MICROFILM DIVIDER

OMB/RECORDS MANAGEMENT DIVISION
SFN 2053 (2/85) 5M

ROLL NUMBER

DESCRIPTION

1108

2007 HOUSE HUMAN SERVICES

HB 1108

2007 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB1108

House Human Services Committee

☐ Check here for Conference Committee

Hearing Date: 01/08/2007

Recorder Job Number: 722

Committee Clerk Signature Judy Bebeck

Minutes:

Representative Clara Sue Price called the hearing to order, the roll was taken, all were present.

HB1108 was opened with Representative Todd Porter, District 34 testifying in favor, for immunity for individuals using external defibrillators. When these first came out in the early 90's, they were meant for the first responders. With technology changes, training should be optional, because the machines now take care of step by step, and the machine will adjust. The current will flow in the right direction. See attached with the entire language. Section one should be taken out, but it is important to encourage people and employees to train. You can not put the machine on wrong, It senses this, and it will not do any harm. When using the machine an alarm goes off to notify first responders.

Dean Lampe, Executive Director of ND Emergency Medical Services Association: You have our support on a due pass for HB1108. See attached.

David Peske, works with N.D. Medical Association: We support the changes purposed here to HB 1108. there are several AED machines throughout the capital.

Jack McDonald I am here on behalf of the YMCA's of ND. We strongly support this bill. We have been using them for several years, and are trying to get them to all the YMCA's.

June Herman, with the American Heart Association. We support this bill and, the good Samaritan law.

Representative Price closing the hearing on HB 1108.

2007 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1108

House Human Services Committee

Check here for Conference Committee

Hearing Date: 01/08/2007

Recorder Job Number: 724

Committee Clerk Signature Judy Kelsch

Minutes:

Chairman Price: Opening HB 1108 for discussion. A motion was made by Representative Weisz for a do pass, and seconded by Representative Conrad. Roll was taken with 12 yeas, 0 nays and 0 absent. Representative Hatlestad offered to carry it to the floor.

Date: 1/8/07
Roll Call Vote #: 12

2007 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. "Click here to type Bill/Resolution No."

House HUMAN SERVICES - HB. 1108 Committee

☒ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken Do Pass

Motion Made By Rep Robin Weisz Seconded By Rep. Kari L. Conrad

Representatives	Yes	No	Representatives	Yes	No
Clara Sue Price – Chairman	✓		Kari L Conrad	✓	
Vonnie Pietsch – Vice Chairman	✓		Lee Kaldor	✓	
Chuck Damschen	✓		Louise Potter	✓	
Patrick R. Hatlestad	✓		Jasper Schneider	✓	
Curt Hofstad	✓				
Todd Porter	✓				
Gerry Uglem	✓				
Robin Weisz	✓				

Total (Yes) 12 No "Click here to type No Vote"

Absent 0

Floor Assignment Reps. Patrick R. Hatlestad

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1108: Human Services Committee (Rep. Price, Chairman) recommends **DO PASS** (12 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). HB 1108 was placed on the Eleventh order on the calendar.

2007 SENATE HUMAN SERVICES

HB 1108

2007 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1108

Senate Human Services Committee

☐ Check here for Conference Committee

Hearing Date: 2-27-07

Recorder Job Number: 3946, 4025

Committee Clerk Signature Mary K Monson

Minutes:

Chairman Senator J. Lee opened the hearing on HB 1108 relating to immunity from civil liability for persons using automated external defibrillators.

Senator J. Lee referred the committee to favorable testimony from Dean Lampe (EMS) who was unable to be present. (Attachment #1)

Representative Todd Porter (District #34) introduced HB 1108 and explained that it was cleanup language that follows the bill that was passed in 1999 regarding automatic external defibrillators and the requirements for placement. He provided for the committee the entire portion of the Century Code. (Attachment #2)

He explained that in 1999, in order to get the immunity that was provided in the bill, they had it tied to a number of things in subsection 1. As times have moved forward the defibrillators have become more automatic and there are less and less requirements.

The two specific pieces are the input from a physician and the location of placement of the machine.

Senator Dever asked if there was going to be training for the new defibrillators in the chambers.

Rep. Porter said it was his understanding that when the EMS donated them they were setting up a training seminar for all of the front desk staff and the Sergeant at Arms in both chambers. He said the beauty of the machines and technology as it has moved forward is that they take less and less training to operate and he gave examples.

June Herman (American Health Association) testified in support of HB 1108. She said they collaborated with Rep. Porter on this piece of legislation. It maintains the strong element of training and the oversight of AED's in the state but it basically delinks the Good Samaritan. What they really want to avoid with today's devices is that there is not a worksite that is hesitant to put one out there. They want the placement of the devices and they want to continue to encourage the training and the oversight that goes with the program.

Dave Peske (ND Medical Association) said they were involved in developing this legislation and they support it.

Caitlin McDonald (YMCA and State Association of Non Public Schools) testified that they strongly support this bill.

Senator Dever asked how many of her facilities have AED's

Ms. McDonald replied that all YMCA's had AED's available. There are 82 non public schools and she wasn't sure of the numbers.

There was no opposing or neutral testimony.

The hearing on HB 1108 was closed.

JOB #4025

Senator J. Lee opened HB 1108 and reviewed the morning's testimony for Senator Erbele.

Senator Heckaman moved a Do Pass on HB 1108.

The motion was seconded by Senator Warner.

Roll call vote 6-0-0. Motion passed. Carrier is Senator Dever.

Date: 2-27-07

Roll Call Vote #: 1

2007 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. HB 1108

Senate **HUMAN SERVICES** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken Do Pass

Motion Made By Sen. Heckaman Seconded By Sen. Warner

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee, Chairman	✓		Senator Joan Heckaman	✓	
Senator Robert Erbele, V. Chair	✓		Senator Jim Pomeroy	✓	
Senator Dick Dever	✓		Senator John M. Warner	✓	

Total (Yes) 6 No 0

Absent 0

Floor Assignment Senator Dever

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1108: Human Services Committee (Sen. J. Lee, Chairman) recommends **DO PASS** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). HB 1108 was placed on the Fourteenth order on the calendar.

2007 TESTIMONY

HB 1108

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Executive Offices
1622 E. Interstate Ave.
Bismarck, ND 58503

(701) 221-0567 Voice
(701) 221-0693 Fax
(877) 221-3672 Toll Free
www.ndemsa.org

HB 1108

January 8, 2007

North Dakota EMS Association
Testimony – House Human Services Committee

Good morning, Chairman Price and members of the committee. My name is Dean Lampe, and I am the Executive Director of the North Dakota Emergency Medical Services (EMS) Association. Thank you for the opportunity to testify in support of Representative Porter's bill.

This bill regarding providing immunity from civil liability for persons using AEDs affects EMS in two ways. First, EMS is involved in the ambulance call that most always occurs in the vast majority of instances when AEDs are used. Second, the, "person who provides the training" under NDCC 32-03.1 is also most often a North Dakota Department of Health licensed EMT and licensed EMS Instructor.

This committee would expect and has the EMS Association's support of the placement and use of AEDs and we welcome this amended language which improves civil immunity to the licensed physician, the person providing training on the device, and the responsible person at the site where the AED is located. Of course, these individuals may not be at the actual occurrence when the use of an AED is required; and, as such, it makes perfect sense to us to protect them further by removing conditions for placement and use of the device which, over time, they may have no control.

The North Dakota EMS Association respectfully requests this committee's support of HB 1108.

or gross negligence. For purposes of this section, "voluntary" is defined as without receiving remuneration of any sort. "Free clinic" is defined as a clinic that is established to provide primary health care to persons who are otherwise unable to obtain medical services due to their lack of access to health insurance or medical assistance.

32-03.1-02.3. Automated external defibrillators - Requirements.

1. Except for a medical services facility or prehospital emergency medical services provider, every person who acquires an automated external defibrillator shall:

   a. Require every individual expected to use the automated external defibrillator to receive American heart association or American red cross training in cardiopulmonary resuscitation and automated external defibrillator use or an equivalent nationally recognized course in cardiopulmonary resuscitation and automated external defibrillator use.

   b. Maintain and test the automated external defibrillator according to the manufacturer's operational guidelines.

   c. Establish an automated external defibrillator use protocol that provides any person who provides emergency care or treatment to an individual in cardiac arrest by using the automated external defibrillator shall contact as soon as possible an appropriate health care provider or emergency medical services provider.

   d. Consider recommendations of a licensed physician in establishing the training, notification, and maintenance requirements of this subsection.

2. Any person who in good faith and without compensation provides emergency care or emergency treatment by using an automated external defibrillator is immune from civil liability for any personal injury resulting from the emergency care or emergency treatment and for any act or failure to act in providing or arranging further medical treatment if the person providing the emergency care or emergency treatment acted as an ordinary, reasonable, prudent person would act under the same or similar circumstances. This subsection does not apply if a personal injury results from the gross negligence or from the willful or wanton misconduct of the person providing the emergency care or emergency treatment.

3. If the requirements of subsection 1 are met, the immunity provision of subsection 2 applies to a licensed physician under subdivision d of subsection 1, the person who provides the training under subdivision a of subsection 1, and the person responsible for the site on which the automated external defibrillator is located.

4. This section does not limit civil liability protection provided by any other law.

32-03.1-03. Criminal immunity. No person who renders aid or assistance necessary or helpful in the circumstances to other persons who have been injured or are ill as the result of an accident or sudden illness, or any mechanical, external or organic trauma, may be criminally charged in this state for having practiced medicine or nursing without a license, provided that the aider shall relinquish direction of the care of the injured person when an appropriate person licensed or certified by this state or by any state or province to provide medical care or assistance assumes responsibility for the care of the injured person.

32-03.1-04. Physicians or surgeons. Nothing in this chapter may be construed to deprive any physician or surgeon licensed in this state of the right to collect reasonable fees for any acts of aid, assistance or treatment; or any other person rendering aid or assistance under this chapter, or those whose property is necessarily damaged in the course of such aid or assistance under this chapter, of the right to reimbursement, from the injured or ill person or that person's estate for any expenses or damages which appeared reasonable and necessary to

AED
RISK INSIGHTS™

The Current State of U.S. AED Laws: Risk and Uncertainty for Community-Based AED Programs

By: Richard A. Lazar
President and CEO, AED Risk Insights, Inc.

Published March 2006,

Introduction

Between the mid-1990s and 2000, the federal government, nearly every state, the District of Columbia, and a number of localities enacted automated external defibrillator (AED)-related Good Samaritan immunity laws in many different forms. The structure, content, complexity, and scope of coverage of these laws vary widely. The level of legislative activity in this area continues to escalate at a robust pace. As of this writing, the AED Law Center is tracking over 40 AED-related bills winding their way through state legislatures.

The public policy goals of AED laws are not well-articulated in the statutes themselves or in the current literature about AED public policy. It is generally understood that these laws are ostensibly intended to reduce legal liability risks facing organizations deploying and lay-bystanders using AEDs in public settings. It is widely perceived, and often stated in published materials, that the existing universe of AED Good Samaritan laws offers broad liability protection to all AED program participants. Unfortunately, this is not true.

In conjunction with the launch of the AED Law Center, AED Risk Insights conducted the most comprehensive review of federal, state, and local AED laws yet undertaken. An overview of our findings is provided below. First, we present selected aggregate highlights of the current condition of AED laws in the United States. Second, we present an AED Law Report Card assessing the quality of AED laws for each state and the District of Columbia. Specific details about each state, the District of Columbia, as well as federal and local laws, can be found in the AED Law Center.

Our findings confirm that the current state of the law is troublesome at best and counterproductive at worst. Broad changes in legislative philosophy and approach are needed if Good Samaritan immunity is truly to be used as a tool to promote the public health goal of widespread community-based AED deployment. Specifically, we believe the following objectives must be achieved before AED public policy can truly drive and support public access defibrillation public health goals:

- Simplify state AED laws by removing operational burdens imposed on AED program participants as conditions of immunity.
- State laws, to the extent they continue to serve as the primary source of AED Good Samaritan immunity, should preempt local laws in order to eliminate legislative conflicts and fragmentation that are now emerging.
- Pursue a federal AED Good Samaritan law that preempts state laws in order to create uniformity and consistency throughout the United States.
- Address AED program design, administration, and operational components through external standards rather than embedding these types of requirements in AED immunity laws.

We expect to publish more detailed information about our findings in the near future. We hope this information will, for the first time, provide policy makers and thought leaders with the data necessary to better structure AED immunity laws in ways that meaningfully protect all AED program participants and truly promote widespread AED deployment. This, in turn, will ultimately lead to increased sudden cardiac arrest survival rates.

Selected U.S. AED Law Highlights as of March 2006

Our research reveals a worrisome state of existing AED laws in the U.S. One of our most important findings is that, in stark contrast to widespread perceptions, **AED Good Samaritan laws do not protect everyone.** This disturbing conclusion is highlighted in the following statistics:

49% of states do not offer immunity protection to untrained AED users

Despite the growing presence of AEDs in public settings and the advances in AED-guided instructions for lay-users, 25 states fail to offer immunity protection to untrained AED users.

24% of states technically do not offer immunity protection to anyone — rather, they offer only placebo immunity

Though they possess so-called AED Good Samaritan immunity laws, at least 12 states fail to offer immunity protection to anyone. This is because these laws incorporate language that protects only reasonable, non-negligent conduct. Conduct amounting to ordinary negligence — expected to be included within meaningful Good Samaritan laws — is not protected.

20% of states do not offer immunity protection to AED acquires or those responsible for AED program sites

As illogical as it seems, 10 states fail to offer immunity protection to those responsible for purchasing and deploying AEDs in public settings.

One state does not offer any immunity protection to trained AED users

Surprisingly, one state fails to offer immunity protection to trained AED users though AED acquirers, trainers, and physicians are offered protection.

AED Law Report Card Overview

The following 2006 AED Law Report Card assesses key AED law characteristics. Overall, AED laws are evaluated in relation to important public health and public policy considerations. AED Risk Insights believes the primary objective of AED laws is to promote the public health goal of widespread public access AED deployment. Doing so requires offering meaningful Good Samaritan immunity protection to all AED program participants in a manner that imposes minimal and only realistically supportable operational burdens on AED programs.

Many organizations today are reluctant to deploy AEDs because of legal liability risks. We therefore evaluate AED laws based on whether or not, in our judgment, they are structured to help mitigate liability risks in ways designed to encourage more organizations to implement AED programs. Structurally, AED laws generally fall on a continuum between the following two diverse approaches:

- Highly controlling medical model: Laws favoring this approach generally contain burdensome operational requirements that are often difficult to understand, difficult to comply with, and typically not well-suited to public access AED response systems; and
- Open access "any-willing-rescuer" model: Laws favoring this approach generally contain fewer operational conditions, are easier to understand, and are easier to comply with.

In their current form, most AED laws incorporate AED program design and operational components as conditions of immunity. This occurs despite the fact that no published standards exist defining a "reasonable" AED program. This is an issue currently left for courts to consider on an ad hoc basis. Yet, requirements embedded within AED laws impose mandatory "standards" and operational burdens on every AED program site regardless of size, scope, or unique characteristics. This unusual mix of often conflicting legislation, and the unrealistic one-size-fits-all approach creates significant risk that AED law requirements will be viewed as establishing a "standard of care."

The inherent and growing risk of the current approach is that immunity protection will be lost because an organization is unable to understand what constitutes compliance, and thus fails to fully act in accordance with with an AED law's terms. We believe the better approach is to simplify AED Good Samaritan laws by removing operational requirements and to address AED program issues through external standards or guidelines not embedded within AED laws themselves.

It is clear from our review that efforts to use AED immunity laws as a tool to design AED programs has led to significantly increased confusion and legal liability risk. Current laws vary in all 50 states, meaning in effect that program design standards vary in all 50 states. Adding further to this confusion is the growing number of local laws that potentially conflict with state requirements. This AED law quagmire often makes it difficult for organizations potentially interested in deploying AEDs to say "yes" since "yes" frequently means increased confusion, burdens, and risk. The current state of U.S. AED laws also creates a situation in which it is nearly impossible for willing bystanders to know whether they have Good Samaritan immunity protection, and thus whether they should or should not retrieve and use a publicly placed AED.

Structure and clarity of AED laws were key evaluation factors in our assessment and grading process. Because we believe AED laws favoring a highly controlling medical model act as a barrier to AED deployment, and actually increase rather than decrease liability risks facing AED programs, we grade these types of laws lower than those favoring an open access model. In our view, the best approach is to simplify AED Good Samaritan laws to offer broad protection to all AED program participants. Any conditions associated with immunity should be very limited in scope, easy to understand, and easy to comply with. The AED Report Card assessment presented below reflects this view.

Organizations are generally expected to comply with the meaning and intent of AED laws regardless of their rated quality or the underlying merits of their provisions. The AED Law Report Card is offered to help organizations better understand the relative quality of applicable AED laws of the states in which they do business, and to help them balance compliance requirements with reasonable AED program design considerations.

AED Law Report Card Grading Criteria

These summary grades for each state and the District of Columbia were based on core grades for four important AED law characteristics as outlined below:

— Understandability of AED-related laws

This rating grades whether the laws, as a whole, are written and organized in a way that makes them easy or difficult to comprehend and follow. Laws that are difficult to comprehend are graded lower than those that are easy to understand.

— Scope and complexity of operational burdens

This rating grades the scope of operational burdens placed on AED program participants and overall complexity from a compliance perspective. It considers the number and types of legal and operational requirements included, the scope of AED program participants upon whom operational burdens are placed, and the time and cost burdens of compliance. Laws that are more burdensome are graded lower than those that are less burdensome.

AED RISK INSIGHTS™ **AED LAW REPORT CARD™**

2006 GRADE ASSESSMENT BY STATE

State	Grade	State	Grade
Alabama	D	Nebraska	F
Alaska	B	Nevada	F
Arizona	F	New Hampshire	B
Arkansas	F	New Jersey	D
California	F	New Mexico	F
Colorado	C	New York	F
Connecticut	F	North Carolina	B
Delaware	F	North Dakota	D
Florida	C	Ohio	D
Georgia	C	Oklahoma	F
Hawaii	F	Oregon	B
Idaho	F	Pennsylvania	F
Illinois	F	Rhode Island	F
Indiana	C	South Carolina	C
Iowa	D	South Dakota	F
Kansas	F	Tennessee	F
Kentucky	F	Texas	C
Louisiana	B	Utah	F
Maine	F	Vermont	F
Maryland	F	Virginia	D
Massachusetts	F	Washington	C
Michigan	A	West Virginia	F
Minnesota	C	Wisconsin	F
Mississippi	D	Wyoming	F
Missouri	F		
Montana	F	District of Columbia	F

— Scope of persons offered Good Samaritan protection

This rating grades the breadth of AED program participant classes offered Good Samaritan immunity protection. It considers whether AED acquirers, site managers, users, trainers, program physicians, and/or others are included as potentially protected classes. Laws that fail to protect untrained AED users automatically receive an overall grade of "F" regardless of other aspects of the law.

— Types of conduct offered Good Samaritan protection

This rating grades the scope of coverage offered to AED program participants. It considers whether, at a minimum, reasonable conduct and ordinary negligence are protected or whether the law fails to offer immunity at all (i.e., only placebo or non-existent coverage) by protecting only reasonable, non-negligent conduct (no protection for ordinary negligence). Laws that fail to protect at least ordinary negligence automatically receive an overall grade of "F" regardless of other aspects of the law.

Detailed AED Law Report Cards for each state and the District of Columbia are available in the AED Law Center (www.AEDRiskInsights.com).

Next Steps for Progress in 2006 and Beyond

In contrast to their perceived purpose, most existing U.S. AED laws actually create confusion and liability risk rather than establishing meaningful protection. AED legislation can and should be used as a tool to promote widespread AED deployment and use. This objective can only be achieved, however, if the current approach to AED public policy is radically altered. Creating AED laws that serve as a true safety net, permit and empower large-scale AED deployment, and encourage all willing persons to act as citizen AED responders will go a long way toward increasing the chances of survival for sudden cardiac arrest victims.

LEGAL NOTICE

Publisher
AED Risk Insights, Inc.
www.AEDRiskInsights.com
Email: info@aedriskinsights.com
Phone: (888) 200-9667

#1

Executive Offices
622 E. Interstate Ave.
Bismarck, ND 58503

(701) 221-0567 Voice
(701) 221-0693 Fax
(877) 221-3672 Toll Free
www.ndemsa.org

HB 1108

February 27, 2007

North Dakota EMS Association
Testimony – Senate Human Services Committee

Good morning, Chairman Lee and members of the committee. My name is Dean Lampe, and I am the Executive Director of the North Dakota Emergency Medical Services (EMS) Association. Thank you for the opportunity to testify in support of Representative Porter's bill.

This bill regarding providing immunity from civil liability for persons using AEDs affects EMS in two ways. First, EMS is involved in the ambulance call that most always occurs in the vast majority of instances when AEDs are used. Second, the, "person who provides the training" under NDCC 32-03.1 is also most often a North Dakota Department of Health licensed EMT and licensed EMS Instructor.

This committee would expect and has the EMS Association's support of the placement and use of AEDs, and we welcome this amended language which improves civil immunity to the licensed physician, the person providing training on the device, and the responsible person at the site where the AED is located. Of course, these individuals may not be at the actual occurrence when the use of an AED is required; and, as such, it makes perfect sense to us to protect them further by removing conditions for placement and use of the device which, over time, they may have no control.

The North Dakota EMS Association respectfully requests this committee's support of HB 1108.

or gross negligence. For purposes of this section, "voluntary" is defined as without receiving remuneration of any sort. "Free clinic" is defined as a clinic that is established to provide primary health care to persons who are otherwise unable to obtain medical services due to their lack of access to health insurance or medical assistance.

32-03.1-02.3. Automated external defibrillators - Requirements.

1. Except for a medical services facility or prehospital emergency medical services provider, every person who acquires an automated external defibrillator shall:

   a. Require every individual expected to use the automated external defibrillator to receive American heart association or American red cross training in cardiopulmonary resuscitation and automated external defibrillator use or an equivalent nationally recognized course in cardiopulmonary resuscitation and automated external defibrillator use.

   b. Maintain and test the automated external defibrillator according to the manufacturer's operational guidelines.

   c. Establish an automated external defibrillator use protocol that provides any person who provides emergency care or treatment to an individual in cardiac arrest by using the automated external defibrillator shall contact as soon as possible an appropriate health care provider or emergency medical services provider.

   d. Consider recommendations of a licensed physician in establishing the training, notification, and maintenance requirements of this subsection.

2. Any person who in good faith and without compensation provides emergency care or emergency treatment by using an automated external defibrillator is immune from civil liability for any personal injury resulting from the emergency care or emergency treatment and for any act or failure to act in providing or arranging further medical treatment if the person providing the emergency care or emergency treatment acted as an ordinary, reasonable, prudent person would act under the same or similar circumstances. This subsection does not apply if a personal injury results from the gross negligence or from the willful or wanton misconduct of the person providing the emergency care or emergency treatment.

3. If the requirements of subsection 1 are met, the immunity provision of subsection 2 applies to a licensed physician under subdivision d of subsection 1, the person who provides the training under subdivision a of subsection 1, and the person responsible for the site on which the automated external defibrillator is located.

4. This section does not limit civil liability protection provided by any other law.

32-03.1-03. Criminal immunity. No person who renders aid or assistance necessary or helpful in the circumstances to other persons who have been injured or are ill as the result of an accident or sudden illness, or any mechanical, external or organic trauma, may be criminally charged in this state for having practiced medicine or nursing without a license, provided that the aider shall relinquish direction of the care of the injured person when an appropriate person licensed or certified by this state or by any state or province to provide medical care or assistance assumes responsibility for the care of the injured person.

32-03.1-04. Physicians or surgeons. Nothing in this chapter may be construed to deprive any physician or surgeon licensed in this state of the right to collect reasonable fees for any acts of aid, assistance or treatment; or any other person rendering aid or assistance under this chapter, or those whose property is necessarily damaged in the course of such aid or assistance under this chapter, of the right to reimbursement, from the injured or ill person or that person's estate for any expenses or damages which appeared reasonable and necessary to