killed Mortensen. Would he then be charged with negligent homicide and that Tiernan had told him, "that's the way it goes when you have a license." Tiernan denied any memory of his reply to Jepson . . p 84-87

Arron Jepson restated the hypothetical. Prosecution objected. Judge ruled witness could only answer if he understood the question. Witness said he did understand the question. Witness Tiernan gave three answers: 1) "I couldn't tell you; 2) I don't think that the nurse - it was the doctor that prescribed the morphine... and 3) "I don't know that the nurse would bear the responsibility." . . . . . P 87 - 89

**ELIZABETH BAKER - RN**

Testimony begins p 90

**Background** included LPN 1971, RN 1994, Salt Lake Community College; 12 year in home health '85-'93 and '94-'98; medicine and oncology Hospital; Telephone triage; Bureau of Licensing State of Utah . . . . . p 90-92  
**Background** - services provided as home health nurse? - set-up plan, assess; referrals; set up home health aid; short term; always thinking discharge planning; a lot of teaching to care giver and patient . . . . . P 92-93  
**Reviewed** 14 documents for trial . . . . . p 93  
Does not know Scott Jepson . . . . . p 93  
**Prepared a report** to DOPL dated Feb 3, 2003 . . . . . p 94  
**Concerns about a patient? "What should you do?"** . . . . . P 94-95  
Sustained objection to a repeat of question . . . . . p 96  
"Is it important to document a concern?" Ans: "Oh, absolutely." Then described old system of boxes etc. . . . . P 95  
Asked about nurses **duty to educate** patient or caregiver . . . . . p 96  
Sustained Objection to compound question . . . . . P 97  
"Does a home health nurse have a duty to educate the patient and/or her caregivers, and, if so , how?" Answers included:



“if I were going to be doing some teaching . . . . . p 98 lines 1-2  
I would recommend ...” . . . . . P 98 line 2  
“I think it’s important...” . . . . . P 98, line 4  
Asked who is responsible for security and administration of a controlled  
substances? Baker answered :  
“I would say whoever the controlled substance is issued to. It’s their  
medication.” . . . . . P 98, lines 10-13  
Who is responsible for security of medication maintained in a home - Ans:  
Family . . . . . p. 98, lines 14-18

**Up to this point Nurse Baker had not been offered by the prosecution as an expert witness, nor had the required foundation be laid for expert testimony concerning the control, handling, and administration of liquid morphine - the central issue in this case, nor had the Court ruled or accepted Baker as an expert witness?**

Asked whether a home health nurse determines if and when a medication can either be physically “delivered” to the patient or caregivers or maintained by them? . . . . . P 98, lines 19-23

**1<sup>st</sup> Objection** - “I am going to object. I think that’s a Legal question. Depends upon what the statute says and the rules say. It’s not subject to an opinion on that point” . . . . . P 98 line 24 thru P 99 line 2

**Judge** replied: “I think the question was put to the witness in the capacity as an Expert Witness and I think she can answer to the extent she understands the question.” . . . . . P 99, lines 3-6

**2<sup>nd</sup> Objection** - “Then I object because she has not been qualified in that area” . . . . . P 99, lines 7-8

**Judge** replied “I think she was being offered as one, is she not, Miss Lima?” . . . . . P 99, lines 9-10

**Lima** says: “She is” . . . . . P 99, line 11

**3<sup>rd</sup> Objection** - “I beg your pardon, Judge. She was offered”[?] - “**she was not offered**, but I guess she is now” [being offered] “as a qualified expert on home health nurs[ing].” [editing added to clarify Atty Jepson’s shock and surprise and reply to Judge’s action of offering the witness himself as an expert]

**Judge** replied, “I think that’s what she is here to testify - . . . . . p 99, lines 15-16

**Further Objection** - “Yeah. The question here is where the legal duty lies as to who makes what determination and I think we can - “ P 99, lines 17-19

**Judge** replies: “The question was put in the context of a home health nurse and the question, as I recall it, was does the home health care nurse have the authority to decide when or how to administer controlled substances.” . . . . .

**4<sup>th</sup> Objection** - “Exactly. And the word authority means nurses are controlled by statute and regulations and so the proper question should be, if it’s asked, what is the statute or where is the regulation and what does it say, not do you have an opinion about what the law is, so **I maintain my objection.** . . . . . P 99, line 25 thru P 100, line 5

**Judge** replied: I think the witness can answer the question and the source and the basis for her answer can then be explored and then I’ll allow it. . . P 100, lines 6-8

**Witness:** If I understand the question correctly, are you asking me if a pharmacist prescribes - or if a physician prescribes a medication for a patient is there any reason why I don’t think that patient should have that medication? P 100, lines 9-13

**Ms. Lima:** Yes. . . . . P 100, line 14

**5<sup>th</sup> Objection** - “**Objection.** That is not what the question was. The question was a determination of authority to act, not what her opinion is.” . . . . . P 100, lines 15-17

Note: The Judge did not rule he accepted Baker as an expert witness or that she was an expert, just that he would allow her to testify and the basis of her testimony could be explored. Jepson never accepted her as an expert but rather continued to object that she was not a qualified expert. A **6<sup>th</sup> Objection** about Baker’s lack of qualifications came at the end of Baker’s testimony on page 136, lines 3-5, concerning which objection - the Judge simply ignored it.

Ms. Lima: rephrased her question re standard of care to be “does a nurse have any say as to whether or not the family can retain the drug?” . . . . . P 100

Ans: “Well the nurse — the person probably wouldn’t be accepted for home health unless it was a safe situation” ... her answers included: . . . . . p 100-101

“**If I felt like it was a safe situation...**” . . . . . p 101, line 3

“**My job would be ...**” . . . . . P 101, line 6

“**If I was concerned and felt like...**” . . . . . P 101, line 7

“**I would involve ...**” . . . . . P 101, line 8

“**...who I was working ...**” . . . . . P 101, line 9

Miss Lima: “Who decides if a controlled substance should be wasted in a home health care setting?” . . . . . P 101, lines 12-13

Ans: “**I think it would be up to the nurse and the family.**” . . . . . P 101, line 14

Asked about standard of care in wasting a controlled substance. Reply was that

“**You would like to have somebody watch you ...**” . . . . . P 101, line 18

Discussed process of wasting - answer included “**I would have ...**” . . P 101 line 7

Discussed making a wasting record - answer included, “**I think as a nurse I would want to record that just to cover myself...**” . . . . . P 102, lines 20-21

Asked where such a record typically be kept? Ans: “**Probably in the patient’s**

record and perhaps in a log...” P 103, lines 1-2  
 Discussed whether there was a written “concern” in Mortensen’s record which was answered in the negative. P 104  
 Discussed which nursing notes Baker had reviewed P 104-105  
**Objection on two grounds** - as to the question about charting and the whole line of charting questioning because there is no allegation in the petition about failure to properly chart and **further objection** to expanding the pleaded issues. P 105 at line 5 thru P 106, line 22  
**Judge Ruled: “THERE ISN’T ANY CLAIM THAT I SEE IN THIS PETITION ABOUT FAILURE TO DOCUMENT IN THE CHARTS AND THAT’S NOT AN ISSUE BEFORE THE BOARD.”** P 106, lines 19-21  
 Ms. Lima again asked if any recording or mention of any concern by Jepson concerning safety or well being -- answered in the negative p 107  
 Ms. Lima asked if Baker had ever taken a controlled substance to her home - answered in the negative P 107  
 Ms. Lima asked if any recording in the notes of wasting P 108  
 Ms. Lima asked if any documentation of morphine prescription - answered in the negative P 108  
 Ms. Lima asked if any recording in the documents of Duragesic patches - answered in the negative P 108  
 Discussion with counsel and Judge about Baker’s report P 108-109  
 Ms. Lima asked again if it is important to document medication P 108

#### X-Examination - Scott Jepson

Charting discussed P 110 - 111  
 Detailed discussion of Oasis Recertification Medication sheet and Jepson’s charting of the Morphine in section 485 of it P 111-114  
 Detailed discussion about case conferences and reporting concerns to case managers P 114-117, line 4  
 Baker asked about her opinion that all prescribed medication need to be left in the home. She answered, **“If the medication is ordered for a patient, it should be in their home.”** P 117, lines 6 -11  
 Jepson read Controlled Substances Act Rule R156-37-502(4) to Baker and asked if a controlled substance were left in the patient’s home, whether he as a nurse could possibly have control over it. She answered: **“You wouldn’t leave it there if it wasn’t a safe situation.”** P 117 line 12 thru P 118 line 7

Jepson then asked again whether he could have control over a medication left in a patient's home and Baker answered, "Yes." . . . . . P 118, lines 8-11

**Background:** Clinical experience was back in 1993 - ans: "That's Correct" p 118

Asked about where she worked and what type of patients she worked with and she replied "Medicine and oncology." . . . . . P 118, lines 17-24

Q: Okay. So you have had some **experience administering morphine**?

A: At the time I was an L.P.N., so **very little**.

Q: **Rarely**?

A: And **usually it was I.M.**

Q: Did you **ever administer I.V. morphine**?

A: **No**.

Q: Okay. And then **since then**, you have not had **positions** or — you haven't had any kind of position where you would have **exposure to being required to administer I.V. morphine**, correct?

A: **Nope**.

Q: So your testimony is that you have **no experience in administration or control of I.V. morphine**?

A: **No**.

Q: Thank you.

Mr. Arron Jepson: **No, means no experience**?

The Witness: **Right** . . . . . P 118, line 25 thru P 119, line 17

## X-Examination - Arron Jepson

Questioned Baker about Oasis Medication sheet - she admitted she did not have the current medication sheet from the Oasis Recertification, that she couldn't have reviewed it, and said, "**I don't know**" when asked , "So you don't know whether the medication was actually charted by Scott Jepson on that sheet

or not, do you? . . . . . p 120, line 2 thru P 121, line 2

Questioned about statutory language in the reporting statute containing the wording "reason to believe." and dictionary definition of the

word "reason" . . . . . P 121, line 3 thru P 122, line 20

Questioned about Baker's reference to "suspected" and dictionary definition of the word "suspicion" . . . . . P 122, line 21 thru P 125, line 6

Questioned re duty to educate and hospital setting which Baker said was "a different setting. . . . . P 125, line 7 thru P 127, line 10

Questioned Baker about her reference to safety - "it's never been an issue" and leaving a 300mg, 20ml flask of morphine in the house. She answered, "If it wasn't

a safe situation **I wouldn't be in there** taking care of the patient." . . . . . P 127, line 13 thru P 128, line 7

Continued X-Examination - Scott Jepson

Questioned Baker about unit dose vials and Baker answered:

"I can't answer." . . . . . P 128-129

Questioned Baker again about his (Jepson's) ability to maintain control of the morphine if he left it in the patient's home and hypothetically a relative of the patient brings her **boyfriend** in the home, with a drug addiction, and he **stole the morphine** -

**"Would I have any personal ability to prevent that?"**

**Ans: No** . . . . . p 129 - 130, line 5

Re-Direct Examination - Cheryl Luke

Prosecution redirect examination was thoroughly confusing, repetitive, and asked one speculative question after another calling for speculative answers: For example: shelf live of morphine, whether a prescription should match the needs of a patient, what would have happened if Scott Jepson had been in a car accident; are Duragesic patches and Lortabs addictive medications, whether Jepson has been involved in Baker's past nursing experiences with liquid morphine; could the morphine have been given directly to the family without Jepson's involvement; is pain management an issue in home health; do doctor's order combinations of drugs; why can Duragesic patches and morphine be given together; could some other form of liquid morphine have been used; does not putting her on the Duragesic patch and not giving her the morphine address the problem of not being able to swallow tablets; can a combination of Duragesic patch and morphine be fatal; . . . . . P 130, line 10 thru P 136 line 2

**6<sup>th</sup> Objection -- to Baker's unqualified testimony — "Objection. She has already clearly stated that she doesn't have the background in administering narcotics to have any expert testimony." P 136, lines 3-4**

**Judge:** ignored objection

Luke continued: Asked Baker if she has used Fentanyl patches. Ans: **"I have used the patch."** . . . . . P 136, line 8  
... can Lortab or Fentanyl patches be fatal if overdosed; if a facility had no wasting

form what would be the **nursing practice that you think** meet minimum standards. . . . . P 136, lines 15-19  
Ans: **"I would have a competent witness."** . . . . . P 136, line 19

**Objection** - there is no minimum - only one standard . . . . . P 136, lines 20-24  
**Judge** - tell witness - not to answer on basis of a minimum - just as to the standard of care. . . . . P 136, Line 25 thru P 137, line 2  
**Luke** continued: where would be appropriate place to make an entry; time period in which a note should be made - Baker answered -  
**"I would do it right there"** . . . . . P 137

Re-X-Examination - Scott Jepson

Would you do it right there if there were no witness? Ans: **"I wouldn't want to do it without a witness."** . . . . . P 138  
Can you sign a document - waste sheet - that doesn't exist? Ans: **I don't believe so."** . . . . . P 138

Questions by Board:

**Miss Forster-Burke:** See any specific policies or manual for First Choice? Ans: No, I haven't seen the policy and procedure manual. . . . . P 139  
If nurse has "concerns" might he call anyone besides social worker? Ans: Maybe the Director of Nursing. . . . . P 139-140  
Documentation of concerns is done where? Ans: communication log. . . . . P 140  
A time that would be obeyed as far as standard of care to do charting? . . . . . P 140

**PROSECUTION RESTED -**

Tab 8

## **ADDENDUM**

## **EXHIBIT 8**

### **Prosecution's Burden of Proof**

**Charging Language & Required Elements of Statutes under Counts I & III**

### **DOPL PETITION - COUNT I**

"Respondent possessed controlled substances outside of his responsibilities as a nurse."

#### **58-37-8(2)(a)(i), UCA    Prohibited Acts - Penalties**

(2) It is unlawful:

for any person

knowingly and intentionally

to possess or use

a controlled substance,

#### **UNLESS**

it was obtained

under a valid prescription or order,

directly from a practitioner

while acting in the course of his professional practice

or as otherwise authorized by this chapter;

#### **58-31b-502 (5), UCA    Unprofessional Conduct**

Unprofessional conduct includes

(5) unlawfully

obtaining, possessing, or using

a prescription drug or illicit drug;

#### **58-1-501(2)(a), UCA    Unlawful & Unprofessional Conduct**

(2) Unprofessional conduct means

conduct by a licensee

that is defined as unprofessional conduct

under this title or under any rule adopted under this title

and includes:

(a) violating, or

~~aiding, or abetting any other person~~

~~to violate~~

any statute, rule, or order



### DOPL PETITION - COUNT III

“Respondent failed to produce a medication he purchased for a patient.  
Therefore, Respondent engaged in unprofessional conduct as defined in:”

#### **58-31b-502(7), UCA    Unprofessional Conduct**

Unprofessional conduct includes

(7) unauthorized

~~taking or personal use of~~

**a patient’s personal property;**

Tab 9

ADDENDUM  
Two Jury Instructions given to Board/Jury

**EXHIBIT 9**

Instruction No. \_\_\_\_\_

Ownership of a Narcotic

A Schedule II Narcotic, prescribed for a patient, becomes the personal property of the patient at that point in time when the narcotic is delivered into the physical possession of the patient.

Argument for the adoption and giving of this Instruction

Public policy and present wide spread practice in the medical field, among Doctors and Nurses, the Joint Commission on Accreditation of Healthcare Organizations (hereafter JCAHO), Drug Enforcement Agency (hereafter DEA) rules and regulations, referred to by JCAHO and Utah laws and rules, and the State of Utah Controlled Substances Act and Rules are uniform in the requirements of licensed doctors and nurses maintaining strict controls over Schedule II controlled substances such that said unused or partially used narcotics be wasted, not given to the patient. That this is a correct statement of the law or what the law should be, is proven by the daily customary administration, handling, and disposition of Schedule II narcotics, including Morphine, in hospital and other nursing care situations statewide, where, for example, as here, an unused vile of morphine, prescribed for a patient, is taken by the nurse and wasted, although the

patient has paid for or has been or will be charged for and will pay for the said narcotic. This Court is asked to take judicial notice of this fact. If the law were contrary to this, DOPL would be flooded with complaints from every patient for the unlawful taking of his/her narcotic whose unused medication is wasted.

Furthermore, if the law were contrary to the above, meaning that a narcotic would become the personal property of a patient upon being billed for or upon the patient, or patient's family, paying for the narcotic, then every single wasting by any nurse of any schedule II narcotic which has been prescribed but unused or partially used, would be an unlawful taking of a patient's personal property and a violation of §58-31b-502(7) UCA. That would be an untenable and impractical situation, which runs diametrically opposed to every day practice, and to the DEA and Utah State Controlled Substances Act and Rules requirements, as I am coming to understand them.

For example, an unused portion of Morphine is not given to a patient leaving the hospital to take home in the event he thinks or feels he might need it at some future point in time, whether an hour, day, week or month. Delivery of the narcotic into the physical possession of the patient is the clear demarcation line between owning the narcotic and not owning it. This goes along with the common saying that possession is nine tenths of the law. In most, if not all cases, certainly in this case, it is the correct statement of the law. I could find no model instruction on this point but respectfully urge the adoption of this instruction in this case. This instruction is consistent with both Federal and State law requirements and the current widespread Medical, Hospital, Home Health Care, Doctor, and Nurse custom and practice.

Instruction No. \_\_\_\_\_

## Impossibility

That which in the constitution and course of nature or the law, no man can do or perform. . .

Impossibility is of the following several sorts:

An act is physically impossible when it is contrary to the course of nature. Such an impossibility may be either absolute, i.e. impossible in any case, (e.g., to stop earth rotation) or relative, (sometimes called “impossibility in fact,”) i.e. arising from the circumstances of the case (e.g., for A. to make a payment to B., he being a deceased person.)

Black’s Law Dictionary, Revised Fourth Edition, p. 889

Tab 10

**ADDENDUM**  
**Ex Post Facto**

**EXHIBIT 10**

The classic definition by the U.S. Supreme court of Ex Post Facto is found in the case of *Calder v. Bull*, 3 U.S. 386, 3 Dall 386, 386, 1 L. Ed. 648 (1798) . A later modification was made which defined an ex post facto law as one which in its operation, *makes that criminal which was not so at the time the action was performed, or which increases the punishment, or, in short, which, in relation to the offense or its consequences, alters the situation of a party to his detriment or disadvantage.* *Dobbert v. Florida*, 432 U.S. 282, 97 S. Ct. 2290, 53 L. Ed. 2<sup>nd</sup> 344 (1977) and following cases. See generally 16B Am Jur 2<sup>nd</sup> §646- 670 and §671 on Bills of Attainder. See also 16A C.J.S. §409. *One of the purposes of the constitutional prohibition against enactment of ex post facto laws is to ensure that the accused individual receives fair notice of the crime and its punishment* (16A C.J.S. §409).

*“...the notion that persons have a right to fair warning of that conduct which will give rise to criminal penalties - is fundamental to our concept of constitutional liberty and as such, is protected against judicial action by the Due Process Clause of the Fifth Amendment.”* (16B Am Jur 2d § 647, page 130.)

*Every ex post facto law must necessarily be retrospective...* (ib, §645, p 126)

Tab 11



## ADDENDUM

## EXHIBIT 11

### Admission by DOPL's Attorney - Karl Perry Nurse Baker gave Personal Opinion Testimony

*...Ms. Baker could testify as to how she would act or handle different situations as posed to her, (Standard of Care). That is how questions were posed to her by the division and is how she answered many of the hypothetical and factual questions.*

(see DOPL's Memorandum Opposing Request for Agency Review, dated February 13, 2004, p. 17, paragraph 2, lines 11-14; see Record on Appeal p. 89)

Tab 12

## **ADDENDUM**

## **EXHIBIT 12**

37 References - “**Lethal**” dose or volume of Morphine

**April Transcript** — 10 references

151:2, 12, 20; 152:25; 158:14; 176:22; 195:5, 10,12; 245:4

**May Transcript** — 24 references

15:2, 5; 33:13; 38:17; 39:11; 40:8; 41:1, 4; 45:3, 5; 80:7; 90:3; 105:20;  
106:12; 110:4; 120:16; 126:22; 128:16, 17; 175:4, 12, 16; 178:20; 182:8

**DOPL Findings, Conclusions, and Order (Record p. 182)** - 3 references

“Excessive dosage and concentration of the morphine” - 5:1-2; 7:17-18

“Lethal” 12:9-11

Tab 13

**ADDENDUM**  
Definitions & Synonyms

**EXHIBIT 13**

**PRODUCE**

The word “**produce**” is defined as: *to bring forth; to present for inspection; cause to appear; write; to bear, yield; to give birth to*; and so forth (see The New Lexicon Webster’s Encyclopedic Dictionary of the English Language, Lexicon Publications, Inc. New York, 1990, p. 798). The synonyms for the word **produce** are: **create, engender, father, generate, hatch, make, originate, parent, procreate, sire, and spawn** (see Roget’s II the New Thesaurus, Houghton Mifflin company, Boston, Mass., 1980, p 722).

As clearly seen, neither the definition nor any synonym for the word **produce** means “**deliver**,” certainly not “deliver into the possession of another.” The word **produce** is not a legal term of art. It is an ordinary English word, the definition and meaning of which can be gleaned from an English dictionary and from its synonyms, which can be found in a common Thesaurus.

**AVAILABLE**

“**Available**” means *capable of being obtained, obtainable*. Its synonyms are: **attainable, disponible, gettable, procurable**. (see Roget’s II the New Thesaurus, Houghton Mifflin Company, Boston, Mass., 1980, p 722; see also *The New Lexicon Webster’s Encyclopedic Dictionary of the English Language*, Lexicon Publications, Inc. New York, 1990, p. 798).

**TOOK & TAKE**

**Took** is past tense of **Take**. **Take** means *to get possession of by using force or superior strength; to steal or remove without right*; *The New Lexicon Webster’s Encyclopedic Dictionary of the English Language*, Lexicon Publications, New York, 1990;

A “**taking**” occurs when a person with a preconceived design to appropriate property to his own use obtains possession of it by means of fraud or trickery. *People v Edwards*, 72 Cal. App. 102, 236 P. 944, 948, *Blacks Law Dictionary*, revised 4<sup>th</sup> edition, 1968, p 1625.

Tab 14

## ADDENDUM

## EXHIBIT 14

### Findings and Conclusions Regarding Jepson's Intent

#### DOPL

**“...Respondent acted with good intentions. . . there is no evidence of any potential or actual injury . . . Respondent generally provided good nursing care . . . an isolated incident. . . it is not likely Respondent would repeat that conduct. . . Respondent has not been previously subject to any disciplinary licensure action. . . rather unique facts of this case. (See DOPL ORDER pp. 12-13; Record p. 192-193) [emphasis added]**

#### DEPARTMENT OF COMMERCE ON REVIEW

The Beckstroms testified that Petitioner [Jepson] was a good nurse and that he took appropriate care of Ms. Mortensen; the only concern they had was that the morphine was not available for Ms. Mortensen if she later needed it. The Division found that Petitioner had no intention to injure Ms. Mortensen, and she was not in fact injured; she did not need the morphine that he kept and later destroyed. **At all times, his intentions were to comply with the law and the standard of care for home health nurses, not to violate them.** Furthermore, Petitioner has no record of any prior disciplinary actions during his many years as a licensed registered nurse. [emphasis added]

Tab 15



## ADDENDUM

## EXHIBIT 15

From Jepson Principle Brief to Dept. Of Commerce, pp 17-18

Record p.114-115

Jack Branin's Eye Witness Testimony -- Wasting of Morphine

Branin testified: (AT )

"I would figure I'm competent" (Supra, P. 213. Line 4). Branin testified he knew the wasting was concerning a morphine vial (supra, p. 207 lines 7-8); that it was a narcotic (p. 209, lines 21-23); that he was shown the label on the vial (p. 210, lines 10-11); that he physically handled the vial (p. 210, line 11); that he looked at and examined the vial (p. 210, lines 15-16); that the glass was amber in color (p. 210, lines 19-21); that he looked at it and handled it and handed it back to Jepson (p. 211, lines 4-6); that he saw Jepson flip off the metal top with his thumb (p. 211, lines 7-11); that he watched as Jepson used a hypodermic needle, put it into the bottle and squirted it down the sink and could see the liquid was gone (p. 211, lines 12-23); that he witnessed the wasting and was advised he would have to sign a form from Jepson's company (p 212, 7-14).

Further, concerning an interview by DOPL, Branin testified in answer to a question whether he didn't pay much attention to the label, that he remembered handling the vial and could not remember whether it has 20 or 15 [ml] because the quantity didn't matter to him, and that, because it was such a large vial of Morphine and was different than the ones that soldiers warmed in their mouths during the Korean War, he "took the vial," and "handled it," and "looked at it." Then he explained his comment about not paying too much attention as meaning,

*...inasmuch as I didn't read it as carefully as I would if I were taking a prescription myself, , but I felt confident that - that what he told me he was getting rid of is exactly what I was looking at because, you know, like I said, initially the whole idea of morphine to me was this small thing a medic could have in his mouth. (p 214, lines 1-25, and p. 215, lines 1-20);*

Then again on redirect Branin testified: that he did see the word morphine on the

vial label (p. 216, lines 22-25); that he took it and looked at it and had the vial [bottle] and that he looked at it, and looked at the numbers and that, *it was quite clear that it said morphine, yes.* (p. 217 lines 1-8).

I objected at trial to the prosecutor's attempt to mis-characterize Branin's testimony to be that he didn't read the label (see transcript p. 214, lines 11-19). Branin's testimony before and after that objection was consistent and unimpeached. His credibility was not challenged, nor was the fact disputed that he testified from personal eye-witness knowledge. There was only one failed attempt by the prosecutor to mis-characterize Branin's testimony. That failed attempt does not constitute "substantial evidence" necessary to support the Judge/Board's conclusion that witness Branin did not know what was in the vial. There was absolutely no basis for that conclusion. Mr. Branin's entire testimony demonstrates he knew what was in the vial. The Judge/Board's conclusion to the contrary is not based upon substantial or any evidence. It must be stricken and reversed consistent with the unimpeached, uncontested, undisputed, and overwhelming evidence that Branin knew what was in the vial, and was therefore a competent witness. His testimony also agrees with Jepson's testimony on the same issue.

That the Court should reverse the Judge/Board's conclusion that Branin was not a competent witness is further buttressed by several other things:

(1) both Counts II and IV, which allege there was no proper witness and no witness, respectively, were unconditionally dismissed after trial; (2) there was no Petition allegation raising an issue about competency of a witness,

and therefore that was not a justiciable issue at trial; (3) Branin was a witness, testified at trial, and whom the Judge/Board believed was present at the wasting; (4) neither Branin's nor Jepson's testimony on this issue was impeached, contested, disputed, nor rebutted in any way, (5) there was no Rule, Statute, or Order cited in the petition as having been violated by Jepson concerning the lack of or the lack of competency of a witness to a wasting, and thus it was not a justiciable issue at trial; and (6) there is no evidence to support it, making said conclusion by the Judge/Board not only unsupported by substantial evidence but totally contrary to the evidence.

Tab 16


**Joint Commission**

on Accreditation of Healthcare Organizations

[Home](#) | [Who Am I](#) | [Search](#) | [Sitemap](#) | [Contact Us](#) | [Careers](#) | [About](#)
[JCAHO](#) > [Accredited Organizations](#) > [Home Care](#) > [Standards](#) > [FAQs](#) > [Care, Treatment and Services](#) >

## Home Care

[Home Care Home Page](#)
[Ambulatory Care](#) | [Assisted Living](#) | [Behavioral Health Care](#) | [Critical Access Hospitals](#) | [Health Care Networks](#) | [Laboratory Services](#) | [Long Term Care](#) | [Office-Based Surgery](#)

### Standards

June 1, 2000

Where Can I Find the Standards?

Standards

Type 1 Recommendations

Facts about the Emergency Management Standards

Standards Review Project

Statement of Conditions

### Draft Standards

### Revisions

### FAQs

[FAQ Index](#)

### Clarifications

### Errata

[Standards Questions - Online Form](#)

### Survey Process

### ORYX

[FAQs about Home Care Accreditation](#)

### Sentinel Events

### Home Care Bulletin

### Organization Update Form

### Consumer Brochure

## Security of Other Medications and Supplies

The Joint Commission has recently revised its interpretation of medication security, from one of "strict" security of prescription medications to one of "reasonable" security, in an effort to get surveyors to address areas that have a higher impact on patient safety.

**Q:** Do all prescription and non-prescription drugs need to be secure?

(New Interpretation)

**A:** Yes. How secure depends on the classification of the medication as a "controlled substance" or not. Certainly all Schedule II controlled substances (narcotics) need to be secure under lock and key based on DEA laws and regulations (standard TX.3.4). Although most states no longer require a "double-lock" system, these products must be stored in a "substantially constructed locked cabinet". In addition, these drugs must be tightly controlled and accounted for, under law and regulation.

For other drugs and products, we expect that the products be "reasonably secure" to prevent diversion or tampering with the products. These products do not need to be locked. However, they should not be kept in areas that are readily accessible to public and easily removed by visitors. For example, prescription medications left in an unlocked drawer in a patient waiting area or patient examination room would not be considered secure. However, if regular prescription medications are kept in a private office, or other area where patients and visitors are not allowed without supervision or presence of a healthcare professional (e.g. ambulatory infusion) they are considered secure, even if not locked. All areas restricted to authorized personnel only are considered "secure" areas.

The security of prescription medications should be addressed in your organization's security management plan (standard EC.1.4). As part of this plan, theft, pilferage and tampering should be reported. If medication security becomes a problem, it

### EASY ACCESS

[Other Programs](#)

### LATEST FROM

4 > [Home Care E](#)  
 March/April 2  
 > [JCAHOnline](#)

### JCAHO SHORT

- > [Shared Vision](#)
- > [Patient Safety](#)
- > [Quality Check](#)
- > [Datamart™](#)
- > [Speak Up](#)
- > [Standards On Submission](#)
- > [Publicizing Your](#)
- > [Sign Up for News](#)
- > [Accreditation](#)
- > [Looking for a](#)
- > [Codman Award](#)
- > [Eisenberg Award](#)
- > [Infomart](#)
- > [Education](#)
- > [Publications](#)

Tab 17

LORRIE LIMA (USB 5872)  
Assistant Attorney General  
MARK L. SHURTLEFF (USB 4666)  
Attorney General  
Division of Commercial Enforcement  
160 East 300 South, Fifth Floor  
PO Box 140872  
Salt Lake City, UT 84114-0872  
Telephone: (801) 366-0521

---

BEFORE THE DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSING  
OF THE DEPARTMENT OF COMMERCE  
OF THE STATE OF UTAH

---

IN THE MATTER OF THE LICENSE OF	:	
W. SCOTT JEPSON, R.N.	:	P E T I T I O N
TO PRACTICE AS A REGISTERED NURSE	:	
IN THE STATE OF UTAH	:	Case No. DOPL-2002- 151

---

PRELIMINARY STATEMENT

These claims were investigated by the Utah Division of Occupational and Professional Licensing (Division) upon complaint that W. Scott Jepson, R.N.. (Respondent) has engaged in acts and practices which constitute violations of the Division of Occupational and Professional Licensing Act, UTAH CODE ANN. §§ 58-1-101 to 58-1-503 (1998), the Nurse Practice Act §§ 58-31b-101 to 58-31b-402 (1998), the Controlled Substances Act, UTAH CODE ANN. §§ 58-37-1 to 58-37-21 (1998) and the Utah Controlled Substances Act Rules, UTAH ADMIN. CODE R15-37-101 to R156-37-610 (2002).

## PARTIES

1. The Division is a division of the Utah Department of Commerce pursuant to UTAH CODE ANN. §§ 13-1-2(2)(a) and 58-1-103 (1998).

2. Respondent is licensed by the Division to practice as a registered nurse pursuant to the Nurse Practice Act. Respondent was licensed at all times material to the allegations contained herein.

## STATEMENT OF ALLEGATIONS

3. a. Respondent was employed as a home health nurse for 1<sup>st</sup> Choice Home Care in Provo, Utah.

b. Respondent was temporarily assigned to provide home nursing care to patient H.M. (name withheld for confidentiality), an elderly, disabled adult.

c. On or about April 11, 2002 Respondent was nursing H.M. Respondent determined that H.M. was unable to swallow her medications. Respondent suggested to H.M.'s family that it consider alternative pain management medications for H.M. The family agreed and Respondent telephoned H.M.'s physician. The physician issued two prescriptions: (1) Duragesic patches, which contains fentanyl, a Schedule II controlled substance, and (2) an injectable morphine sulfate, a Schedule II controlled substance. Respondent picked up the prescriptions at the physician's office and he took them to a pharmacy for filling. The pharmacy was unable to fill the prescription for morphine sulphate. Respondent retained the morphine sulphate prescription. Respondent told H.M.'s family that he would get the prescription filled and deliver the drug to H.M. later that same evening.



d. Respondent took the prescription for morphine sulphate to another pharmacy. However, the pharmacy was unable to package the morphine sulphate in the quantity the prescription required. Respondent traveled back to the prescribing physician's office and obtained a prescription by a physician for the morphine sulphate in the quantity available at the pharmacy. Respondent had the prescription filled at the pharmacy and paid for the medication and administration supplies from his own funds.

e. Respondent telephoned H.M.'s family and informed it that he would deliver the morphine sulphate the following day.

f. On or about April 12, 2002 Respondent informed H.M.'s family that he had destroyed the morphine sulphate and that he could not turn it over to them because it would be illegal distribution of a controlled substance.

g. On April 30, 2002 Respondent told a Division investigator that he took H.M.'s medication to his home and he stored it in the refrigerator. Respondent stated that he destroyed the medication without a witness. Respondent stated that he was concerned H.M.'s family was attempting to euthanize H.M. with the medication.

h. Respondent did not ask H.M.'s physician to withdraw the morphine sulfate prescription. Respondent did not report his suspicions regarding H.M. and her family to any physician, local law enforcement or state agency.

#### APPLICABLE LAW

4. The Division may discipline the license of any licensee as follows:

(a) the licensee or applicant has engaged in unprofessional conduct as defined by statute or rule under this title.

(b) the applicant or licensee has engaged in unlawful conduct as defined by statute or rule under this title.

UTAH CODE ANN. § 58-1-401(2)(a) and (b) (1998).

5. Unprofessional conduct is defined by statute to include:

(a) violating, or aiding or abetting any other person to violate any statute, rule, or order regulating an occupation or profession under this title;

(g) practicing or attempting to practice an occupation or profession regulated under this title through gross incompetence, gross negligence, or a pattern of incompetency or negligence;

UTAH CODE ANN. § 58-1-501 (2)(a) and (g) (1998).

6. Unprofessional conduct is further defined by statute as follows:

(5) unlawfully obtaining, possessing, or using any prescription drug or illicit drug;

(7) unauthorized taking or personal use of patient's personal property.

UTAH CODE ANN. § 58-31b-502(5) and (7) (1998).

7. Unprofessional conduct is defined by administrative rule as follows:

(4) failing to maintain controls over controlled substances which would be considered by a prudent practitioner to be effective against diversion, theft, or shortage of controlled substances;

UTAH ADMIN. CODE R156-37-502(4) (2002).

8. Unlawful conduct is defined by statute to as follows:

(i) for any person knowingly and intentionally to possess or use a controlled substance, unless it was obtained under a valid prescription or order, directly from a practitioner while acting in the course of his professional practice, or as otherwise authorized by this subsection.

UTAH CODE ANN. § 58-37-8(2)(a)(i) (1998).

9. A nurse has a statutory responsibility when providing nursing care to elderly or disabled patients as follows:

(1) Any person, including but not limited to, a social worker, physician, psychologist, nurse, teacher, or employee of a private or public facility serving adults, who has reason to believe that any disabled or elder adult has been the subject of abuse, emotional or psychological abuse, neglect, or exploitation shall immediately notify the nearest peace officer, law enforcement agency, or local office of Adult Protective Services within the Department of Human Services, Division of Aging and Adult Services.

UTAH CODE ANN. § 76-5-111.1(1)(2)(a)(i) (1998).

10. The Division has the authority to assess administrative fines as follows:

(1) After proceeding pursuant to Title 63, Chapter 46b, Administrative Procedures Act, and Title 58, Chapter 1, Division of Occupational and Professional Licensing Act, the division may impose administrative penalties of up to \$10,000 for unprofessional conduct or unlawful conduct under this chapter.

UTAH CODE ANN. § 58-31b-402(1) (1998).

#### COUNT I

11. Paragraphs 1 through 10 are incorporated by reference as if fully set forth.

12. Respondent possessed controlled substances outside of his responsibilities as a nurse.

Therefore, Respondent engaged in unlawful and unprofessional conduct as defined in UTAH CODE ANN. §§ 58-37-8(2)(a)(1), 58-31b-502(5) and 58-1-501(2)(a) establishing grounds to sanction his license pursuant to UTAH CODE ANN. § 58-1-401(2)(a) and (b) and to impose an administrative fine pursuant to UTAH CODE ANN. § 58-31b-402(1).

#### COUNT II

13. Paragraphs 1 through 10 are incorporated by reference as if fully set forth herein.

14. Respondent failed to administer medication to his patient as prescribed by a physician. Respondent maintained a patient's narcotics medication at his residence and he disposed of a controlled substance without a proper witness as is standard practice in nursing.

Respondent failed to report his suspicion that the patient may be a victim of abuse or potential abuse per his legal obligation in UTAH CODE ANN § 76-11-1(1). Therefore, Respondent engaged in unprofessional conduct as defined in UTAH CODE ANN §§ 58-1-502(2)(g) establishing grounds to sanction his license pursuant to UTAH CODE ANN § 58-1-401(2)(a) and to impose an administrative fine pursuant to UTAH CODE ANN § 58-31b-402(1).

### COUNT III

15 Paragraphs 1 through 10 are incorporated by reference as if fully set forth herein.

16 Respondent failed to produce a medication he purchased for a patient. Therefore, Respondent engaged in unprofessional conduct as defined in UTAH CODE ANN § 58-31b-502(7) establishing grounds to sanction his license pursuant to UTAH CODE ANN § 58-1-401(2)(a) and to impose an administrative fine pursuant to UTAH CODE ANN § 58-31b-402(1).

### COUNT IV

17 Paragraphs 1 through 10 are incorporated by reference as if fully set forth herein.

18 Respondent maintained a controlled substance at his home and he destroyed the medication without a witness. Therefore, Respondent engaged in unprofessional conduct as defined in UTAH ADMIN CODE R156-37-502(4) establishing grounds to sanction his license pursuant to UTAH CODE ANN § 58-1-401(2)(a) and to impose an administrative fine pursuant to UTAH CODE ANN § 58-31b-402(1).

WHEREFORE, the Division requests the following relief:

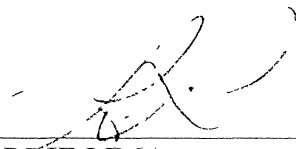
1 That Respondent be adjudged and decreed to have engaged in the acts alleged herein,

2. That by engaging in the above acts Respondent be adjudged and decreed to have violated the above-referenced statutes and rule of the Division of Occupational and Professional Licensing Act, the Nurse Practice Act, the Controlled Substances Act and the Utah Controlled Substances Act Rules;

3. That an order be issued imposing an appropriate sanction against Respondent's license to practice as a registered nurse in Utah.


4. That an appropriate administrative fine be assessed against Respondent.

DATED this 1st day of July, 2002.

  
\_\_\_\_\_  
LORRIE LIMA,  
Assistant Attorney General

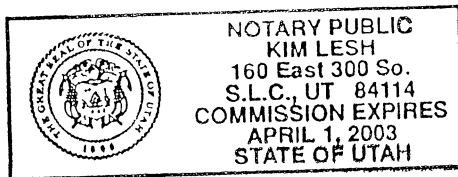
STATE OF UTAH )  
 )  
 : ss.  
COUNTY OF SALT LAKE )

On this 5 day of July, 2002 Shane Tiernan personally appeared before me, and after being duly sworn and deposed, says that he has read the foregoing petition and he knows the contents thereof and the same is true to the best of his knowledge, except as to matters stated on information and belief, and that as to those matters he believes them to be true.

  
SHANE TIERNAN,  
Investigator  
Division of Occupational and  
Professional Licensing

SWORN AND SUBSCRIBED to before me this 5 day of July, 2002.

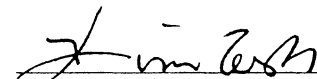
Lincoln  
NOTARY PUBLIC



MAILING CERTIFICATE

I hereby certify that on the 5 day of July, 2002, a true and correct copy of the foregoing NOTICE OF AGENCY ACTION and PETITION was sent first class mail, postage prepaid, to the following:

W. SCOTT JEPSON  
654 W 650 S  
OREM UT 84058

  
\_\_\_\_\_  
Kim Lesh  
Administrative Secretary

Tab 18



BEFORE THE DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSING  
OF THE DEPARTMENT OF COMMERCE  
OF THE STATE OF UTAH

---

IN THE MATTER OF THE LICENSE OF	:
W. SCOTT JEPSON, RN	:
TO PRACTICE AS A	: ORDER
REGISTERED NURSE	:
IN THE STATE OF UTAH	: Case No. DOPL-2002-151

---

The attached Findings of Fact, Conclusions of Law and Recommended Order are hereby adopted by the Regulatory and Compliance Officer of the Division of Occupational and Professional Licensing of the State of Utah.

Dated this 16<sup>TH</sup> day of June, 2003.



W. Ray Walker  
W. Ray Walker  
Regulatory and Compliance  
Officer

Agency review of this Order may be obtained by filing a request for agency review with the Executive Director, Department of Commerce, within thirty (30) days after the date of this Order. The laws and rules governing agency review are found in Section 63-46b-12 of the Utah Code, and Section R151-46b-12 of the Utah Administrative Code.

BEFORE THE DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSING  
OF THE DEPARTMENT OF COMMERCE  
OF THE STATE OF UTAH

---

IN THE MATTER OF THE LICENSE OF	:	
W. SCOTT JEPSON, RN	:	FINDINGS OF FACT
TO PRACTICE AS A REGISTERED NURSE	:	CONCLUSIONS OF LAW
IN THE STATE OF UTAH	:	AND RECOMMENDED ORDER
	:	Case No. DOPL-2002-151

---

**Appearances:**

Lorrie Lima and Cheryl D. Luke for the Division of  
Occupational and Professional Licensing

Arron F. Jepson for Respondent

**BY THE BOARD:**

An April 25, 2003 hearing was conducted in the above-entitled proceeding before J. Steven Eklund, Administrative Law Judge for the Department of Commerce, and the Board of Nursing. Board members present were Linda Cornaby Helen Zsohar, Theresa M. Rock, Marilyn Johnson, Lynn F. Price, Bernadette Bittner, Sandra Lookinland and Diane Forster-Burke. The remaining Board members (Steven R. McColley and Cathy C. Hadden) were not present. There is currently one vacancy on the Board.

J. Craig Jackson, Director of the Division of Occupational and Professional Licensing, was not present. Given his absence, Mr. Jackson designated W. Ray Walker as the presiding officer to review and act upon the Recommended Order submitted by the Board in this proceeding.

Thereafter, evidence was offered and received. The April 25, 2003 hearing was adjourned on that date and resumed on May 30, 2003. Further evidence was then offered and received and the hearing concluded on that date.

The Board now enters its Findings of Fact, Conclusions of Law and submits the following Recommended Order for review and action by the Division:

#### FINDINGS OF FACT

1. Respondent is, and at all time relevant to this proceeding has been, licensed to practice as a registered nurse in this state. Division licensing records reflect that Respondent became so licensed March 25, 1991. Respondent was employed as a home health nurse for First Choice Home Health from June 2001 through September 2002.

2. Respondent was temporarily assigned to provide home nursing care to Hazel Mortensen, an elderly disabled adult. Respondent initially provided nursing care to Ms. Mortensen commencing April 5, 2002. Ms. Mortensen resided with Karen and Garth Beckstrom, who is Ms. Mortensen's daughter and son-in-law.

3. Respondent returned to the Beckstrom's home on April 11, 2002 and he determined that Ms. Mortensen was not able to swallow her medications at that time. Respondent then suggested to the Beckstroms that they consider alternative pain management medications for Ms. Mortensen. Mr. and Mrs Beckstrom agreed with

Respondent's assessment.

4. Respondent then contacted Dr. Erik Hogensen, who was Ms. Mortensen's attending physician. Based on Respondent's assessment of Ms. Mortensen, Dr. Hogensen issued prescriptions for Duragesic patches, a Schedule II controlled substance containing fentanyl, and injectable morphine sulphate, also a Schedule II controlled substance.

5. Respondent and Mr. Beckstrom obtained those prescriptions at Dr. Hogensen's office and they proceeded to a pharmacy to obtain the medications. The pharmacist filled the Duragesic prescription. However, the morphine sulphate prescription could not be filled in the multi-unit dosage for which it had been written.

6. Respondent attempted to locate multi-unit dose morphine sulphate vials at other hospitals or pharmacies. However, he was not able to obtain that medication for Ms. Mortensen as prescribed by Dr. Hogensen. Respondent and Mr. Beckstrom returned to the Beckstrom's home.

7. Respondent then contacted B & H Pharmacy, which was also not able to dispense the morphine sulphate in the prescribed multi-unit doses. However, that pharmacy had morphine sulphate available in a 20ml with 15mg/ml vial. Mr. Beckstrom gave Respondent \$26.00 to pay for the morphine sulphate.

8. Respondent then returned to Dr. Hogensen's office and

obtained a prescription from a Dr. James Rose for the morphine sulphate in the quantity available at B & H Pharmacy. Respondent then had Ms. Mortensen's prescription filled at that pharmacy at approximately 8:00 p.m. on April 11, 2003.

9. There is a lack of sufficient and credible evidence that Respondent told the Beckstroms that he would get the prescription filled and deliver Ms. Mortensen's medication to them on the evening of April 11, 2002. Respondent proceeded to his home with the morphine sulphate. There is also a lack of sufficient and credible evidence to find that Respondent contacted the Beckstroms by telephone that evening and informed them that he would deliver the morphine sulphate on the following day.

10. Ms. Mortensen's condition had improved on April 12, 2002 and the Beckstroms thus believed that the morphine sulphate was no longer necessary. Based on the substantial and credible evidence presented, Mr. Beckstrom left a telephonic message for Respondent, thus instructing him not to have the morphine sulphate prescription filled if he had not yet obtained that medication for Ms. Mortensen.

11. Respondent arrived at the Beckstrom home approximately 15 minutes later. He informed the Beckstroms that he had obtained the morphine sulphate and he had left that medication at his home. Respondent's assessment of Ms. Mortensen's condition

was consistent with that of the Beckstroms. Given the excessive dosage and concentration of the morphine sulphate which Respondent had obtained from B & H Pharmacy, he had elected not to leave Ms. Mortensen's medication in the Beckstrom's home.

12. Respondent returned to the Beckstrom's home on April 13, 2002. Based on the substantial and credible evidence presented, Mrs. Beckstrom inquired whether Respondent had the morphine sulphate with him. Respondent replied that he could not provide that medication to them because it would be an illegal distribution of a controlled substance and he had destroyed the morphine sulphate.

13. Based on the substantial evidence presented and the more reasonable inferences drawn therefrom, Respondent elected to dispose of the morphine sulphate at his residence. However, that disposal occurred in the presence of a witness who did not understand what was contained in the vial. The standard of care in nursing practice requires the presence of a competent witness when a medication is wasted and that the wasting of the medication is documented. Respondent wasted the morphine sulphate without a competent witness and without any documentation of that wasting.

14. There is a lack of sufficient evidence that Ms. Mortensen needed the morphine sulphate after it had been prescribed and prior to Respondent's wasting of that medication.

Thus, there is a no basis to find that Respondent failed to administer the morphine sulphate to Ms. Mortensen. There is also a lack of sufficient evidence that Respondent had any reason to believe Ms. Mortensen may be the victim of actual or potential abuse. Thus, there is no basis to find that Respondent failed to report any such abuse.

15. Respondent possessed Ms. Mortensen's morphine sulphate in his home and he failed to deliver that prescribed medication to the Beckstroms. That medication should have been available at the Beckstrom's home and thus accessible to any nurse as might have been subsequently needed for Ms. Mortensen. Based on the substantial and more credible evidence presented, both Respondent and the Beckstroms understood that the latter would not administer that controlled substance to Ms. Mortensen.

#### CONCLUSIONS OF LAW

The Division contends Respondent has engaged in unprofessional and unlawful conduct violative of various statutes and a rule which governs the practice of nursing. The Division initially asserts Respondent improperly retained Ms. Mortensen's medication at his residence and he thus possessed that controlled substance outside of his responsibilities as a nurse.

The Division next asserts Respondent was either grossly incompetent, grossly negligence or he engaged in a pattern of incompetence or negligence. Specifically, the Division contends

Respondent failed to administer the morphine sulphate to Ms. Mortensen, he improperly retained that medication at his home, he disposed of it without a proper witness and he failed to report that Ms. Mortensen may be an actual or potential victim of abuse.

The Division next contends Respondent improperly retained the morphine sulphate intended for Ms. Mortensen and he failed to produce that medication for her. Finally, the Division asserts Respondent failed to maintain proper controls over that medication.

The Division urges that Respondent's nursing practice should be subject to supervision and possibly restricted to certain work settings. The Division also suggests that Respondent be required to complete some remedial education and that a fine be assessed in this proceeding.

Respondent contends there is a lack of any evidence that he has violated any statute or rule which governs his practice of nursing. Given the excessive dosage and concentration of the morphine sulphate which Respondent obtained through his efforts, he asserts he properly possessed the morphine sulphate at his home within his responsibilities as a nurse. Respondent also asserts the morphine sulphate was not necessary after Ms. Mortensen's condition had improved and there was no basis to have then administered that medication to her.

Respondent further contends that, once the morphine sulphate



was no longer needed for Ms. Mortensen, he had a responsibility to waste that medication and it was wasted in the presence of a competent witness. Respondent asserts the morphine sulphate did not become Ms. Mortensen's personal property because he never delivered it to her.

Respondent also asserts that, as a home health nurse, he appropriately retained the medication at his residence for a brief time before it was wasted. Respondent urges he had no reason to believe that Ms. Mortensen was the subject of either actual or potential abuse and he thus had no obligation to report any such abuse. Respondent argues no disciplinary action should be entered in this proceeding.

§58-1-401(2) provides the Division may revoke, suspend, restrict, place on probation, issue a public or private reprimand to, or otherwise act upon the license of any licensee who:

- (a) . . . has engaged in unprofessional conduct, as defined by statute or rule under this title;
- (b) . . . has engaged in unlawful conduct as defined by statute under this title . . .

§58-1-501(2) generally defines unprofessional conduct to include:

- (a) violating . . . any statute, rule, or order regulating an occupation or profession under this title;

- (g) practicing . . . an occupation or profession regulated under this title through gross incompetence, gross negligence, or a pattern of incompetency or negligence.

§58-31b-502 specifically defines unprofessional conduct in the practice of nursing to include:

(5) unlawfully obtaining, possessing, or using any prescription drug or illicit drug;

(7) unauthorized taking or personal use of a patient's personal property.

Unprofessional conduct relative to controlled substances is defined by rule. Specifically, R156-37-502(4) provides such unprofessional conduct includes:

(4) failing to maintain controls over controlled substances which would be considered by a prudent practitioner to be effective against diversion, theft, or shortage of controlled substances. . . .

§58-37-8(2)(a) of the Utah Controlled Substances Act provides it is unlawful:

(i) for any person knowingly and intentionally to possess or use a controlled substance, unless it was obtained under a valid prescription or order, directly from a practitioner while acting in the course of his professional practice, or as otherwise authorized by this chapter.

Respondent lawfully obtained the morphine sulphate from B & H Pharmacy. However, Respondent engaged in both unprofessional and unlawful conduct - violative of §58-31b-502(5) and §58-37-8(2)(a)(i) - when he unlawfully possessed that prescribed controlled substance in his home and he failed to deliver that medication to the Beckstrom's home.

Respondent also engaged in unprofessional conduct violative of §58-31b-502(7) - when he took Ms. Mortensen's prescribed medication and possessed the morphine sulphate in his home. Respondent violated the applicable standard of care because he failed to duly deliver that medication to the Beckstroms. Respondent also thus engaged in unprofessional conduct as defined by §58-1-501(2)(a).

The Board thus concludes Counts I and III of the July 1, 2002 Petition have been established by a preponderance of the evidence. Accordingly, the Board finds and concludes a proper factual and legal basis exists to enter a disciplinary sanction as to Respondent's nursing license.

The Board finds and concludes Ms. Mortensen did not need the medication after it had been prescribed. Accordingly, no factual basis exists that Respondent failed to administer necessary medication to Ms. Mortensen. There is a lack of sufficient evidence that Respondent had any reason to believe that Ms. Mortensen may be a victim of actual or potential abuse. Accordingly, there is no evidence that Respondent failed to report any such abuse and he did not violate §76-5-111.1(1), which provides:

Any person, including but not limited to, a . . . nurse . . . who has reason to believe that any disabled or elder adult has been the subject of abuse, emotional or psychological abuse, neglect, or exploitation shall immediately notify the nearest peace officer,

law enforcement agency, or local office of Adult Protective Services within the Department of Human Services, Division of Aging and Adult Services.

Respondent inappropriately kept the morphine sulphate at his home and he disposed of that controlled substance without a competent witness and any documentation. However, the Board finds and concludes that such conduct - standing alone - fails to establish a violation of §58-1-502(2)(g) because it does not represent either gross negligence, gross incompetence or a pattern of incompetency or negligence. Accordingly, the Board finds and concludes there is a lack of sufficient evidence that Respondent violated Count II of the July 1, 2002 Petition.

The Board finds and concludes there is a lack of sufficient evidence to establish Respondent violated R156-37-502(4). That rule governs a failure of a practitioner to maintain controls over controlled substances in an institutional setting as to effectively prevent the diversion, theft or shortage of such substances.

R156-37-502(4) does not strictly apply in a home health care setting and the fact that Respondent possessed the morphine sulphate in his home and he wasted that medication without a competent witness and proper documentation does not establish a violation of that rule. Accordingly, the Board finds and concludes there is a lack of sufficient evidence that Respondent violated Count IV of the July 4, 2002 Petition.

Respondent failed to exercise good judgment when he elected to retain the morphine sulphate in his home rather than deliver that medication to the Beckstroms. Respondent simply failed to recognize that Ms. Mortensen's medication should have been available at the Beckstrom's home if Ms. Mortensen's condition again deteriorated as to subsequently warrant the use of the Duragesic patches and the morphine sulphate for breakthrough pain.

The Board acknowledges that the quantity of morphine sulphate which Respondent ultimately obtained could be potentially lethal if inappropriately administered. Nevertheless, Respondent knew the Beckstroms would not administer the morphine sulphate to Ms. Mortensen, he should have delivered that medication to the Beckstroms and Respondent failed to do so in his zealous attempts to obtain and then exclusively control access to that medication.

The Board does not doubt that Respondent acted with good intentions. Significantly, there is no evidence of any potential or actual injury caused by Respondent's misconduct. To the contrary, Respondent generally provided good nursing care to Ms. Mortensen during the brief time that he was her home health care nurse.

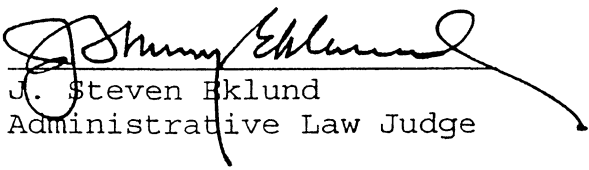
The Board concludes Respondent's misconduct represents an isolated incident. The Board further concludes it is not likely

Respondent would repeat that conduct with another patient in a home health care setting. Moreover, Respondent has not been previously subject to any disciplinary licensure action. Accordingly, the Board finds and concludes the Recommended Order set forth below is a sufficient admonishment to Respondent based on the rather unique facts of this case.

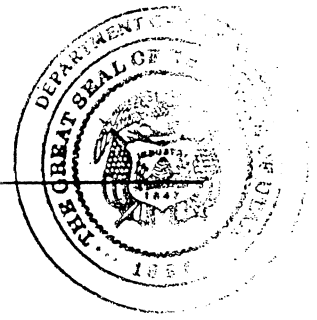
#### RECOMMENDED ORDER

WHEREFORE, IT IS ORDERED that Respondent be publicly reprimanded for the unprofessional and unlawful conduct set forth herein. Respondent shall abstain from such conduct in the future and assure that medications prescribed for any of his patients in a home health care setting are maintained in their home for administration to the patient as may be warranted.

On behalf of the Board of Nursing, I hereby certify the foregoing Findings of Fact, Conclusions of Law and Recommended Order were submitted to W. Ray Walker, Regulatory and Compliance Officer for the Division of Occupational and Professional Licensing, on the 13<sup>th</sup> day of June, 2003 for his review and action.

  
J. Steven Eklund  
Administrative Law Judge

Tab 19



---

**BEFORE THE DEPARTMENT OF COMMERCE  
OF THE STATE OF UTAH**

---

IN THE MATTER OF THE REQUEST FOR AGENCY REVIEW OF  <b>W. Scott Jepson</b> PETITIONER	: : : : : :	FINDINGS OF FACT, CONCLUSIONS OF LAW and RECOMMENDED ORDER   DOPL
--	----------------------------	--

---

**INTRODUCTION**

This matter came before the Department of Commerce ("Department") upon a request for agency review filed by W. Scott Jepson ("Petitioner") following an order of the Division of Occupational and Professional Licensing ("Division") concluding that Petitioner had engaged in unprofessional and unlawful conduct.

**STATUTES OR RULES PERMITTING OR REQUIRING REVIEW**

Agency review of the Division's decision is conducted pursuant to the Utah Administrative Procedures Act ("UAPA"), Utah Code Ann., § 63-46b-12, and Utah Administrative Code, R151-46b-12.

**ISSUES REVIEWED**

1. Did the Division properly interpret and apply controlling statutes and rules?
2. Did the Division err in finding that Petitioner disposed of the morphine sulphate prescribed for a home health nurse patient without a proper witness and documentation?



3. Did the presiding officer abuse his discretion in (a) excluding an exhibit offered by Petitioner concerning the standard of care and (b) allowing the testimony of an expert witness?

4. Is public reprimand a proper sanction where Petitioner did not intend to harm the patient, and the patient was not in fact harmed by not having the controlled substance available at her residence?

### **FINDINGS OF FACT**

1. Petitioner is a licensed registered nurse employed as a home health care nurse for First Choice Home Health (“First Choice”).

2. The appropriate standard of care for home health nurses is to maintain medications prescribed for patients at the patients’ homes

3. On April 5, 2002, Petitioner began providing nursing care to Hazel Mortensen, an elderly disabled adult. Ms. Mortensen had been living with her daughter and son in law, Karen and Garth Beckstrom.

4. On April 11, 2002, Petitioner determined that Ms. Mortensen was unable to swallow her medications. Petitioner contacted Dr. Erik Hogenson, Ms. Mortensen’s primary care physician, to obtain alternate pain management medication. Based on Petitioner’s assessment of Ms. Mortensen, Dr. Hogenson prescribed Duragesic patches, a Schedule II controlled substance containing fentanyl, and injectable morphine sulphate, also a Schedule II controlled substance.

5. Petitioner and Mr. Beckstrom obtained the prescriptions from Dr. Hogenson’s office and proceeded to a pharmacy to obtain the medications. The pharmacist filled the Duragesic patches, and Mr. Beckstrom later took that medication

home. However, the injectable morphine sulphate was not available at the pharmacy. Petitioner attempted to locate the morphine sulphate at other pharmacies but was unable to obtain the morphine prescription in the multi-unit dosage as prescribed by Dr. Hogenson.

6. Petitioner eventually found a pharmacy that could fill the prescription in a different dosage. Petitioner returned to Dr. Hogenson's office and obtained a new prescription from Dr. James Rose for the morphine sulphate. Petitioner had the new prescription filled at approximately 8:00 p.m. on April 11, 2002, after which he proceeded to his home.

7. The evidence is conflicting as to whether there was communication between Petitioner and the Beckstroms that evening after Petitioner had obtained the morphine sulphate. Petitioner left his residence in the morning on April 12, 2002, leaving the morphine sulphate behind while he checked on other patients. Ms. Mortensen's condition had improved significantly that morning, and the Beckstroms thus believed that the morphine sulphate was no longer necessary. Mr. Beckstrom left a telephone message for Petitioner, instructing him not to have the morphine sulphate prescription filled if he had not yet obtained that medication for Ms. Mortensen.

8. Petitioner had not received the message before he arrived at the Beckstrom home approximately fifteen (15) minutes later without the medication. He informed the Beckstroms that he had obtained the morphine sulphate but had left it at his home. Mr. Beckstrom paid Petitioner for the medication.

9. Petitioner returned to the Beckstrom home on April 13, 2002. Mrs. Beckstrom inquired whether Petitioner had brought the morphine sulphate with him.

Petitioner responded that he could not provide the medication to them because it would be an illegal distribution of a controlled substance and that he had destroyed the medication. The Beckstroms had expected Petitioner to leave the medication at their home so that it would be available if Ms. Mortensen later needed it and another home health nurse could administer it to her.

10. Petitioner elected to dispose of the morphine sulphate in his residence, and did so in front of a witness, Mr. John Branin. However, Petitioner did not document the disposal because First Choice did not have any forms regarding wasting of medications.

11. First Choice was aware of Petitioner's handling of the morphine sulphate. After conducting its own investigation, First Choice reported the incident to the Division which subsequently filed a Petition against Petitioner alleging the following:

Count I. Petitioner possessed controlled substances outside of his responsibilities as a nurse. Therefore, Petitioner engaged in unlawful and unprofessional conduct as defined in Utah Code Annotated §§ 58-37-8(2)(a)(1), 58-31b-502(5) and 58-1-501(2)(a).

Count II. Petitioner failed to administer a medication to his patient as prescribed by a physician. Petitioner maintained a patient's narcotics medication at his residence and he disposed of a controlled substance without a proper witness as is standard practice in nursing. Petitioner failed to report his suspicion that the patient may be a victim of abuse or potential abuse per his legal obligation in Utah Code Annotated § 76-11.1(1). Therefore Petitioner engaged in unprofessional conduct as defined in Utah Code Annotated § 58-1-502(2)(g).

Count III. Petitioner failed to produce a medication he purchased for a patient. Therefore, Petitioner engaged in unprofessional conduct as defined in Utah Code Annotated § 58-31b-502(7).

Count IV. Petitioner maintained a controlled substance at his home and he destroyed the medication without a witness. Therefore, Petitioner engaged in unprofessional conduct as defined in Utah Administrative Code R156-37-502(4).

12. A hearing was conducted on April 23 and May 30, 2003, before the Board. The Board concluded that Counts I and III were established but it dismissed Counts II and IV. The Board's findings of fact and conclusions of law were adopted by the Division Director's designee on June 16, 2003, and an Order was specifying a public reprimand of Petitioner.<sup>1</sup>

13. On July 15, 2003, Petitioner filed a timely request for agency review. In addition, Petitioner requested an order staying the enforcement of the Division's Order and requested oral argument.

## CONCLUSIONS OF LAW

### A. Applicable Laws and Rules

1. The Division may revoke, suspend or otherwise sanction the license of any licensee who engages in unlawful or unprofessional conduct as defined by statute or rule under Title 58 of the Utah Code. Utah Code Ann. § 58-1-401(2)(a) and (b). Unlawful and unprofessional conduct are defined in various statutory provisions as indicated below.

2. The Utah Controlled Substances Act ("C/S Act") makes it unlawful for anyone to knowingly and intentionally possess a controlled substance unless it was obtained under a valid prescription. Utah Code Ann. § 58-37-8(2) provides:

(a) It is unlawful:

(i) for any person *knowingly and intentionally* to possess or use a controlled substance analog or a controlled substance, unless it was obtained under a valid prescription or order, directly from a practitioner while acting in the course of his professional practice, or as otherwise authorized by this chapter;

---

<sup>1</sup> References in these Findings of Fact and Conclusions of Law to the Division's findings or Division's conclusions mean the Board's findings and conclusions of law, as adopted by the Division.

(Emphasis added). “An ultimate user, or any person who possesses any controlled substance pursuant to a lawful order of a practitioner” is “not required to obtain a license and may lawfully possess controlled substances”. Subsection 58-37-6(2)(c)(iii).

3. The term “unprofessional conduct” has been defined in various sections of the Division of Occupational and Professional Licensing Act and by Division rule, Title 58 of the Utah Code. Under the following pertinent provisions, unprofessional conduct has been defined to include:

- violating...any statute, rule, or order regulating an occupation under this title – Section 58-1-501(2)(a);
- for a nurse to unlawfully obtain, possess or use any prescription drug or illicit drug – Section 58-31b-502(5);
- for a nurse, the “unauthorized taking or personal use of a patient’s personal property”- Subsection 58-31b-502(7); and
- “failing to maintain controls over controlled substances which would be considered by a prudent practitioner to be effective against diversion, theft, or shortage of controlled substances” – Utah Admin. Code, R156-37-502(4).<sup>2</sup>

#### **B. Division’s Order**

4. Although the Division acknowledged that the quantity of morphine was potentially lethal if inappropriately administered, it found that the standard of care for home health nurses is to keep prescription medications at the homes of patients. The Division applied that standard of care to the definitions of unlawful and unprofessional conduct to conclude that Petitioner engaged in both unlawful and unprofessional conduct as follows:

- Petitioner lawfully obtained the morphine sulphate from the pharmacy, but he later unlawfully possessed the medication in his home and failed to deliver it to the Beckstrom home, violating Subsections 58-31b-502(5) and 58-37-8(2)(a)(i).

---

<sup>2</sup> Hereafter, this rule is referred to as Rule 502(4).

- Petitioner engaged in unprofessional conduct violative of Subsection 58-31b-502(7) (taking of personal property), and thereby Subsection 58-1-501(2)(a) when he took the patient's medication home with him.

The Division further found that Petitioner disposed of the morphine without a competent witness and without documentation. Nevertheless, the Division dismissed for lack of proof Count II (alleging violation of failure to administer medication and failure to report abuse) and Count IV (alleging violation of gross negligence/incompetence or pattern of such – Subsection 58-1-502(2)(g), and failure to maintain controls over controlled substances – Rule 502(4), and destroying the morphine without a witness). The Division determined that Rule 502(4) was not strictly applicable in a home health setting. It then considered various mitigating factors including the potential lethal quantity of morphine sulphate at issue and its finding that Petitioner acted with good intentions, that he caused no harm to the patient, and he had not previously been disciplined by the Division. Accordingly, the Division ordered a public reprimand and ordered Petitioner to henceforth maintain medications at the homes of his home health patients.

### **C. Standards of Review**

5. The standards for agency review within the Department of Commerce correspond to those established by UAPA<sup>3</sup>. Accordingly, the Executive Director will apply different standards of review depending on whether the issue is one of fact, law, or legal discretion. *WWC Holding Co., Inc. v. Pub. Serv. Comm'n of Utah*, 2001 UT 23, ¶ 7, 44 P.3d 714.

6. The party challenging an agency's findings of fact must show that the finding is not supported by substantial evidence when viewed in light of the whole record. Section 63-46b-16(4)(g). The burden remains upon the party challenging the

---

<sup>3</sup> Utah Admin. Code, R151-46b-12(7).

facts to marshal all of the evidence in support of the decision and to show that despite such evidence, the decision is not supported by substantial evidence. Utah Admin. Code R151-46b-12(3)(c); *First Nat'l Bank v. County Bd. Of Equalization*, 799 P.2d 1163, 1165 (Utah 1990). The failure to so marshal the evidence permits the Executive Director to accept the findings of fact made by the Division as conclusive. Utah Admin. Code R151-46b-12(3)(c); *Campbell v. Box Elder County*, 962 P.2d 806, 808 (Utah Ct. App. 1998).

7. When reviewing the Division's interpretation of general questions of law, the Executive Director applies a correction-of-error standard, granting no deference to the Division's decisions. *Morton Int'l, Inc. v. Utah State Tax Commission*, 814 P.2d 581, 587-88 (Utah 1991). However, on matters of ultimate fact, mixed findings of fact and law, and the Division's interpretation of statutory law it is empowered to administer, the Division's decisions are reviewed for reasonableness. *Associated Gen. Contrs. v. Bd. of Oil, Gas & Mining*, 2001 UT 112, ¶ 18, 38 P.3d 291. Thus, when the Division has specialized knowledge that is helpful in interpreting a statute, the Utah Supreme Court has stated:

[I]nstances involving "ultimate facts, mixed findings of fact and law, and [an agency's] interpretation of the . . . statutory law it is empowered to administer" are limited to situations where the agency has been granted explicit or implicit discretion under the statute, *where the agency possesses expertise concerning the operative provisions at issue, or where the agency is otherwise in a better position than the courts* to assess the law due to its experience with the relevant subject matter.

*Id.* (emphasis added, citations omitted). "Generally, an agency's interpretation of its own rules, especially where the Legislature has granted the agency discretion in that area, is subject to deference by a reviewing court." *State v. Garcia*, 965 P.2d 508, 512 (Utah Ct. App. 1998). The Utah Supreme Court has also applied a reasonableness standard to the

Division's determination of whether a licensee has engaged in unprofessional conduct. *Vance v. Fordham*, 671 P.2d 124, pp. 127-128 (Utah 1983). Finally, whether the sanction of public reprimand is appropriate under the circumstances of this case is also reviewed for reasonableness. *Johnson-Bowles v. Division of Sec.*, 829 P.2d 101, 114 (Utah App.), *cert. denied*, 843 P.2d 516 (Utah 1992).

**D. Petitioner's Challenges**

8. Petitioner's challenges to the Division's interpretation and application of the laws and rules in this case are numerous, duplicative, and in some cases difficult to discern. Therefore, in these Findings of Fact, Conclusions of Law and Recommended Order, the twenty-two points Petitioner raises as his challenges to the Division's Order will be distilled to the essential issues.

(a) Antithetic Allegations:

9. Petitioner argues that the Division's initial petition contained "antithetic allegations", and that he was charged with both failing to maintain effective controls over the morphine sulphate under Count IV and failing to relinquish control over the morphine in Counts I & III. Even if such allegations were in fact conflicting and improper, no such problem exists in the final order of the Division. The Division expressly concluded that Petitioner had not violated Rule 502(4) and dismissed the charges in Count IV.<sup>4</sup> Because the Division's final order is the subject of this agency review, and not the allegations in the petition, the argument as to antithetic allegations is not pertinent to this review.

(b) Application of Rule 502(4):

---

<sup>4</sup> Petitioner mischaracterizes the Division's conclusions when he represents that the Division found "he obeyed Rule 156 by maintaining control." A conclusion that Petitioner did not violate Rule 502(4) is not the same as a conclusion that he *obeyed* that Subsection, particularly in light of the next paragraph in the Division's findings of facts and conclusions of law, which state that the Subsection does not apply to home health settings.



10. Petitioner challenges the Division's conclusions that Rule 502(4) does not apply to home health nurses. In this case, the Division was in a better position than the Executive Director to give effect to the regulatory objective to be achieved by Rule 502(4). The State Legislature explicitly gave the Division the power to adopt rules identifying and defining activities that constitute "unprofessional conduct" which may form the basis for disciplinary actions. *See* Utah Code Ann. §58-1-501 ("unprofessional conduct' means conduct...defined as unprofessional conduct, under this title or under any rule adopted under this title"). Pursuant to such authority, the Division drafted and later adopted Rule 502(4), defining the failure to maintain controls over controlled substances as unprofessional conduct. Therefore, as the agency with explicit discretion to define unprofessional conduct *and* as the drafter of Rule 502(4), the Division was clearly in a better position than the Executive Director to interpret that Subsection. *See Garcia*, at 512. Thus, the Division's interpretation of Rule 502(4) should be reviewed for reasonableness.

11. The Division's interpretation of Rule 502(4) and the resulting conclusion that the Rule does not apply to home health nurses is reasonable. The environment in a patient's home is different from that in an institution. In an institutional setting, individuals who are on the premises for health care services, those who accompany them, vendors, maintenance staff and the general public could potentially come into contact with an unsecured controlled substance. Therefore, security measures would be appropriate in such a setting to keep controlled substances in a designated area where only authorized personnel can access them. In a home health care setting, however, the danger of public access is practically non-existent. The patient or his/her caregivers

control access to the home and to the medications in the home. Therefore, it is not unreasonable for the Division to conclude that Rule 502(4) does not apply to home health care situations.

(c) Standard of Care:

12. Even if Rule 502(4) applied to home health nurses, however, pursuant to that Rule, the level of controls to be maintained in a particular situation is determined by what “would be considered by a prudent practitioner to be effective against diversion, theft, or shortage of controlled substances”. The Board determined that a reasonably prudent nurse would not consider taking home a patient’s medication an effective means of preventing diversion, theft, or shortage of controlled substance, but would instead be concerned about the possible danger that the patient who needs her medication cannot access it. Thus, the Board found that the standard of care for a home health nurse was to keep medications prescribed for a patient at the patient’s home.

13. It is clear from Petitioner’s submissions that he does not agree with the Board’s finding of the standard of care. However, Petitioner has failed to adequately challenge that finding. What is the appropriate standard of care for a specific profession is a finding of fact. *Vance* at pp. 127-128 (Utah 1983). Petitioner has failed to marshal the evidence in favor of the finding of the standard of care for home health nurses and to show that despite that evidence, the finding is not supported by substantial evidence. Utah Admin. Code, R151-46b-12(3)(c); *First Nat’l Bank*, at 1165. Instead, Petitioner has reviewed the evidence in favor of his position. Therefore, the Executive Director may accept the Division’s finding of fact regarding the standard of care as conclusive. Subsection R151-46b-12(3)(c); *Campbell* at 808.

14. Moreover, there is substantial evidence in the record that the standard of care is to maintain prescription medications at the patient's home. Elizabeth Baker, who had more than twelve years of experience as a home health nurse, testified that prescription medications should be kept at the home of a patient, that the home health nurse has a duty to educate the patient and her caregivers about controlled substances, and that the patient's caregivers are responsible for the security of the medications. Dr. Eric Hogenson testified that the morphine prescribed for Ms. Mortensen should have been available for more than one episode, that it should have been kept at the patient's home, and that he did not think that the Beckstroms would attempt to administer it to Ms. Mortensen. Petitioner also believed that the Beckstroms would comply with any instructions he gave regarding Ms. Mortensen's medications. Dr. Hogenson stated that the morphine Petitioner ultimately obtained for Ms. Mortensen was not a shocking amount. Although Dr. Hogenson's practice is to prescribe morphine pills for his home health patients, on this occasion, he relied upon Petitioner's assessment and recommendation that injectable morphine would be appropriate to meet Ms. Mortensen's needs. Dr. James Rose testified that he wrote a subsequent prescription for Ms. Mortensen at Petitioner's request. Dr. Rose prescribed this "potent substance" with the understanding that a registered nurse would administer the morphine. There was also testimony that the Beckstroms could have obtained the morphine prescription themselves and maintained it at their home for future administration by a nurse.

15. It is true that Petitioner presented opposing evidence through expert witnesses, including a nurse who stated that the standard of care was not to leave the morphine at the patient's home, and two doctors who were also concerned about the

strength of the medication and the danger of leaving it at the Beckstrom home. However, there was substantial evidence on the Division's side as noted above, and the Executive Director is not in a position to substitute her judgment for that of the Board which has expertise in nursing and can better judge the testimony presented in light of their knowledge, training and experience in nursing. The Utah Court of Appeals has stated:

We are in no position to second guess the detailed findings of the ALJ which were adopted by the Board. It is not our role to judge the relative credibility of witnesses. In undertaking such a review, this court will not substitute its judgment as between two reasonably conflicting views, even though we may have come to a different conclusion had the case come before us for de novo review. It is the province of the Board, not appellate courts, to resolve conflicting evidence, and where inconsistent inferences can be drawn from the same evidence, it is for the Board to draw the inferences.

*Albertsons Inc. v. Department of Emp. Sec. et al.*, 854 P.2d 570, 575 (Utah App. 1993)  
(citations omitted).

16. Although the morphine was in a potentially lethal dose, Petitioner could have educated the family about its dangers and could have instructed the family not to attempt to administer it to Ms. Mortensen themselves. There was no evidence presented to suspect that the Beckstroms would disregard such instruction, and Petitioner has not contested the Division's Finding #15 that the Beckstroms would not administer the controlled substance to Ms. Mortensen.

(d) Standard of Care Is Enforceable Even Though Not Yet In Writing:

17. Petitioner complains that there is no statute, rule or other written standard stating that a home health nurse cannot take a patient's controlled substances home.

However, the standard is enforceable even though it is not written, because:

- The subject of professional performance is too comprehensive to be codified in detail.

- Members of a profession can properly be held to understand its standards of performance.
- Members of the same profession in the process of administrative adjudication will interpret standards of performance.

*Vance*, at p. 129. In *Vance*, the Utah Supreme Court upheld the general statutory standard of “unprofessional conduct” even though the Osteopathic Committee had not previously defined unprofessional conduct by published rules. The Court found it relevant that “the standard of ‘unprofessional conduct’ could be applied by expert professionals to judge another professional’s conduct”, and stated that certified professionals “could be held to a higher standard of awareness of the profession’s unmodified standards in the treatment of patients...” *Id.* at 129. *See also In re Topik*, 761 P.2d 32 (Utah Ct. App. 1988), *cert. denied*, 773 P.2d 45 (Utah 1989).

18. Pursuant to the authority in *Vance* therefore, the standard of care as to medications prescribed for home health care patients need not be written in a statute or rule in order to be enforceable and effective against a home health nurse who violates that standard. As discussed above, there was substantial evidence presented regarding the standard of care, and the Board is comprised of several licensed nursing professionals who are themselves familiar with the standards of care for nurses.

(e) Unlawful and Unprofessional Conduct:

19. Even though Petitioner is correct that initially he lawfully obtained the morphine prescription, because the proper standard of care for home health nurses is to keep controlled substances within the dominion and control of the patient, Petitioner’s conduct in taking the morphine home violated the unlawful possession and unauthorized taking statutes, and accordingly, the unprofessional conduct statutes (Subsections 58-1-501(2), 58-37-8(2)(a)(1), 58-31b-502(5) and (7)). Petitioner admits that he obtained the

morphine sulphate for Ms. Mortensen's use, that he took the medication to his home where other nurses could not access it if she needed it without having to first locate him, kept it there against the patient's and her family's wishes, and later destroyed it. These facts clearly meet the definition of "possession" and "taking".

20. "Possession" and "use" are jointly defined in the C/S Act as the "ownership, control, occupancy, holding, retaining, belonging, maintaining..." of controlled substances, and "it is sufficient if it is shown that the person... had the ability and intent to exercise dominion and control over it". Subsection 58-37-2(1)(dd). Petitioner was not the ultimate user of the morphine, and although he originally lawfully obtained it for Ms. Mortensen's use, he never administered it to her and kept it from her against her family's wishes and against the proper standard of care for home health nurses. Subsection 58-37-6(2)(c)(iii). Thus, his maintaining the morphine was no longer lawful, and he unlawfully possessed it by virtue of the fact that he had the ability and intent to exercise dominion and control over it. Subsections 58-37-8(2) and 58-37-(2)(1)(dd).

21. By such exercise of dominion and control over the morphine, Petitioner also engaged in the unauthorized taking of the morphine. The term "taking" is not defined in either the Nurse Act or the C/S Act. However, the Black's Law Dictionary definition of "taking" indicates that this term is akin to the C/S Act's definition of "possession". A "taking" is "the act of laying hold upon an article, with or without removing the same. It implies a transfer of possession, dominion, or control." *Black's Law Dictionary*, Revised Fourth Edition, at p. 1626.

22. Petitioner argues that possession is necessary for a taking, reasoning that because Ms. Mortensen never had possession of the morphine, he could not have been guilty of a “taking” or a transfer of possession under Utah Code Ann. § 58-31b-502(7). However, case law cited by Petitioner supports the conclusion that a taking may be found if the person from whom something is taken had the *right of possession*; she need not have physical possession:

The third essential element in the crime of larceny is that the thing taken and carried away should be the property of another. That is, someone other than the taker must have in the thing taken a general or special property right which is invaded by the trespass committed in the taking. Considered as an element of larceny, “ownership” and “possession” may be regarded as synonymous terms; for one who has the *right of possession* as against the thief is, so far as the latter is concerned, the owner. Since appellant acquired possession of the money by fraud and chicanery, he held it all the while without right, and as against him Mrs. Benoit had the right of possession. It is of no consequence that the legal title to the bills was in the county.

*People v. Edwards*, 72 Cal. App. 102, 236 P. 944 (Ca. 2d App. Dist. 1925) (emphasis added; citations omitted).

23. It is clear that Ms. Mortensen had the right of possession of the morphine. The prescription was written for her. Had Petitioner not picked up the prescription, the Beckstroms would have done so and Ms. Mortensen would have had physical possession. Therefore, Petitioner’s argument that Ms. Mortensen did not have physical possession is not valid. The Division’s conclusions that Petitioner unlawfully possessed and engaged in the unauthorized taking of the morphine such that he engaged in unlawful and unprofessional conduct are reasonable, correct and should be upheld. Petitioner was not the ultimate user, he had no authority to keep the medication from the patient (per the standard of care), and he maintained possession and control of the medication.

(f) Petitioner's Claims That He Complied with Rule 502(4):

24. Petitioner also maintains that his conduct does not constitute the unlawful possession or unauthorized taking of a controlled substance because at all times he complied with Rule 502(4). However, Petitioner's arguments fail on the same grounds that he uses to challenge the Division's decision. Rule 502(4) does not specifically state that it applies to home health nurses; nor does it specifically state that a home health nurse can take a patient's prescription medication home as a means of maintaining appropriate controls over the medication. Petitioner has not cited any other statute, rule or other writing that specifically authorizes him to take the medication home. Petitioner is actually arguing that the appropriate standard of care is to keep the morphine from a patient's home under Rule 502(4), but the Board concluded otherwise as has been addressed above.

(g) Rulemaking Act and Ex Post Facto Laws:

25. Petitioner claims that the Division failed to follow Rule 502(4), improperly restricted the applicability of that Subsection without complying with rulemaking requirements, and created new crimes and ex post facto laws. He further maintains that the Division's interpretation improperly requires home health nurses to engage in the illegal distribution of medications to the family members of a patient. These additional arguments stem from Petitioner's incorrect position that the Division improperly interpreted Rule 502(4). Because that has been addressed above, it is not necessary to go into any detail in addressing these additional arguments.



26. There is no validity to Petitioner's argument that the Division violated the Administrative Rulemaking Act by creating new laws that are being applied retroactively. Rather, as concluded above, the Board reasonably interpreted existing statutes and rules regarding unprofessional conduct and determined the proper standard of care. Furthermore, the protection against ex post facto laws applies only to criminal punishment, not civil remedies such as professional licensing disciplinary sanctions. *See In the Matter of the Discipline of Peter M. Ennenga*, 2001 UT 111, ¶¶ 18, 21, 37 P.3d 1150 (holding that sanctions resulting from attorney discipline proceedings are civil remedies, not criminal punishments subject to the prohibition against ex post facto laws).

(h) Witness to Disposal of Morphine:

27. The Division found that Petitioner disposed of the morphine without a competent witness who understood what was contained in the vial and without adequate documentation. It further found that the standard of care for nurses is to dispose of medication in the presence of a competent witness and with proper documentation. Petitioner states that there was a competent witness, and that the petition made no allegation regarding lack of documentation. Whether there is substantial evidence in the record for these two findings is not relevant upon agency review, because the record indicates that the petition originally filed against Petitioner did not allege any failure to document and because the charges based upon these findings, namely, Counts II and IV, were dismissed. Thus, the findings were not relevant to the final Order of the Division. That the Division's Order contained these findings is harmless error.

28. An error is "harmless" if it is sufficiently inconsequential that there is no reasonable likelihood that the error affected the outcome of the proceedings. *Morton*

*Int'l, Inc. v. State Tax Comm'n*, 814 P.2d 581, 584 (Utah 1991). Regardless of the Division's findings regarding the disposal of the morphine, the Division dismissed Counts II and IV in the petition which contained allegations regarding that issue. The Division's decision regarding Counts I and III, however, did not relate to how the medication was destroyed. As recommended previously, the Division should be upheld on its conclusions that Counts I and III were established, and the findings about the disposal do not affect that outcome.

(i) Challenges As to Abuse of Discretion:

29. Petitioner states that the presiding officer abused his discretion in (a) admitting the testimony of Dr. Baker and (b) failing to admit an exhibit he offered, a document entitled "Security of Other Medications and Supplies". The standard of review as to whether evidence was properly admitted at a hearing is abuse of discretion or reasonableness. *Mule-hide Products Co. v. White*, 2002 App 1, ¶ 12, 40 P.3d 1155. The exhibit was published on the web site of the Joint Commission on Accreditation of Healthcare Organizations on its "Home Care Page" and was offered by Petitioner to show the standard of practice for home health nurses. However, the content of the exhibit clearly shows that it does not apply to home health care settings but applies to an institutional setting. The exhibit refers to public access, patient waiting areas, patient examination rooms, and private offices. Thus, the presiding officer's decision to exclude the document to prove the standards in a home health setting was reasonable and he did not abuse his discretion in excluding the exhibit.

30. Admitting Ms. Baker as an expert witness was also reasonable. Ms. Baker was introduced by the Division as an expert witness in the Division's Expert Witness

Disclosure dated March 11, 2003. At the hearing, the Division questioned her about her qualifications and then went on to question her about her opinions on the issues in the case. Petitioner's counsel objected to a question posed to her by the Division, stating that it was a legal question. The presiding officer permitted the question as appropriate for an expert witness. Petitioner's counsel at first did not agree with that assessment, but then appeared to accept that Ms. Baker was in fact being offered and was testifying as an expert witness. He stated, "[s]he was not offered, but I guess she is now, as a qualified expert witness on home health nurse." Thereafter, Petitioner did not attempt to voir dire the witness, object to her qualifications or otherwise notify the presiding officer that he had any concerns that Ms. Baker was testifying as an expert witness. Because of Petitioner's failure to make an objection at the hearing, he cannot raise that issue now on agency review. A "party must raise an objection in an earlier proceeding or waive its right to litigate the issue in subsequent proceedings." *Brinkerhoff v. Schwendiman*, 790 P.2d 587, 589 (Utah Ct. App. 1990).

(j) Other Issues:

31. Petitioner raises other issues such as the presiding officer allegedly falsely assured him that there would be no decision by the Board on the issue of a "taking" and that the Board engaged in gender bias against him. However, Petitioner has not adequately briefed these issues, nor did he properly preserve them for agency review. *Brinkerhoff* at p. 589. Therefore, the Executive Director should decline to consider them.

**E. Propriety of Sanction**

32. Although the Division has broad discretion under Subsection 58-1-401 to determine the appropriate sanction against Petitioner's license for his violations of law, a

review of the mitigating factors indicates that a private reprimand with a requirement that Petitioner notify his employers of the reprimand is a more appropriate sanction in this case. The Beckstroms testified that Petitioner was a good nurse and that he took appropriate care of Ms. Mortensen; the only concern they had was that the morphine was not available for Ms. Mortensen if she later needed it. The Division found that Petitioner had no intention to injure Ms. Mortensen, and she was not in fact injured; she did not need the morphine that he kept and later destroyed. At all times, his intentions were to comply with the law and the standard of care for home health nurses, not to violate them. Furthermore, Petitioner has no record of any prior disciplinary actions during his many years as a licensed registered nurse. Therefore, it is recommended that the sanction of public reprimand be modified as set forth in these Findings of Fact, Conclusions of Law and Recommended Order.

**F. Petitioner's Submissions**

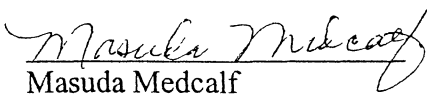
33. Throughout his memoranda, Counsel for Petitioner raises serious and improper charges of misconduct against the Division and the Board, including statements such as “they make stuff up as they go” and they think they are “above the law”. Petitioner also requests that sanctions and fines be imposed against the Division and the Board. Petitioner, however, has cited no provision of UAPA that would permit the Executive Director to impose such sanctions and fines. Furthermore, a review of the record in this case indicates no ill will or misconduct by the Division or the Board. What the record indicates is that the Division and the Board took actions they found necessary to protect the public, as they are required to do under the law. Utah Code Ann. § 13-1-1.

## RECOMMENDED ORDER

For the foregoing reasons, the decision of the Division of Occupational and Professional Licensing finding that Petitioner engaged in unprofessional and unlawful conduct should be affirmed.

However, the sanction of public reprimand should be modified to a private reprimand for unprofessional and unlawful conduct as established in this case. In addition, within 30 days of this Order on Review, Petitioner shall notify his current employer of the private reprimand, and thereafter any future employers until five years after this Order on Review. Respondent shall deliver controlled substances prescribed for his home health patients to the patients' home and shall maintain them there for administration to patients as may be warranted.

**DATED** this 30<sup>th</sup> day of July, 2004.

  
Masuda Medcalf  
Administrative Law Judge

---

BEFORE THE DEPARTMENT OF COMMERCE  
OF THE STATE OF UTAH

---



---

IN THE MATTER OF THE REQUEST	:	
FOR AGENCY REVIEW OF	:	
	:	<b>ORDER ON REVIEW</b>
<b>W. Scott Jepson</b>	:	
PETITIONER	:	DOPL

---

Because the parties have more than adequately briefed the issues in this case, pursuant to her discretion in Utah Code Ann. §63-46b-12(4) and Utah Admin. Code, R151-46b-12(6), the Executive Director of the Department of Commerce hereby denies Petitioner's request for oral argument.

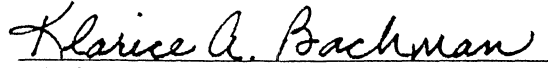
The Order Granting Stay previously issued in this matter is lifted.

The Findings of Fact, Conclusions of Law, and Recommended Order in this matter are ratified and adopted by the Executive Director. The decision of the Division of Occupational and Professional Licensing concluding that Petitioner engaged in unprofessional and unlawful conduct is hereby affirmed.

However, the Division's sanction of public reprimand is hereby modified to a private reprimand for unprofessional and unlawful conduct as established in this case. In addition, within 30 days of this Order on Review, Petitioner shall notify his current employer of the private reprimand, and thereafter any future employers until five years after this Order on Review. Respondent shall deliver controlled substances prescribed for

his home health patients to the patient's home and shall maintain them there for administration to the patient as may be warranted.

DATED this 30<sup>th</sup> day of July, 2004.

  
Klarice A. Bachman, Executive Director  
Department of Commerce

### NOTICE OF RIGHT TO APPEAL

Judicial Review of this Order may be obtained by filing a Petition for Review with the Court of Appeals within 30 days after the issuance of this Order on Review. Any Petition for Review must comply with the requirements of Sections 63-46b-14 and 63-46b-16, Utah Code Annotated. In the alternative, but not required in order to exhaust administrative remedies, reconsideration may be requested pursuant to *Bourgeois v. Department of Commerce, et al.*, 981 P.2d 414 (Utah App. 1999) within 20 days after the date of this Order on Review pursuant to Section 63-46b-13.

## CERTIFICATE OF MAILING

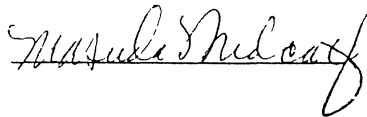
I certify that on the 3<sup>rd</sup> day of July, 2004, the undersigned mailed a true and correct copy of the foregoing Findings of Fact, Conclusions of Law and Order on Review by certified and first class mail, properly addressed, postage prepaid, to:

Arron F. Jepson  
10660 South 540 East  
Sandy UT 84070

and caused a copy to be hand-delivered to:

J. Craig Jackson, Director  
Division of Occupational and Professional Licensing  
160 East 300 South  
Salt Lake City, UT 84111

Karl Perry, Assistant Attorney General  
Office of the Attorney General  
160 East 300 South  
Salt Lake City, UT 84111

A handwritten signature in cursive script, appearing to read "Mark D. McCall", written over a horizontal line.