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S.C. SUPREME COURT

THE STATE OF SOUTH CAROLINA
In the Supreme Court

ON WRIT OF CERTIORARI TO THE SOUTH CAROLINA COURT OF APPEALS

Appellate Case No. 2021-001290

South Carolina Department of Health and
Environmental Control,. . . . . Respondent,

v.

James W. Davenport,. . . . . Petitioner.

APPENDIX–VOLUME 2 of 4

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INDEX TO APPENDIX

Volume 1

Record on Appeal (Volume 1 of 4). A0001

Volume 2

Record on Appeal (Volume 2 of 4). A0507

Volume 3

Record on Appeal (Volume 3 of 4). A1014

Volume 4

Record on Appeal (Volume 4 of 4). A1521

Record on Appeal (Redacted Audio and Video Recordings)

DHEC Ex. 2–Iva P.D. Body-cam footage. . . . . [separate electronic file]

DHEC Ex. 3–Medic 61 call to AnMed ED. . . . . [separate electronic file]

DHEC Ex. 9–Davenport interview with DHEC. . . . . [separate electronic file]

Final Brief of Appellant-Respondent.. . . . . A1756

Final Brief of Respondent-Appellant on Primary Appeal. A1793

Final Reply Brief of Appellant-Respondent. A1821

Final Brief of Respondent-Appellant on Cross Appeal.. . . . . A1838

Final Brief of Appellant-Respondent.. . . . . A1854

Final Reply Brief of Respondent-Appellant on Cross Appeal.. . . . . A1869

Supplemental Brief of Appellant-Respondent.. . . . . A1885

Supplemental Brief of Respondent-Appellant.. . . . . A1893

Court of Appeals Unpublished Decision No. 2021-UP-273. . . . . A1903

Respondent-Appellant's Petition for Rehearing and Suggestion for Rehearing En Banc. A1907

Order Denying Petition for Rehearing. A1911

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT
Shirley C. Robinson, Administrative Law Judge

Appellate Case No. 2018-001868
Case No. 18-ALJ-07-0003-CC

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SC Court of Appeals

South Carolina Department of Health
and Environmental Control,.....Appellant/Respondent,

v.

James W. Davenport,.....Respondent/Appellant.

RECORD ON APPEAL
VOLUME 2 OF 4

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INDEX
VOLUME 1 of 4

Motions & Orders

ALC's Final Decision and Order issue March 20, 2018 1-12

Davenport's Petition for Attorneys Fees & Court Costs dated March 21, 2018 13-37

DHEC's Memorandum in Opposition to Davenport's Petition for Attorney's Fees & Court Costs filed April 5, 2018 38-49

Davenport Reply Brief in Support of Petition for Attorney Fees & Court Costs dated April 16, 2018 50-70

ALC's Order Granting Respondent's Petition for Attorney's Fees issued August 1, 2018 .. 71-79

DHEC's Motion to Alter or Amend (Reconsider) Order Granting Petition for Attorney's Fees filed August 13, 2018 80-106

Davenport's Memorandum of Law in Opposition to Petitioners Motion for Reconsideration of Attorney Fee Order dated August 27, 2018 107-116

ALC's Order on Petitioner's Motion to Alter or Amend issued September 20, 2018 117-119

Decisions

DHEC's Administrative Order issued October 21, 2016 120-129

DHEC Board's Notice Declining Final Review Conference dated December 7, 2016.....130-131

Pleadings & Briefs

Davenport's Request for Contested Case Hearing dated January 6, 2017 132-144

Transcripts

Deposition Designations of Scott Jay Stoller taken June 8, 2017 (admitted post-trial per Court instructions, see R., pp. 1234 and 1516-1517).....145-158

Trial Transcript, July 24, 2017 159-350

Kimberly Aiken direct examination by Mr. Wicevic 179-242

Kimberly Aiken cross examination by Mr. Rothstein 242-263

Kimberly Aiken redirect examination by Mr. Wicevic 263-266

James Davenport cross examination by Mr. Wicevic 266-350
Trial Transcript, July 25, 2017 351-500
Wayne Keith Eudy direct examination by Mr. Wicevic 353-370
Wayne Keith Eudy cross examination Mr. Rothstein 370-406
Wayne Keith Eudy redirect examination by Mr. Wicevic 406-419
Dr. Thomas Kickham direct examination by Mr. Wicevic 419-480
Dr. Thomas Kickham cross examination by Mr. Rothstein 480-500

INDEX
VOLUME 2 of 4

Trial Transcript, July 25, 2017, continued 501-578
Dr. Thomas Kickham cross examination by Mr. Rothstein, continued 501-568
Dr. Thomas Kickham redirect examination by Mr. Wicevic 568-575
Dr. Thomas Kickham recross examination by Mr. Rothstein 575-578
Trial Transcript, July 26, 2017 579-906
Dr. Frank DeAngelo direct examination by Mr. Rothstein 584-594
Dr. Frank DeAngelo voire dire by Mr. Wicevic 594-600
Dr. Frank DeAngelo direct examination by Mr. Rothstein, continued 600-619
Dr. Frank DeAngelo cross examination by Mr. Wicevic 619-653
Dr. Frank DeAngelo redirect examination by Mr. Rothstein 653-659
Harry Dean Douglas direct examination by Mr. Wicevic 660-678
Harry Dean Douglas voire dire by Mr. Rothstein 678-682
Harry Dean Douglas direct examination by Mr. Wicevic, continued 682-716
Harry Dean Douglas cross examination by Mr. Rothstein 716-793
Harry Dean Douglas redirect examination by Mr. Wicevic 793-794
Dr. Edgar DesChamps direct examination by Mr. Wicevic 794-804
Dr. Edgar DesChamps voire dire by Mr. Rothstein 804-809
Dr. Edgar DesChamps direct examination by Mr. Wicevic, continued 809-838
Dr. Edgar DesChamps cross examination by Mr. Rothstein 838-899

Dr. Edgar DesChamps redirect examination by Mr. Wicevic 899-903
Dr. Edgar DesChamps recross examination by Mr. Rothstein 903-906
Trial Transcript, July 27, 2017 907-1001
Robert Wronski direct examination by Mr. Wicevic 910-973
Robert Wronski cross examination by Mr. Rothstein 973-1001

INDEX
VOLUME 3 of 4

Trial Transcript, July 27, 2017, continued 1002-1226
Robert Wronski cross examination by Mr. Rothstein, continued 1002-1080
Robert Wronski redirect examination by Mr. Wicevic 1080-1092
Leo Deason direct examination by Mr. Rothstein 1125-1129
Leo Deason voire dire by Mr. Wicevic 1129-1143
Leo Deason direct examination by Mr. Rothstein, continued 1143-1171
Leo Deason cross examination by Mr. Wicevic 1171-1209
Leo Deason redirect examination by Mr. Rothstein 1209-1210
First Sergeant Derrick Crus direct examination by Mr. Rothstein 1210-1225
First Sergeant Derrick Crus cross examination by Mr. Wicevic 1225-1225
Trial Transcript, July 28, 2017 1227-1502
Richard Naugler direct examination by Mr. Rothstein 1234-1285
Richard Naugler cross examination by Mr. Wicevic 1285-1287
Dr. Arnold Alier direct examination by Mr. Rothstein 1287-1344
Dr. Arnold Alier cross examination by Mr. Wicevic 1344-1355
Dr. Arnold Alier redirect examination by Mr. Rothstein 1355-1359
Sheila Kaiser direct examination by Mr. Rothstein 1360-1388
Sheila Kaiser cross examination by Mr. Wicevic 1388-1394
Sheila Kaiser redirect examination by Mr. Rothstein 1394-1395
James Davenport direct examination by Mr. Rothstein 1396-1484
James Davenport recross examination by Mr. Wicevic 1484-1494

INDEX
VOLUME 4 of 4

Trial Transcript, July 28, 2017, continued 1503-1517

Transcript of Motion Hearing on June 13, 2018 (Motion for Attorney's Fees) 1518-1569

Exhibits

Petitioner DHEC Trial Ex 1 (pp. 1-7, 14-16, 27, 31, 42-43, 65, 89-90, 93-96, 105, 125, 133-134, and 138-139) 1570-1596

Petitioner DHEC Trial Ex 2 (video file) 1597

Petitioner DHEC Trial Ex 3 (audio file) 1598

Petitioner DHEC Trial Ex 4 1599

Petitioner DHEC Trial Ex 6 1600-1610

Petitioner DHEC Trial Ex 7 1611-1612

Petitioner DHEC Trial Ex 9 (audio file) 1613

Petitioner DHEC Trial Ex 10 1614-1615

Petitioner DHEC Trial Ex 11b 1616-1621

Petitioner DHEC Trial Ex 16 1622

Petitioner DHEC Trial Ex 17 1623

Petitioner DHEC Trial Ex 19 1624

Petitioner DHEC Trial Ex 20 1625

Petitioner DHEC Trial Ex 21 1626

Petitioner DHEC Trial Ex 22 1627

Petitioner DHEC Trial Ex 23 1628

Petitioner DHEC Trial Ex 24 1629

Petitioner DHEC Trial Ex 25 1630

Respondent Davenport Trial Ex 2 (proffered but not admitted, see R. p.1495) 1631-1640

Respondent Davenport Trial Ex 3 1641

Respondent Davenport Trial Ex 4 1642

Respondent Davenport Trial Ex 5 1643
Respondent Davenport Trial Ex 8a 1644
Respondent Davenport Trial Ex 10 1645
Respondent Davenport Trial Ex 12 1646-1648
Respondent Davenport Trial Ex 14 1649
Respondent Davenport Trial Ex 15 1650-1676
Respondent Davenport Trial Ex 16 1677-1688
Respondent Davenport Trial Ex 21 1689-1693
Respondent Davenport Trial Ex 22 1694-1698
Respondent Davenport Trial Ex 25 1699-1722
Respondent Davenport Trial Ex 26 (not admitted) 1723
Respondent Davenport Trial Ex 27 1724
Respondent Davenport Trial Ex 28 1725
Respondent Davenport Trial Ex 29 1726-1727

Other Materials or Documents

Letter from D. Rothstein to Hon. Shirley C Robinson dated June 25, 2018 1728-1729

Certificate of Appellant 1730

iphone?
A: Correct.
Q: Okay. I don't have a new iphone with me, but is the iphone bigger or smaller than this pamphlet?
A: It's probably about the colored part of that pamphlet.
Q: So you think the screen of the iphone is about the colored part of this pamphlet?
A: Yeah. He had one of those big ones.
Q: I'm going to ask you to measure the diagonal of the colored part of that pamphlet.
A: Okay. Seven and a quarter, seven and a half.
Q: Okay. So you think the screen on the iphone is about, it was at least approximately that size, seven and a half, seven and a quarter inches?
A: Approximately.
Q: Okay. Could have been a little smaller than that?
A: Could have been.
Q: Okay. Do you have the new iphone by any chance?
A: No. I got the antique model.
Q: And, you know, I'm getting older. I just got bifocals about two years ago, but I noticed

that during the deposition you had some trouble reading some of the print on some of the reduced stock. Do you agree with that?

A: Yes, sir.

Q: How many times did you look at that video on that screen that was on the new iphone, on Mr. Stoller's iphone.

A: Once, maybe twice. I'm not sure. I think we might have looked at it twice.

Q: Where were you physically located when you were viewing the video?

A: We were in the back of the Emergency Department. There's an area that sometimes doesn't have any patients in it.

Q: Okay. Was there ambient noise around where you were?

A: I don't think -- at the time there wasn't a lot of patients back there. I don't think there was any patients back there. It might have been a staff member or two. I don't recall.

Q: Okay. Have you ever seen the video on a big screen before?

A: During the deposition we watched it on a computer screen I believe.

Q: And I understand that after you saw the video,

you never had any discussions with Mr. Davenport about what you saw in the video, is that correct?

A: Correct.

Q: Okay. You never initiated any type of disciplinary action against Mr. Davenport?

A: No. After I saw the video, then we agreed to send it on to DHEC and let them deal with it.

Q: And that was Mr. Stoller's idea. He said, I'm going to send this onto DHEC. What do you think of that?

A: Yes, sir.

Q: Okay. And you said, fine with me. Right?

A: Yes, sir.

Q: Now, part of these policies and procedure manual or the protocol manual that's Exhibit 1, if you'll pull that out again. Part of that contains what are called clinical policies. Do you recall we talked about those in your deposition?

A: Yes, sir.

Q: And if you'll turn to page, it's Bates page 122.

A: Hospital diversion policy? Is that page 122?

Q: I'm sorry. 112. I misspoke. It's policy 22

on page 112.
A: Disciplinary policy?
Q: Yes. That's policy 22, right?
A: Yes, sir.
Q: And, do you recognize this as the disciplinary policy that would have been in effect at the time you met with Mr. Davenport and then later saw the video at the hospital?
A: Yes, sir.
Q: And if you'll look down, the last sentence under the paragraph that says policy, it states, if in the opinion of the Anderson County EMS medical Director, and that's you, correct?
A: Yes, sir.
Q: Okay. An action for failure to act on the part of the pre-hospital care provider is of such nature that the action or failure to act is inconsistent with or in violation of these procedures or the practiced standards -- I'm sorry, practice standard generally accepted in the medical community, the actions described below shall occur. Did I read that correctly?
A: Yes, sir.
Q: Now that word shall, is that equivalent to an

order? I mean that's a mandatory ---

MR. WICEVIC: Your Honor ---

Q: --- term, isn't it?

MR. WICEVIC: --- I'm going to object. We've spoke at this regarding this relevance issue at length. Compliance with these disciplinary polices are local, it's for Anderson County. It's not significant to your decision, it's not important for the Department to know whether or not they complied with this particular disciplinary policy. It does not relate to the facts at issue in this matter. So I'd ask that Mr. Rothstein be directed not to ask questions concerning compliance with these disciplinary policies.

THE COURT: Mr. Wicevic, I'm going to disagree. It's relevant to me, so I'm going to allow the question.

Q: And just for clarification, Dr. Kickham, that document we're looking at is in the same protocol book that we've been talking about this whole hearing. Isn't that right?

A: Yes, sir.

Q: Okay. Did you follow the disciplinary procedure set forth in this policy 22 with

regard to Mr. Davenport?
A: I'd have to read through this, but I don't think we followed it word for word. No, sir.
Q: In fact this kind of lays out the due process that employees, either paramedics or EMT's within the Anderson EMS umbrella are entitled to when they're accused of some type of disciplinary infraction. Isn't that right? Or practice below the standard of care.
A: Yes, sir.
Q: And the employee in question is supposed to be given an written explanation of the violations, isn't that right? Read procedure number one.
A: Under number one it says pre-hospital care provider will be notified in writing of the issues concern -- yes, sir.
Q: Okay. And you can follow. I'll read it again because I don't know if the Judge picked up on that. Procedure number one, the pre-hospital care provider, and that term includes paramedics and EMT's, right?
A: Correct.
Q: The pre-hospital provider will be notified in writing of the issues, concerns that merit attention by the Anderson County EMS Medical

Director, correct?
A: Correct.
Q: Okay. So that would require Mr. Davenport to have been notified of the specific patient issues that you and or Mr. Stoller had with regard to his care, is that right?
A: Correct.
Q: Okay. And you never notified him specifically, even what patient encounters you all were investigating, did you?
A: We did not notify him in writing. We did it verbally.
Q: So that was a violation of this procedure, right?
A: Correct.
Q: All right. And then later in that item number one, it gives you the authority to immediately suspend a employee pending further investigation, right?
A: Correct.
Q: Okay. And then you're supposed to provide written notice to the employee within three working days of the suspension, correct?
A: Correct.
Q: That wasn't done in this case either, was it?

A: Correct.
Q: Okay. The next paragraph, item two, a written explanation by the individual, meaning the paramedic or EMT in question, explaining the incidents shall be presented to the Anderson County EMS Director within three working days. Did you ever ask Mr. Davenport, or did Mr. Stoller ever ask Mr. Davenport for a written explanation of his side of the story?
A: I did not. I believe Scott did.
Q: Okay. Well the first time you actually informed Mr. Davenport of what the cases were was the meeting on Friday the 25th when you and Mr. Stoller met with him, isn't that right?
A: Yes. That's the first time that I notified him was at the meeting. I'm sure he knew from Scott what the meeting was about.
Q: Okay. Item number three, the Anderson County EMS Medical Director or the individual may request a second meeting to further discuss issues and concerns. Did you ever request a second meeting with Mr. Davenport?
A: No, sir.
Q: Okay. Did you ever give Mr. Davenport the opportunity to request a second meeting with

you?
A: Other than the meeting we had right after the first meeting?
Q: You're talking about the meeting at the hospital ---
A: Yes, sir.
Q: --- before you went on duty Friday afternoon?
A: Right. Those were the only two meetings.
Q: Okay. Was that meeting pursuant to this policy, or was that just a meeting you took at Mr. Davenport's request?
A: Correct. It was ---
Q: The latter, right?
A: --- the latter.
Q: Now the next bullet says, after reviewing all the information, the Medical Director will issue a disposition of this matter. The Medical Director may exercise one or more of the following options, right?
A: Correct.
Q: And then there's I guess six, seven, eight bullets of possible remed- -- or disciplinary action that you can take, correct?
A: Correct.
Q: You could take no action and consider the

matter resolved. You can require remediation training. What does that mean, remediation training?

A: Additional courses like advanced cardiac life support or trauma life support.

Q: More clinical type courses?

A: Correct.

Q: A clinical refresher?

A: Correct.

Q: Okay. Mr. Davenport didn't need any clinical remediation training, did he?

A: Not in my opinion.

Q: Okay. So the disciplinary action you imposed in terms of requiring him to take that PEPL course was somewhere between no action and the remediation piece. Isn't that right? Or the clinical remediation training?

A: I'm not sure if it was between those or not. But if it's going down the list -- I see what you're saying. The list might be going in order of seriousness or something.

Q: The last item on the list has revokation of practice privileges.

A: Correct.

Q: That's pretty severe ---

A: Correct.
Q: --- punishment, right?
A: Right.
Q: And then you could also temporarily suspend the privileges or suspend it for -- suspend specific practice privileges. So if a paramedic was having trouble with intubations, you could say, I'm going to order you not to do intubations until you get remedial training, right?
A: Correct.
Q: That's what that refers to? So once you announce your disposition then the paramedic or EMT subject to the discipline is supposed to be notified in writing that he may appeal to a patient safety committee, right?
A: Correct.
Q: Okay. And you never gave Mr. Davenport the opportunity to appeal to a patient safety committee in this case, did you?
A: Correct.
Q: And under this policy you're supposed to be the presiding officer of the patient safety committee, right?
A: Correct.

Q: Okay. Have you ever in your 24 years at Anderson County presided over a patient safety committee meeting?

A: No.

Q: All right. I'm going to ask you to turn to the next policy, number 23.

MR. WICEVIC: And, Your Honor, before we get started, I'm going to make the same objection of relevance concerning this medical error reporting policy. Again, the QA process within Anderson County is not relevant to the Department's ultimate decision. You know, I strongly believe that this case is about the facts alleged against Mr. Davenport. Those facts concern the March 19th, 2016 call. I think whether this particular case or the cases that were investigated by Anderson County went through the medical error reporting policy is not of significance to The Court.

MR. ROTHSTEIN: Your Honor, this is again another one of these mandatory polices that's in the protocols book. And, I mean, the fact that they didn't bother to follow it, I think, is relevant as to what the underlying motivation for escalating this beyond, you know, Anderson

County was, sending this to DHEC.

THE COURT: I'm going to allow the question.

Q: Do you recognize, Dr. Kickham, do you recognize -- I'm sorry, policy 23?

A: Yes, sir.

Q: And that sets forth sort of a philosophy of quality assurance in reviewing potential medial errors, right? Sort of in general.

A: Correct.

Q: And if you'll look the paragraph above the bottom there where it says clinical review process, you see that last heading at the bottom?

A: Yes, sir.

Q: If you look at the paragraph immediately above that states that, all Anderson County EMS providers involved in reviewing errors and evaluating care are committed to an educational parentheses non-punitive approach to correcting circumstances that lead to a medical error. You believe that is an accurate reflection of your policy for quality assurance and medical error reporting in Anderson County?

A: Yes, sir.

Q: Okay. Do you know who Keith Eudy is?

A: Just from today.
Q: Okay. Have you ever met him prior to today?
A: Maybe, but I don't recall.
Q: Is he part of the regular QA educational process as described in policy number 23?
A: He doesn't come to the quality improvement meetings. No, sir.
Q: Okay. Have you ever seen the report that he testified about other than at your deposition? Have you ever seen that chart review that ---
A: I don't think so.
Q: And, in fact, when we were doing your deposition, you didn't know who did the chart review, right?
A: I think that's correct.
Q: Okay. The name Keith Eudy only came up the day after your deposition when we talked to Mr. Stoller. Is that right?
A: I'm not sure.
Q: At the time you did your deposition you didn't know who did the chart review, right?
A: That's correct.
Q: Okay. Have you ever -- and you don't think you've ever seen that document before in your entire life prior to it being shown to you at

the deposition, right?
A: I don't think I saw it, no.
Q: So would you agree that that chart review that Mr. Eudy testified about a little ago that he performed was not part of the Anderson County QA policy?
A: It's routinely done in certain exceptional cases for lack of a better word. So Mr. Stoller would have someone that he knew review calls that were of a serious nature that we needed to address quickly. So in that sense he or someone like him reviewing calls is part of the quality improvement program. Assisting Mr. Stoller in reviewing charts and giving feedback to him and myself. So it wasn't part of the bimonthly quality improvement committee meeting. But it was important for serious cases that needed to be addressed soon.
Q: So you were aware that Mr. Stoller had used an outsider reviewer outside of the normal QA process in cases where he wanted to take immediate action against a paramedic or an EMT?
A: Correct. Cases that couldn't wait for the next QI meeting and needed to be done more in person.

Q: There were actually three cases in Mr. Eudy's report. Would you consider the two cases from February, the pediatric seizure patient and the elderly man from the nursing home. Were you familiar with those two cases?

A: Yes, sir.

Q: Okay. Would you consider those to be urgent matters that needed to go outside the normal QA process?

A: I think those could be handled more by the QI officer in most cases.

Q: Okay. And the QI officer for Iva Rescue Squad was a gentleman, or maybe still is, is a gentleman named Craig Lawless. Isn't that right?

A: Correct.

Q: Okay. And he's been there for a number of years while under your medical control in that regard?

A: Correct.

Q: Okay. And Mr. Lawless's job as the QI officer is to look through patient care reports, to check for compliance with the protocols, isn't that right?

A: Correct.

Q: Okay. And if he see a deviation from what he thinks is what's required by the protocols, he flags it, or I think they call it a fallout. Isn't that right?

A: Yes, sir.

Q: Okay. And then I think you said you have eight or nine agencies under your umbrella?

A: Correct.

Q: Okay. Every other month, you meet together with the QI officers from all those different agencies and you talk about the fallout reports, right?

A: Correct.

Q: Okay. And you'll look to see if there's any trends or any remedial education that needs to be done to address, sort of, patterns of the fallouts, is that right?

A: Correct.

Q: And, you meet every other month, and I think you testified in your deposition, correct me if I'm wrong, that you meet on the odd numbered months, is that right?

A: Correct.

Q: Okay. So it would be January and then skip February, you meet in March, right?

A: Correct.
Q: So if Mr. Lawless had seen a problem with the February run report, either one of those two run reports with Mr. Davenport, he could have brought it to your attention at the March QI or QA meeting, isn't that right?
A: Correct.
Q: And that never happened, did it?
A: Not that I'm aware of.
Q: Okay. In fact you couldn't remember a time when Mr. Davenport was discussed at all in the QA or QI meetings, could you?
A: No, sir.
Q: Okay. And Mr. Davenport was sometimes a participant in the QA, QI meetings, right?
A: Correct.
Q: Getting back to this policy number 23, if you'll turn. There's something you define in the policy as the clinical review process. Is the clinical review process filed in Mr. Davenport's case?
A: It's a general statement. I think in general it was followed.
Q: Now let me read that to you. It says, the clinical review process is designed to

investigate all questions regarding clinical care issues. The process insures that Anderson County EMS providers are aware of and can act on current issues as they arise in order to provide timely feedback, education, and track clinical performance. Did I read that correctly?

A: Yes, sir.

Q: Okay. So, did Mr. Davenport ever receive timely feedback for the two cases that occurred in February of 2016?

A: Not that I'm aware of.

Q: Did any of those -- well let me ask you this way. To your knowledge, did Mr. Eudy's chart review, was that ever discussed with Mr. Davenport to your knowledge?

A: Not to my knowledge.

Q: Now, if you'll turn over to page 116, Bates page 116. It describes the procedures in the clinical review process, right?

A: Yes, sir.

Q: All right. First item on the list is contact with the Anderson County EMS Director, okay? Were you made aware, or did anyone make you aware as the Anderson County EMS Director of

any suspected concerns about Mr. Davenport's calls from February of 2016 prior to Mr. Stoller bring it to your attention?

A: Prior to Mr. -- no.

Q: Okay. How did you find out about the issue with the stabbing call? Was that from Mr. Stoller or was that from some concerned person following this ---

A: It was from Mr. Stoller. I think it was a phone call. Yeah. It would have been a phone call.

Q: All right. And again, you send this out to all paramedics, QA officers, training officers under your umbrella, right?

A: Yes, sir.

Q: So if they observe a problem with a patient care issue, they know that they're supposed to contact you as part of this clinical review process, right?

A: Correct. I think it goes to Scott first and then it comes to me based on number one, but ...

Q: Okay. So was Scott your designee to receive the complaints?

A: That's what it says under number one, contact

the county EMS Director. I'm thinking that's supposed to be Scott. It doesn't come directly to me.

Q: Okay. And item number two, set number two on the next page says that all Anderson County EMS provider management personnel are responsible for notifying the Anderson County EMS Director at anytime there's a question surrounding medical care or decision making, right?

A: Correct.

Q: Thank you. How was included in that term, Anderson County EMS providers management personnel?

A: Tell me where the sentence is again.

Q: I'm sorry.

A: I lost you.

Q: Under item number two.

A: Okay.

Q: Are you on page 117?

A: Yes.

Q: Okay.

A: Anderson County providers management personnel are responsible for notifying Anderson County EMS Director anytime ...

Q: And I was asking who was included in Anderson

County EMS provider management personnel?

A: Well it's basically Mr. Stoller, Mr. Davenport, Ms. Kaiser, and myself.

Q: Would it also include the Chiefs of the different rescue squads and training officers within the rescue squads that are under your umbrella?

A: If it pertained to their rescue squad. Yes, sir.

Q: And what about the QI, QA officers for each rescue squad? Would those be considered management personnel?

A: Correct.

Q: And so if they saw a problem, they have a duty to at least notify you or Scott Stoller of the problem, right?

A: Correct. The protocols -- like this page for example has to apply to Medshore Ambulance Service and each of the rescue squads. So that hierarchy of management would be a little bit different from Medshore for example versus Iva Rescue Squad. But yes, I think that would include those people.

Q: Okay. So once you get the complaint in, item number three talks about investigating the

complaint, right?
A: Yes, sir.
Q: Okay. And the investigation is supposed to be done by the Anderson County EMS Director?
A: Yes, sir.
Q: And that's Mr. Stoller, correct?
A: Yes, sir.
Q: Okay. And it lists a number of items that can be considered in the investigation, right? There's the review of the initial concerns or questions, review of the patient care record, review of the dispatch record, interview with the crew involved, interview with other people like bystanders, patient's family, hospital staff, on down the line, right?
A: Correct.
Q: Okay. I think you testified about the investigation, at least to the extent that you were part of it, involved looking at two things, right? You were sent the PCR, the patient care reports ---
A: Correct.
Q: --- and you saw Kim Aiken's statement, right?
A: Correct.
Q: Ms. Aiken wasn't the crew member in the two

calls from February was she?
A: I'm not sure.
Q: Did you ever talk to a Jennifer Brickle as a part of your investigation?
A: No, sir.
Q: Did you ever get any documents from Ms. Brickle?
A: No, sir.
Q: Have you ever talked to a Tommy Miller about any of the patients from February?
A: No, sir.
Q: Do you recall when you were discussing the case with Mr. Davenport, seeing any statements from Ms. Brickle or Mr. Miller?
A: No, sir.
Q: To your knowledge, did Mr. Stoller interview any of the patient or family members involved in any of these three incidents?
A: No, sir.
Q: Do you recall ever seeing as part of this investigation, any records from the actual hospital, either the Emergency Department or the Operating Room regarding the stabbing patient?
A: No, sir.

Q: Next, if you turn the page, step number four is determining the magnitude of the case, right?
A: Yes, sir.
Q: Okay. And the first bullet says, action or care appears appropriate or there's a minor deviation from what would be considered acceptable, right?
A: Yes, sir.
Q: Second bullet is for deviations of a significant nature, correct?
A: Correct.
Q: And before you saw the video, do you believe you had all the medical or the information you needed to determine whether from a medical and clinical standpoint, Mr. Davenport acted appropriately with regard to this patient?
A: Before the video?
Q: Right.
A: Can you say that question again?
Q: Yeah. Probably not a great question, but before you saw the video -- let's put aside the time when you looked at the video on the iphone, right? Before that date, when you were meeting with Mr. Davenport and Mr. Stoller on Friday the 25th of March, do you believe that

you had the necessary information to determine whether Mr. Davenport's medical care was appropriate?

A: Yes.

Q: Okay. You knew from the patient care report that the patient's vital signs were stable, right?

A: Correct.

Q: Okay. You knew that the pain level of the patient was a four, correct?

A: Correct.

Q: You knew that the patient was reported to be in mild distress, right?

A: Correct.

Q: Okay. You knew that the knife was still impaled in the stomach of the patient, right?

A: Correct.

Q: Okay. You knew that the patient was ambulated from the couch or inside the residence to the ambulance?

A: I don't think I knew that part.

Q: Look at item 11b. That's the patient care report that I think you testified ---

A: Yes, sir.

Q: --- you already had, right?

A: Yes, sir.
Q: Turn to the second page, the narrative.
A: Yes, sir.
Q: Third line down says, the knife was secured with dressing and tape. Patient was then assisted to unit and placed on stretcher. You see that?
A: Yes, sir.
Q: Okay. When you saw, patient assisted to unit, did you think he was walked to the stretcher?
A: At the time I did not think so. I probably did -- it says it right here in black and white, but I ---
Q: Okay. You also testified that you had seen Ms. Aiken's statement at that meeting, right?
A: Yes.
Q: In fact, you think you met with Ms. Aiken before you actually met with Mr. Davenport, correct?
A: Yes. I believe that's true.
Q: Turn to Exhibit 4, which is Ms. Aiken's statement.
A: Yes, sir.
Q: I'm looking down at the fourth line, at the end of that line says, Medic Davenport placed

bandages to hold the knife in place, then I EMT Aiken placed tape on the bandages. Medic Davenport helped the patient walk to the stretcher. You see that?

A: Yes.

Q: Okay. So you knew at the time you met with Mr. Davenport that the patient was walked to the stretcher?

A: Based on this -- you know, I didn't know -- I'm just trying to think back in time that he was actually walked out of the house to the unit. It says in the report he was walked to the unit and put on the stretcher, which I should have read that more clearly. This says walked to the stretcher. Stretcher could have been right next to the patient. So he could have stood him up and ... So I'm just saying if I knew before the video, the video was more informative.

Q: Okay.

A: Maybe I didn't ---

Q: You also knew at the time you met with Mr. Davenport and Mr. Stoller on that Friday, before you saw the video, you knew that Ms. Aiken rode the call in as a BLS call, right?

A: Yes, sir.
Q: Okay. And after you had all that knowledge, you said that Mr. Davenport shouldn't be suspended any longer, right? You reinstated his medical control, correct?
A: Correct.
Q: Okay. The only remediation that was ordered was for him to take I think what they call PEPL class, right? The ethics and leadership class, correct?
A: And review the protocols and take a protocol test.
Q: And take a protocol test, which Mr. Davenport took within a day or two and passed it, right?
A: I'm sure he took it several times.
Q: So the only thing that changed in terms of the video -- the video didn't affect Mr. Davenport's medical care. It affected the verbal interactions he had with the patient. Isn't that right?
A: Correct.
Q: And I think you testified earlier you thought that Mr. Davenport had committed abuse towards this patient?
A: Verbal abuse. Yes, sir.

Q: You're determination that Mr. Davenport was verbally abusive, were you aware that Mr. Davenport had prior interactions with this patient?
A: Yes.
Q: And what specifically in the video do you think constituted verbal abuse?
A: I believe what -- just the beginning part, the first verbal exchange with Mr. Davenport and the patient.
Q: Mr. Davenport said, did anybody ever tell you you're an idiot, or something along those lines?
A: I think he used the word dumbass.
Q: Okay. When you saw this little video screen on Mr. Stoller's iphone, did you see that Mr. Davenport was smiling when he was saying, did anybody ever call you an idiot?
A: I'm not sure. He may have been.
Q: Okay. And then he said, well you're being called one now, right?
A: Correct.
Q: Okay. Any other abuse in your mind that occurred during that encounter?
A: There might have been.

Q: Okay. Now would you agree with me that the comment that Mr. Davenport made to that patient was somewhat reassuring? For example, if you said to somebody, oh my god you've got a knife in your stomach, that would be a little different reaction to the patient then say, that was a pretty stupid thing to do. Did anybody ever tell you you're an idiot? Right?

A: I think he used some reassuring words and sentences reassuring him that he was going to be okay.

Q: Okay. I mean he's joking with a patient about that was an idiotic thing to do. That's somewhat reassuring to the patient that the patient is not, I mean it's not a serious -- the patient's not going die in the next 10 or 15 minutes, right?

A: Can you ask that question again?

Q: Yeah. You agree that could have a calming effect on a patient if the medic is sort of joking around.

A: If the medic is joking around, yes.

Q: Okay. And you never talked to the patient to see how the patient interpreted that sort of banter or comment from Mr. Davenport, did you?

A: No, sir.
Q: Okay. Were you aware that this patient had a fairly extensive history with the Iva Rescue Squad?
A: I became aware of that during our discussions.
Q: Were you aware that Mr. Davenport had seen this patient out and about in the small town of Iva from time to time.
A: No. I was aware that they had been to that person's house several times.
Q: Does that change your impression of the verbal interaction if Mr. Davenport had prior interactions with this patient, and then came in and said, man did anybody ever tell you you're an idiot, well you're being told one now. That's different than if he comes into the house and says, you're an idiot. You see there's a difference in the tone there?
A: There can be a difference in the tone.
Q: In your discussion with Ms. Aiken, did she ever tell you or Mr. Stoller that she thought that Mr. Davenport had abused that patient?
A: No.
Q: Okay. And in her written statement, there's nothing in there about her accusing Mr.

Davenport of abuse, is there?
A: Correct.
Q: And under your policies, if a EMT witnesses another EMT or paramedic abusing a patient, they have a duty to report that, isn't that right?
A: Correct.
Q: Ms. Davenport never reported Mr. Davenport -- Ms. Aiken never reported Mr. Davenport for patient abuse, right?
A: Correct.
Q: Okay. Now the second part of the video exchange if I'm remembering it correctly, correct me if I'm wrong, but there's a question I think the Police Officer may have asked the patient why he, you know, was trying to kill himself or always trying to harm himself. Do you agree with that?
A: Yes, sir.
Q: Okay. And the patient said something to the effect, I stabbed myself hoping I would bleed out, right?
A: I can't remember exactly.
Q: Do you remember Mr. Davenport saying, well that's not where your heart is? Remember that

in the video?
A: I believe he said something to that effect.
Q: Okay. Could that be reassuring to the patient that he's not going to bleed out from the injury, that he didn't hit his heart, and maybe it's in a less, sort of, vital area of the body?
A: Possibly.
Q: And then the patient said something to the effect, maybe I'll know next time. You remember hearing that comment on the video?
A: Not exactly.
Q: Do you recall the Police Officer saying, well let's not have a next time, meaning let's not have another suicide attempt, right?
A: Yes, sir.
Q: Okay. Mr. Davenport said, yeah just stop doing stupid stuff, or maybe he even said stupid shit. Do you remember that?
A: Vaguely.
Q: Okay. He never encouraged the patient to attempt suicide again, and was not coaching him about where to put the knife next time, was he?
A: Not to my knowledge.
Q: Okay. You didn't interpret the video that way,

that Mr. Davenport was suggesting a better way for the patient to kill himself the next time he attempted it, right?

A: I don't recall that.

Q: And then do you recall Mr. Davenport -- there's a discussion about why the patient did that. Why he would want to harm himself. You recall that on the video?

A: Vaguely.

Q: Okay. And Mr. Davenport tried to reassure the patient that, oh you don't have it so bad. I stepped on a GD, goddamn IED in Afghanistan and blew my nuts off, right? You remember that in the video?

A: Portions of it.

Q: Okay. So Mr. Davenport was trying to tell the patient, you know, things could be a lot worse. I mean, trying to put some perspective to the patient, right? That his problems may seem minor compared to other people's problems, right?

A: Yes, sir.

Q: Do you think that is an appropriate interaction with a suicidal patient?

A: I think in general reassuring the patient can

be appropriate action.
Q: And then, did you notice the interaction from the Police Officer in the video?
A: One of them I think I remember.
Q: And you recall the Police Officer saying, don't make me be bad guy, to the patient. Do you remember that?
A: Yes. I think that had to do with the handcuffs.
Q: Almost like he's talking to a third grader, right?
A: I didn't really interpret it that way.
Q: Okay. Do you think it's appropriate to patronize or coddle a suicidal patient?
A: No.
Q: And then there was a discussion in the video about the knife. Mr. Davenport told the patient that he was going to have to go to the OR to get the knife taken out. Do you recall that?
A: Yes, sir.
Q: And the patient objected and said, you mean I gotta go to the OR? You can't just pull the knife out right here? You remember that?
A: Yes, sir.

Q: Okay. Mr. Davenport didn't pull the knife out, did he?
A: No, sir.
Q: Okay. He said he had the skills to pull the knife out, but he'd lose his job. Isn't that right?
A: Correct.
Q: Okay. The most critical thing about this patient when they arrived on the scene was number one making sure the patient is not hemorrhaging or bleeding out anywhere. Isn't that right?
A: I don't know if that could be determined on the scene.
Q: But that's an important consideration when you come to a stabbing, one of the first, I guess with a critical, what do you call it, critical interventions is to make sure the patient is not hemorrhaging?
A: You can't make sure that they're not hemorrhaging. You can assess them for hemorrhage and treat them appropriately. You can assess for hemorrhaging, you can't make sure they're not.
Q: Okay. The second thing is you want to make

sure that that -- you want to stabilize the object in place, isn't that right?

A: I don't know if that'd be the second thing, but it's one of the things.

Q: That's a pretty important thing to stabilize that knife into place so it doesn't move, correct?

A: Correct.

Q: Okay. And Mr. Davenport -- you still have that Exhibit 25, the photograph? Looks like a pretty good job of stabilizing that knife in place?

A: Yes, sir.

Q: And did you ever talk to anyone at the ER about how difficult it was for them to undo the taping job that Mr. Davenport had done on this patient to keep the knife in place?

A: No, sir.

Q: Okay. Looking at that photograph, do you have any problems with the way that Mr. Davenport stabilized that knife in place?

A: No, sir.

Q: And then the next thing that I recall seeing on the video is Mr. Davenport says, okay we're going to lift you up and walk you out to the

ambulance. You remember that?
A: Yes, sir.
Q: Okay. And you believe that that was inappropriate care for Mr. Davenport to stand the patient up and walk with assistance out to the ambulance, right?
A: Yes, sir.
Q: Okay. Anytime you move this patient, there's going to be some risk involved in the patient, right?
A: Correct.
Q: Okay. And if you brought in a stair chair for example, the patient's still going to have to stand up off the couch to get onto the stair chair, isn't that right?
A: Or you could pick him up.
Q: Okay. So you could either -- are you suggesting that the medic should have picked the patient up and moved him onto a stair chair?
A: No. Put him on a stretcher.
Q: Okay. Do you know if that house -- you have any paramedics that have ever been to that house and taken the patient -- and brought the stretcher into the house before?

A: I am not aware.
Q: Well let's get back to a stair chair a second. So either have to lift the patient up to put him into the stair chair, or he has to stand up and get into the stair chair, right?
A: Correct.
Q: Okay. And then if you had the stair chair, have you ever put a patient on a stair chair before?
A: No.
Q: Okay. Have you ever seen the stair chair that Iva Rescue Squad has?
A: I've seen stair chairs but I don't know if I've seen their's or not.
Q: Okay. Are you aware that the stair chair has straps that go across the body in an x shape fashion to secure the patient into place?
A: I think that's standard. Yes, sir.
Q: Okay. And when you put a patient on a stair chair, you want to make sure they're secured in there pretty tight so they don't fall out of the chair as they're ---
A: Right.
Q: --- bumping them down the stairs, right?
A: Correct.

Q: So you've got to crank down on the straps to make sure the patient's secured into that chair, isn't that right?
A: Yes, sir.
Q: So you don't know anything about where the knife was in relation to where those straps would have been coming across the body in a stair chair, do you?
A: No, sir.
Q: Okay. And if you crank down on the straps too hard, you could compress the patient's chest or abdomen, isn't that right?
A: Correct.
Q: And that could actually push the knife further down or further into the body cavity of the patient, right?
A: I'm not so sure about that, but yes you could tighten the straps down too tight.
Q: Okay. And I know you said you've never used it. Have you ever seen anybody take a patient out of his house on a stair chair?
A: I've seen videos.
Q: Okay. They kind of are on wheels and they bump down the steps, isn't that right?
A: Correct.

Q: Okay. And that jostling motion could have an affect on the position of that knife, right?
A: Correct.
Q: So you don't know whether the stair chair was the safest way to get that patient out of the house or walking the patient out of the house was the safest way, do you?
A: No, sir.
Q: Okay. That's a judgement call that the paramedic has to make on the scene, isn't that right?
A: Yes, sir.
Q: There's nothing in the protocols that tells the patient how to get this knife wound victim out of the house, right?
A: Well the protocols say that the stretcher should be brought in to the home and that the patient should not be walked out.
Q: The protocols also say that they can deviate if you can explain it and document it, right?
A: Correct.
Q: Okay. So the mere fact that Mr. Davenport walked that patient out of the house is -- I mean it violates the protocol in the sense that he didn't bring the stretcher in, take the

patient out, but Mr. Davenport can explain it and document it, it's okay, right? I mean you never ordered Mr. Davenport, don't walk that patient out of the house, right?

A: Well it's in the protocols not to walk the patient out of the house.

Q: Now if the patient was on the stair chair, they get out of the house, they get to the back of the ambulance, how do you get from a stair chair into the stretcher that you're transporting to the hospital?

A: You'd put them next to each other and lift him up or have him assist you over onto the stretcher.

Q: Okay. So either the patient has to stand up again, or be lifted and placed into the stretcher, right?

A: They might not have to stand up, but they'd have to assist themselves over onto the stretcher or be assisted.

Q: Okay. Now was there anything wrong with Mr. Davenport laying this patient down supine flat on the stretcher?

A: I think in general you'd want to try and keep him in the position that you found them in as

best you can.
Q: Now I think you've testified that in our opinion, this was a critical trauma or a serious trauma, right?
A: Yes, sir.
Q: Give me one minute. I may go onto something else. Another way to get that patient out of the house would have been on a spine board, is that right?
A: Correct.
Q: Okay. And describe to The Court what a spine board is.
A: A spine board is rigid usually fiberglass. It's usually about six foot tall, about two feet wide. And it's used to lay the patient down. Then usually secure them with multiple straps kind of like seat belts, and it holds them in place on the spine board.
Q: And what position is the patient in if they're being carried out on a spine board?
A: Hopefully supine. Sometimes you have to lay them on their side, sometimes you have to lay them prone.
Q: Okay. In this situation where you've got a guy with a knife in his stomach, it's probably not

real safe to put him on his side, is it?
A: Correct.
Q: Okay. So this patient if he were taken out on a spine board, would be in a supine position, correct?
A: Correct.
Q: Okay. So there's nothing wrong with laying the patient down flat in the supine position, right?
A: Correct.
Q: Dr. Kickham, if you'll turn to page 43 of Exhibit 1. That's the multiple trauma and shock protocol. You see that? Are you on that page 43?
A: Yes, sir.
Q: All right. And if a paramedic assess the situation and determines there's multiple trauma or shock, this protocol would apply. Under management the paramedic is supposed to initiate spinal immobilization, right?
A: Correct.
Q: Okay. And what's involved in spinal immobilization?
A: Spinal immobilization is to try and transport the patient on the long spine board to minimize

the possibility of further injury to the spine.
Q: And besides the spine board that you described a minute ago, what else is involved in spinal immobilization?
A: Cervical collars would place around the neck, which are rigid plastic collars to minimize movement of the neck in cases of possible neck injury. The spine board also has the straps, like seat belt straps I described earlier.
Q: You believe that the protocols require full spinal immobilization for this stabbing patient?
A: As a mechanism of transport, it can be utilized for this patient in lieu of walking them to the transport truck. So if the have difficulty getting the patient out of the house on the stretcher, they could use the spine board as a device to assist that.
Q: Okay. Were you aware that this patient in previous calls has become agitated and aggressive and tried to get off of the stretcher?
A: No, sir.
Q: Okay. That would be something that you would want to know in terms of whether, or what the

appropriate way to get the patient out of the house, right?

A: I think prior encounters with the patient could be taken into consideration in transporting the patient, but I didn't see whether that was done or not.

Q: Okay. Let me ask you to flip back a page to trauma T- 1. It's on Bates page 42. This is the general trauma protocol, right? I think you testified earlier that you thought this was applicable to Mr. Davenport's care of this particular patient?

A: Yes, sir.

Q: Okay. And under critical trauma I think we talked about the load and go situation earlier. I'm not going to go back over that. Under other trauma -- you see it half way down the page, other trauma colon?

A: Yes, sir.

Q: It says all patients complaining of neck back pain, or patients with a significant mechanism of injury will receive full spinal immobilization. You see that?

A: Yes, sir.

Q: Okay. So did you consider this a significant

mechanism of injury?
A: Yes, sir.
Q: Okay. Is a gunshot wound a significant mechanism of injury?
A: Yes, sir.
Q: Okay. What if I shot my pinky off? You would consider that to be trauma, right?
A: Correct.
Q: And that is a trauma with a significant mechanism of injury, right?
A: Correct.
Q: Okay. Are you suggesting that if a patient shoots their pinky off with a gun, that the paramedic has to do the full spinal immobilization on that patient?
A: I'm not sure I know how to answer that question. Do I ... I think I know what you're asking but ... Do they need full spinal immobilization, no.
Q: Okay. But that's a trauma ---
A: Correct.
Q: --- with a significant mechanism of injury, right
A: Correct.
Q: So if you took this policy literally, that

patient would need to have a full spinal immobilization.

A: Correct.

Q: Okay. That doesn't make any sense, does it?

A: Correct.

Q: Okay. So that's an example of where a rigid following of a protocol is nonsense, wouldn't you agree with that?

A: That's where the education -- correct. It's where the education, training, and experience comes in.

Q: Okay. And you would agree with me that Mr. Davenport has extensive medical education and training, right?

A: Correct.

Q: Far surpasses the normal civilian paramedic?

A: Correct.

Q: And I think you also testified that this issue of whether something's a critical case or significant or major trauma, I think you said it's sort of in the eye of the beholder. I think you said that term severe trauma is a generalization. Do you remember testifying about that when Mr. Wicevic was asking you questions?

A: A generalization? Yes, sir.
Q: Yeah. And I think you said that the medics and EMT's know severe when they see it?
A: Yes. Sometimes it's very obvious. Sometimes it's not so obvious.
Q: Okay. So if a patient had never seen -- I mean, I'm sorry. If a paramedic had never seen a stabbing patient with an impaled object, they might view that as a very serious trauma, right?
A: Correct.
Q: But someone like Mr. Davenport who's seen that type of an injury before and has had experience with that type of injury is going to take a more, sort of, calm, cool, and collected approach to address the patient's needs rather than just, oh it's a knife it's a severe trauma, you know, all the bells and whistles have to go off, right?
A: I think in general he's seen major trauma, and ... Can you rephrase the question. I know what the question is but it's hard to answer the way you ...
Q: I think the point was that the terms severe is not defined in the policy, severe trauma is not

defined in the policy, right? And you testified that it's sort of in the eye of the beholder. Is that a fair characterization?

A: Well there's parts of the policies that delineate it and parts where there is judgement call.

Q: Okay. And I think your testimony was paramedics with their training and experience know severe when they see it, right?

A: Correct.

Q: Okay. And in this case Mr. Davenport didn't view this as a severe trauma, isn't that right?

A: Correct.

Q: Okay. He saw that the patient was stable based on his assessment of the patient, right?

A: In his opinion, yes.

Q: Okay. The patient's vital signs that were taken in the truck during the transport appeared to be stable, correct?

A: Correct.

Q: Okay. The patient had an oxygen saturation rate of 98 or 99 percent on the way to the hospital, right?

A: Correct.

Q: Okay. In the picture you looked at earlier,

the patient's not blue or not pale. So it looks like his respiration seems to be okay, correct?

A: Correct.

Q: And so if Mr. Davenport made the medical judgement that that's a stable patient, he just has a knife in his stomach that's now been secured into place, that's a judgement call for Mr. Davenport to make based on his experience and training, isn't that right?

A: Correct.

Q: And if Mr. Davenport determined that patient was stable, that patient doesn't need supplemental oxygen, right? No respiratory distress?

A: No, sir.

Q: Okay. And that patient ---

A: I mean, no. That was a statement. It wasn't really a question.

Q: Okay. The patient ---

A: So yes, the patient still needs oxygen, IV, cardiac monitor, regardless of his assessment. His assessment turned out to be correct, and the patient was delivered to the Emergency Department, and wheeled by myself, he looked

relatively stable. That doesn't negate the fact that he could have changed his condition on transport. So it doesn't negate the IV, monitor, and oxygen.

Q: In a place I wrote down what constitutes a BLS call versus what constitutes an ASL call. And I think you gave some examples of BLS calls. Let me see if I can find it. Minor laceration, sprained ankle, and bee stings. Remember?

A: Well bee stings could be advanced call, so ... There's not very many basic calls. But the mechanism of injury could make it an advanced call, so there is grey area there.

Q: Okay. In your opinion, most calls need to be treated as ALS calls, is that ---

A: Correct.

Q: --- fair to say? Okay. I think you also said if there's no immediate distress for the patient, that can be considered a BLS call. If the patient, no immediate distress, that can be a BLS call, right?

A: It can be.

Q: Okay. And if it's a BLS call, the EMT basic can ride in the back of the ambulance on the way to the hospital, correct?

A: Correct.
Q: And if a paramedic starts the treatment on a stable patient, under your policies, the paramedic can transfer the care of that patient to a BLS or EMT basic if the patient is stable in the mind of the medic, is that right?
A: Correct.
Q: Let me ask you to turn to page 125 of Exhibit 1.
THE COURT: I'm sorry. What page are we going to Mr. Rothstein?
MR. ROTHSTEIN: Sorry. 125, Your Honor.
THE COURT: 125, okay.
Q: This is the non-paramedic transport of patient policy, correct?
A: Yes, sir.
Q: Okay. Forth bullet in this policy that's in the protocols. It says second sentence, if the technician determines that the patient is stable and all patient care needs can be managed by a lower level provider, patient care can be transferred to a technician of lower certification for care while en route to the hospital. You see that?
A: Yes, sir.

Q: So your policy allows the technician or the paramedic to determine that the patient is stable on scene, right?
A: Correct.
Q: And if that determination is made, he can transfer the care to a EMT basic or a lower level provider without -- on the trip to the hospital, right?
A: Yes, sir.
Q: Okay. And that's not abandonment of the patient, is it? If they comply with that policy?
A: If it's a basic call from the beginning, no.
Q: Okay. And if they're en route to the hospital and a problem develops or complications develops, the patient starts to decompensate, and it now becomes something that's beyond the capability of the EMT basic, at that point the basic can say, he I need some help here, and the medic can switch back, switch places, isn't that right?
A: Yes, sir.
Q: Okay. And if the basic does not think, or is uncomfortable riding the call, if they think this is beyond my capability, the burden is on

the EMT basic to raise that to the paramedic, isn't that right?

A: Yes.

Q: In fact, looking down further on Exhibit 1 policy 26, look down to the second to last bullet. Paramedic must accompany the patient to the hospital if the BLS crew or crew member expressed any discomfort with assuming the care for the patient, right?

A: Correct.

Q: So if Ms. Aiken said, James I don't feel comfortable handling this patient. You know, this is beyond my training. I want you to handle it, Mr. Davenport should take over the care of that patient, right?

A: Correct.

Q: And so this is regardless of whether or not the paramedic believes any ALS procedures are warranted, correct?

A: Yes.

Q: And it says, it is the obligation of the BLS crew and or crew member to state that they are not comfortable with managing this patient, right?

A: Yes, sir.

Q: Okay. So if this were beyond Ms. Aiken's sort of capabilities as an EMT basic, she has a duty to sort of inform Mr. Davenport that she's not comfortable riding that call, right?
A: That's correct.
Q: Okay. In your review of the video, did you ever see Ms. Aiken say, I can't take this call?
A: She appeared uncomfortable and she asked Mr. Davenport -- I'm not sure her exact words, but are you sure this is okay.
Q: Okay. Mr. Davenport said the patient's stable, this is a BLS call. There's nothing more that I'm going to do for the patient that you can't -- I mean, I'm paraphrasing -- that you can't handle, right?
A: I think he said something to the effect of, I'm not going to do anything for him.
Q: Okay. Did you interpret that to mean, I'm just not going to take care of this patient? You know, I'm disgusted with him, I'm not going to touch him anymore?
A: I think if need be and he became unstable, he would change places with her and manage the patient, yes.
Q: But my question was when Mr. Davenport said,

I'm not doing anything for him, did you interpret that by Mr. Davenport says, I'm done with this guy. I'm not going to provide, I'm refusing to provide care to this patient?

A: I didn't interpret him as refusing. I interpreted it as I'm not going to do anything, I'm not going to put an IV in him, I'm not going to give him any pain medicine. Therefore you can ride with him.

Q: Okay. And that was an accurate statement right? Mr. Davenport didn't put an IV in the patient, right?

A: Correct.

Q: And he didn't administer pain medication, right?

A: Correct.

Q: And we already saw that the pain level was a four, doesn't need pain mediation, right?

A: Well, maybe.

Q: And when you met with Ms. Aiken, did you ask her how she interpreted Mr. Davenport's statement, you know, I'm not going to do anything for the patient?

A: No.

Q: Let me ask you to look at her statement,

Exhibit 4.

A: Okay.

Q: Look down about half way, let's see, the eighth line down I think. Eight lines down. Sentence starts, medic Davenport then stated that it was a basic life support call and that I would be fine, right?

A: That's what she has written. Yes, sir.

Q: Okay. So then she talks about Police Officers that were there, and they got in the back of the truck to take the photos. And then she says, I then asked him again, would I be okay to ride this call? Medic Davenport then stated to me that he would not do anything more for the patient than what I could do. Right?

A: That's what it says.

Q: Okay. So he's telling Ms. Aiken, you've got this call. The patient's stable. It's BLS call. You're okay to ride it. Isn't that right?

A: Yes, sir.

Q: And Ms. Aiken didn't voice any objection after that. She got in the back of the truck, and they went to the hospital. Isn't that right?

A: As far as I know.

Q: Okay. And you used a phrase earlier, trauma alert. You recall using that term?
A: Yes.
Q: Trauma alert?
A: Yes, sir.
Q: Okay. That's not something that Mr. Davenport called into the hospital and said, I've got a trauma alert right. That was a determination that the AnMed people made based on what Mr. Davenport reported. Isn't that correct?
A: Correct.
MR. ROTHSTEIN: Your Honor, I've got a little bit longer to go. I mean I know it's getting late. I don't know if you want to try and finish him up today so he doesn't have to come back. I mean I don't want to keep The Court here too much longer.
THE COURT: How much longer do you have?
MR. ROTHSTEIN: Probably another 15 or 20 minutes.
THE COURT: Okay. And them Mr. Wicevic?
MR. WICEVIC: Probably another 20, 30.
THE COURT: Y'all are killing me.
MR. ROTHSTEIN: I know you don't want to stay here until seven, Your Honor.
THE COURT: I don't. I hate to have Dr. Kickham

come back. Dr. Kickham, you're coming from Anderson, correct?

DR. KICKHAM: Yes, ma'am.

THE COURT: I hate to have you come back. Is there anyway you all can kind of shorten the balance of your cross and your re-direct, so we can get them and we can get him out of here?

MR. ROTHSTEIN: I'll try and finish it up quick. Give me two minutes.

THE COURT: Okay. Very good.

Q: Dr. Kickham, were you aware that Ms. Aiken had gotten in trouble before for riding in calls that were beyond her certification or ALS level calls?

A: Not to my memory.

Q: Were you ever contacted by anyone at DHEC about this matter prior to your deposition being taken?

A: I received a phone call from -- I can't pronounce his name -- Vito's associate, and she gave me the approximate dates of the hearing. And then my other discussions with Vito.

Q: Okay. All your discussions with anyone at DHEC have been with the lawyers, right?

A: Correct.

Q: Okay. You never talked to Mr. Naugler, the investigator from DHEC?
A: No, sir.
Q: Okay. You never provided any information for Mr. Naugler at DHEC?
A: No, sir.
Q: Did you ever speak to Mr. Wronski at DHEC?
A: No, sir.
Q: Did Mr. Wronski ever ask you for information about the investigation with Mr. Davenport?
A: No, sir.
Q: Now after you met with Mr. Davenport, I think it was that second meeting on Friday. I think it was sometime right before you getting ready to start work. You estimate it would be about 2:00, 2:30 in the afternoon?
A: Yes, sir.
Q: At that time, had you and Mr. Stoller decided the appropriate punishment for Mr. Davenport's matter?
A: I don't know if punishment's the right word, but yes.
Q: Okay. His remediation had already been announced?
A: Yes.

Q: Were you aware that later that day, about 5:09 in the afternoon, Mr. Stoller sent this QA matter to DHEC?
A: No, sir.
Q: Is there anywhere in your procedure manual where DHEC is part of the QA process?
A: Not that I'm aware of.
Q: Now in your experience as the medial control officer, or I'm sorry, physician for Anderson County, have you seen situations where patients have -- I'm sorry, where paramedics have killed patients by their actions or inactions?
A: I'm not sure. I know there's been cases where patients expired that have then been reviewed and QI'd.
Q: You've QI'd some pretty serious things like heart attacks that weren't resuscitated appropriately, is that right?
A: Correct.
Q: And airways that were not established in a timely manner?
A: Correct.
Q: And you've required paramedics under your medical control to go back to remedial training for things like advanced cardiac life support,

right?
A: Correct.
Q: Or how to intubate a patient properly?
A: Correct.
Q: And you've sort of suspended their abilities to perform those types of procedures under your medical control until they can establish that they can do it safely, right?
A: Correct.
Q: Have you ever sent a case to DHEC in your 24 years as a Medical Control Physician?
A: Personally, no.
Q: Now I think at the very beginning of the case, Mr. Wicevic asked you if you had ever had any disciplinary action taken against you by the South Carolina Board of Medical Examiners. I think your answer to that was no, right?
A: Correct.
Q: In April of 1999, you settled a wrongful death malpractice case against you ---
MR. WICEVIC: Your Honor, I'm going to object to this. I don't know the relevance of civil lawsuits against Dr. Kickham.
MR. ROTHSTEIN: Well the relevance of it is, Your Honor, that Mr. Davenport's situation had no

adverse patient outcome. Dr. Kickham has been involved in cases that had very adverse outcomes including death, and his license was never affected.

THE COURT: I'm sorry. It has no relevance in this matter. I'm sustaining Mr. Wicevic's objection.

Q: Do you agree that paramedics have a very stressful job?

A: Yes.

Q: Okay. And I think in your deposition we talked about you thought that Mr. Davenport may have been having a bad day from what you saw on the video, isn't that right?

A: I don't remember stating that.

Q: Okay. You're aware that Mr. Davenport has a through the knee amputation in his left leg?

A: Correct.

Q: Okay. And do you believe that the injuries he suffered in combat are painful injuries?

A: Are or were?

Q: Currently are.

A: I'm not aware.

Q: Okay.

A: I don't know.

Q: Were you concerned -- I think you used the term either attitude adjustment or he needed some time off to get his head right. Do you remember saying that in the deposition after you saw the video?
A: No, sir.
Q: You don't recall saying that? You recall using the phrase burn out? You thought Mr. Davenport may have been burned out?
A: I don't believe I used that. It might have been in response to a question.
Q: I'd ask you to turn in your deposition to page 152. And I'm going to direct you ---
A: I guess I'm in the front?
Q: I beg your pardon?
A: I guess I'm in the front, right?
Q: Yeah, of page 152.
A: Okay.
Q: And I'm going to direct you to line 14.
A: Okay.
Q: My question was, so your determination -- let me sort of paraphrase it and see if you will agree with me, is not so much that Mr. Davenport needed technical remediation. It was more of an attitude adjustment or a change in

his outlook toward medicine, is that right? And your answer was, yes. I think he had the knowledge base. I know he has the knowledge base. And he has the skill level. I'm sure he's proven that over and over in his former jobs, plus my discussions with him, he's very knowledgeable. I think my thought is as providers advance in their careers, it's very easy, I hate this word, to get burned out. But it's very easy to get burned out and not provide optimal care. And it's not so much a knowledge base as doing the right thing and getting back on track. You see that?

A: Yes, sir.

Q: And then I asked you -- are you on the next page, 153?

A: Yes, sir.

Q: Line ten, have you experienced or observed providers such as the paramedics or EMT's or emergency physicians exhibit signs of stress or burn out? And you said, yes. Right?

A: Yes, sir.

Q: Okay. Did you do anything, like take Mr. Davenport aside and say, James I saw this video and you can't talk to patients like that. I

don't know if you were hurting or having a bad day, but don't call patients idiots. Did you ever take him aside and have a conversation like that with him after you saw the video?

A: No, sir.

Q: Did you ever take any steps to determine whether Mr. Davenport was suffering from some type of either stress or depression or mental health issue that might have affected his interaction with patients?

A: No, sir.

Q: And you ever referred Mr. Davenport to the employee assistance program at Anderson County or asked him to have, like, a fitness for duty evaluation done to see if he was suffering from stress or some other mental health condition that might have affected his interaction with the patient on that day?

A: No, sir.

MR. Rothstein: I don't have any further questions, Your Honor.

THE COURT: Okay.

DR. KICKHAM - RE-DIRECT EXAMINATION BY MR. WICEVIC:

Q: Dr. Kickham, still good to go?

A: Yeah.

Q: Okay. I'll make this quick.
A: I'm sorry I can't remember your last name.
Q: It's fine. It's a strange one. Okay. And I'll try to make this as quick as possible. Let's start by looking at GP-4 and 4a in Exhibit 1. And I just want The Court to understand your interpretation of your protocols. Page 7, the proved skill table. Can you explain why there's a column of standing orders and there's x's?
MR. ROTHSTEIN: What page are you on, Vito?
MR. WICEVIC: Page 7, Exhibit 1. It's GP-4a.
Q: You see where I'm referring?
A: Yes, sir.
Q: Can you explain what those mean?
A: Standing orders what's written. A physician order can be verbal.
Q: Is there a standing order for intravenous access?
A: Yes.
Q: Is there a standing order for oxygen?
A: Yes.
Q: Okay. There's discussion about deviations from protocols and you can look back with me or I can just represent to you that the introduction

indicates that, yeah, you can made deviations from the protocols, you've just got to be able to explain them and have it documented. Did Mr. Davenport explain any deviations to you?

A: In our discussion verbally, he explained as best he could why he did what he did.

Q: And what was that?

A: That he didn't think that the patient had the potential for further harm or injury, and that he had seen a lot of trauma in his career, and this was minor.

Q: Now did he document the deviations?

A: Not on the patient care report.

Q: There's some talk about various terms within the EMS industry, trauma, load and go. When a new EMT comes aboard one of your services, is there a requisite level of knowledge you expect them to know and understand?

A: Yes.

Q: Okay. Would that knowledge contribute to their understanding of trauma?

A: Yes.

Q: The word trauma. What about load and go?

A: I think that's a fairly common term they would learn in school, in training and then in

practical environment.
Q: T-3, is page 43.
A: Yes, sir.
Q: It's multiple trauma shock protocol. There was some reference to your deposition transcript, and Mr. Rothstein pointed out that you determined, or it appeared that there was no -- and I can direct you to it. It's page 110. I believe you still have the transcript up there. I believe you indicated that there was no indication at the time of multiple injuries. Is that correct?
A: Line 14?
Q: Yes, sir.
A: There could be multiple injuries. That protocol's meant for more falls, car wrecks, where they have more than one injury.
Q: Was the applicability of T-3 more about the potential for this patient?
A: Correct.
Q: Is that because -- I mean you're pre-hospital. There's no way for you to readily know exactly what's wrong with the patient.
A: Correct.
Q: There's mention of Mr. Eudy's report. I can

refer to you. I believe it's Exhibit 26. I'm not sure if it's up there.

A: Yes, sir.

Q: Do you recall the report?

A: I think we looked at it at the deposition.

Q: Do you recall whether or not you agreed with that report?

A: I think in general I agreed with it.

Q: All right. QI reviews, are names discussed at QI reviews, EMT names generally?

A: Generally, no.

Q: Okay. Let me ask you this, generally what has greater minimization of movement, walking a patient or using a carrying device?

A: I would say the carrying device would be less movement.

Q: Okay.

THE COURT: Dr. Kickham, could you speak a little louder.

DR. KICKHAM: I'm sorry, Your Honor.

A: I think the carrying device would be less movement than walking the patient.

Q: I think Mr. Rothstein had some questions, and I think it was focusing on this T-3 protocol. He talked about hemorrhaging, and I believe you

said, you can't make sure they're not hemorrhaging. I was just seeing if you had an explanation of that statement.

A: Well with penetrating injury, you could be bleeding inside the abdomen or peritoneal cavity, and you might not know how much bleeding you're having. So if someone's having a lot of bleeding, their abdomen becomes distended with the blood, and it can become more obvious. But you have no way of knowing. That's why the go to the Operating Room emergently, and the wound gets explored, and then they remove the knife in the Operating Room.

Q: Was that a concern you had here?

A: Yes.

Q: Towards the end of your cross-examination with Mr. Rothstein, I believe you acknowledged that Mr. Davenport did not make the determination to call a trauma alert. It's AnMed's determination.

A: Yes.

Q: That being said, I believe during the video Mr. Davenport acknowledged that this patient was going to require to have surgery and go to the

Operating Room. Is that correct?
A: Correct.
Q: Okay. Dr. Kickham, do you have any opinion as far as whether a trauma alert should have been called prior to ---
MR. ROTHSTEIN: Object.
Q: --- arrival?
MR. ROTHSTEIN: Object, Your Honor. He's asking opinion testimony. He's not qualified Dr. Kickham as an expert witness. It's improper.
MR. WICEVIC: He's been offering opinions the whole day. The applicability of these protocols. Let me back up. See if this would be more acceptable.
THE COURT: Okay.
Q: Is there a protocol regarding trauma alerts?
A: For the Emergency Department? It's similar to what's in the protocols.
Q: Well I'm talking ---
A: In terms of mechanism of injury, shock, those types of things.
Q: Is there a trauma alert protocol, or is there a protocol for EMT's, Anderson County EMT's that addressed when they are to have a trauma alert?

A: Yes.
Q: Where would that be?
A: I believe it was in the ---
Q: I'm sorry?
A: It's not in here, so maybe it was after this -- it was probably on the next revision. So I would say no.
Q: Okay. I think that's all I have. That's all I have.
MR. ROTHSTEIN: Your Honor, can I ask two questions on re-direct?
THE COURT: Very quickly.

DR. KICKHAM - RECROSS-EXAMINATION BY MR. ROTHSTEIN:

Q: Okay. Dr. Kickham, if you'll look at page 6 of Exhibit 1, the intravenous access protocol.
A: Yes, sir.
Q: That protocol doesn't say every patient should have an IV, does it?
A: No, sir.
Q: Okay. It actually says, assess patient for indications, right?
A: Correct.
Q: And then if the paramedic determines that an IV is appropriate, the standing order part under management tells the paramedic what type of

fluid to administer to that patient, isn't that right?

A: Correct.

Q: Okay. So Mr. Davenport by not ordering an IV on this patient didn't violate a order to provide normal saline to the trauma patient, did he?

A: They're separate, but they are together. So if you go to the IV protocol, it's got IV intravenous fluids I believe.

Q: So the intravenous protocol is again, a flow chart. If the paramedic says, IV not warranted, he doesn't start an IV, right?

A: Correct.

Q: But if he starts an IV, your standing order tells him what type of IV to administer, or what type of fluid to administer to that patient.

A: Well the converse is true as well. If the patient needs fluid then he needs an IV. Obviously can't get fluid without an IV.

Q: Are you suggesting this stabbing patient needed fluid?

A: It turns out he did not need fluids, but the potential for blood loss was there, so the

potential for administering fluid was there.

MR. ROTHSTEIN: I don't have any further questions, Your Honor.

THE COURT: Okay. Dr. Kickham?

DR. KICKHAM: Yes, ma'am?

THE COURT: We are finished with you.

DR. KICKHAM: Thank you for not bringing me back tomorrow. I appreciate it.

THE COURT: Well let me just make sure. Are you all finished with Dr. Kickham?

MR. ROTHSTEIN: Yes, ma'am.

MR. WICEVIC: Yes, Your Honor.

DR. KICKHAM: I guess I was premature in that statement, wasn't I? Sorry.

THE COURT: Yes. But you are excused. You don't have to return.

DR. KICKHAM: Thank you.

MR. ROTHSTEIN: One house keeping matter, Your Honor.

THE COURT: Uh-huh.

MR. ROTHSTEIN: Obviously we didn't make as much progress today as we were hoping. We've got an expert witness who's a trauma surgeon. He's flying in tonight, and he has surgery on Thursday morning.

THE COURT: Uh-huh.

MR. ROTHSTEIN: So I talked to Mr. Wicevic about taking him out of order. I still hope that's okay with you that if we do Dr. DeAngelo first in the morning and then I get him back on the road so he can catch his flight. That's ...

THE COURT: Okay. And also we missed part of today's testimony. So what I wanted to do is maybe start earlier in the morning. As opposed to 10:00, start at 9:00 in the morning so that we can try to get this wrapped up.

MR. ROTHSTEIN: I think that's a good idea.

THE COURT: Okay.

(Whereupon, the hearing adjourned at 6:15 p.m. and was reconvened on Wednesday, July, 26, 2017 at 9:08 a.m.)

STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT
Docket No. 17-ALJ-07-0003-CC

South Carolina Department of Health and Environmental Control,	)
Petitioner,	)
v.	)
James Davenport,	)
Respondent.	)

ADMINISTRATIVE HEARING

****

Wednesday, July 26, 2017
9:08 a.m. - 5:57 p.m.

The hearing before the Honorable Shirley Canty Robinson, was taken at the Edgar A. Brown Building, 1205 Pendleton Street, Suite 224, Columbia, South Carolina, on the 26th day of July, 2017 before Travis McLeod, Court Reporter and Notary Public in and for the State of South Carolina.

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INDEX

	PAGE:
DR. FRANK DEANGELO:	
MR. ROTHSTEIN . DIRECT EXAMINATION.	6
MR. WICEVIC . . . . . VOIR DIRE.	16
MR. ROTHSTEINDIRECT EXAMINATION (CONT.)	22
MR. WICEVIC . . . CROSS-EXAMINATION.	41
MR. ROTHSTEIN . RE-DIRECT EXAMINATION.	75
HARRY DEAN DOUGLAS:	
MR. WICEVIC . . DIRECT EXAMINATION.	82
MR. ROTHSTEIN . . . . VOIR DIRE.	100
MR. WICEVIC .DIRECT EXAMINATION (CONT.) . . .	104
MR. ROTHSTEIN . . CROSS-EXAMINATION.	138
MR. WICEVIC . RE-DIRECT EXAMINATION. . . .	215
DR. EDGAR DESCHAMPS:	
MR. WICEVIC . . DIRECT EXAMINATION.	217
MR. ROTHSTEIN . . . . VOIR DIRE.	226
MR. WICEVIC .DIRECT EXAMINATION (CONT.) . . .	231
MR. ROTHSTEIN . . CROSS-EXAMINATION.	260
MR. WICEVIC . RE-DIRECT EXAMINATION. . . .	321
MR. ROTHSTEIN . RECROSS-EXAMINATION.	321
Certificate	329

EXHIBITS

(Petitioner's Exhibits 1-14 and Respondent's Exhibits 1-22 were marked prior to the hearing.)

Petitioner's Exhibit Number 12 223
(Dr. Deschamps CV)
Petitioner's Exhibit Number 27 82,99
(Mr. Douglas CV)
Respondent's Exhibit Number 21 81
(Curriculum Vitae of Frank DeAngelo)

(The original exhibits were retained by Judge Robinson.)

STIPULATIONS

It is stipulated and agreed that this hearing is being taken pursuant to the rules of the Administrative Law Court and the South Carolina Rules of Civil Procedure.

THE COURT: Good morning. And I am going to call this hearing to order. We're at this point taking witnesses out of order, or are we agreed to begin with Mr. Wicevic?

MR. ROTHSTEIN: Yes, Your Honor. I discussed with Mr. Wicevic about us putting our expert witness on the stand.

THE COURT: Okay.

MR. ROTHSTEIN: As I mentioned, he's from Philadelphia and he's scheduled for surgery tomorrow.

THE COURT: Okay.

MR. ROTHSTEIN: So we'd like to get him back.

THE COURT: Okay. Is there anything we need to take up prior, other than calling the witnesses out of order?

MR. ROTHSTEIN: Just one matter, Your Honor. Yesterday, it was kind of late in the day when Dr. Kickham was on the stand. I started asking him a line of questioning about a malpractice claim that he was involved in. Mr. Wicevic objected and Your Honor sustained the objection. I'd like to proffer that testimony just for the record as to what that testimony would have been had Your Honor allowed that

like of questioning, just for the record.

THE COURT: Uh-huh.

MR. ROTHSTEIN: In 1999, Dr. Kickham had a medical malpractice lawsuit brought against him. This is a matter of public record in Anderson County. That case was settled. It was a wrongful death case. It was settled on a confidential sentiment amount. It was approved by The Court, but there's no discussion about what the amount of payment was other than what the approval of attorney's fees and cost were, attorney's fees being a percentage one third percentage. That case arose out of a gentleman who slipped and fell on a dock, presented himself to the emergency room. Dr. Kickham I think was not the doctor taking care of the patient initially. The patient came back about two days later complaining of a headache. Dr. Kickham did what's called a lumbar puncture, and he performed a CT, which is an imaging study that would show whether there's fluid in the brain. Once the lumbar puncture was done the fluid rapidly released through the hole that was created by the lumbar puncture. The patient's brain herniated and the patient

subsequently died about two or three days later. And the point of that testimony was that Dr. Kickham still had his active medical license. He never had his medical license revoked by the Board of Medical Examiners. And I know that's a different licensing body than DHEC. But the point I was going to ask Dr. Kickham about was whether he believed it would have been fair for DHEC to have pulled his license for one occurrence of alleged negligence. That's the proffer.

THE COURT: Thank you. Okay. Now at this point, are you ready to call your witness, Mr. Rothstein?

MR. ROTHSTEIN: Yes, Your Honor. We call to the stand Frank DeAngelo.

THE COURT: Mr. Deangelo, is it doctor?

DR. DEANGELO: Yes.

THE COURT: Okay. Before taking your seat, face the court reporter, raise your right hand, he will swear you.

DR. FRANK DEANGELO, having been duly sworn, testifies as follows:

DR. DEANGELO - DIRECT EXAMINATION BY MR. ROTHSTEIN:

Q: Good morning, sir. Would you please state your

full name for the record?
A: Frank J. DeAngelo.
Q: And I've never had experience in the military. I certainly don't mean any disrespect. I don't know if it's proper refer to you as Colonel DeAngelo or Dr. DeAngelo in this proceeding. How would you prefer that I address you?
A: You can call me Dr. DeAngelo.
Q: Okay.
A: But actually Frank is certainly fine.
Q: And, Dr. DeAngelo, there's a microphone in front of you. If you could try and speak into that as we go through the questions today. Where do you currently live?
A: I live in Villanova, Pennsylvania.
Q: Okay. And what do you do for a living?
A: I'm a trauma surgeon.
Q: And where are you currently employed for the civilian side of your employment?
A: Atlantic City Regional Medical Center in Atlantic City.
Q: I'm going to hand you a document that's marked previously as Respondent's Exhibit 21. Do you recognize that as a copy of your curriculum vitae?

A: Yes.
Q: And is that CV up to date?
A: Yes, except for my thoracic oral boards. I didn't take them in June of 2017. I hope to take them in June of 2018.
Q: Okay. Other than the issue of your oral boards, is it generally complete and current?
A: Yes.
Q: Okay. I won't go through the entire CV, but will you give The Court sort of a brief summary of your -- first we'll start with your medical education and training?
A: I went to Hahnemann University School of Medicine in Philadelphia, which is now called Drexel University. It merged with Drexel.
Q: When did you graduate from Hahnemann or Drexel for medical school?
A: My diploma says Hahnemann.
Q: And what year did you graduate medical school?
A: 1990.
Q: Did you earn any honors during medical school?
A: Yes. On my CV I have some honors, rotations in medicine, surgery rotations, surgery sub-internship.
Q: After you graduated from Hahnemann where did

you do your, I guess they call it post-graduate medical education?

A: I did a year at Hahnemann and then that was just an internship. And then for my full five year general surgery residency I went to Episcopal Hospital, also in Philadelphia.

Q: Okay. And what were the years of your residency in general surgery?

A: 1991 to 1996.

Q: Okay. Did you have any fellowship after you completed your general surgery residency?

A: Yes I did. I had a cardio-thoracic fellowship at State University of New York in Brooklyn.

Q: Okay. And explain to The Court what a fellowship is or how it differs from a residency.

A: It's sort of a continuation of your residency. You're still in training and closely supervised by attending surgeons, but you're training in a specific sub-specialty of surgery. In this case it was cardio-thoracic.

Q: Is a fellowship required to be a board certified physician or surgeon?

A: Yes.

Q: Okay.

A: Well, yes.
Q: Okay. Did you have any additional graduate medical education or training?
A: Yes. Then I did a trauma, surgical critical care trauma at Lincoln Medical Center in Bronx, New York.
Q: And I see on your resume there's a mention of a, looks like a second residency in cardio-thoracic surgery. Is that right?
A: Yeah. Well, okay. Before I started the accredited two year fellowship, I did one year of just general thoracic surgery. That's not an -- you can't get boarded in thoracic surgery. That was really just a year of extra experience. And I did that because I didn't get an accredited spot to begin the next year. They gave it to me the following year. And they said, well do you want to come up and start working with us in a non-accredited position. And I was happy to do it because I did have a special interest in thoracic surgery, which is different -- there's two branches of cardio-thoracic, cardiac heart and thoracic lung. And had a particular interest in lung surgery.

Q: Do you hold any board certifications?
A: Yes. In general surgery and surgical critical care.
Q: And I think you mentioned when you're updating your CV that you're attempting to be board certified in another field?
A: Yes. I would like to get my cardio-thoracic boards, all though I don't do it and I never will do it. It's just another something to put on my wall of my office at this point.
Q: How long have you been working in the Atlantic City hospital that you mentioned earlier?
A: Since the Summer of 2013.
Q: And do you work in the emergency department or the ER, or ED there?
A: Trauma surgeon, I work in the trauma bay, which is attached to the ER but a different department. Obviously we work closely together.
Q: What level trauma center is the hospital in Atlantic City that you work at?
A: It's level two.
Q: Okay. Can you explain to The Court what a level two trauma center is?
A: Level two trauma center, the main thing is we

don't have the ability to put someone on a heart lung pump. The other difference between -- there are several differences between level one and level two. To be honest with you, I'm not completely familiar with all of them. The main thing is we don't have the ability to put someone on a heart lung bypass. We also don't have in-house neurosurgical residents. Two of the most important requirements that I'm aware of to be level one you have to have the ability to put someone on a heart lung bypass machine, you have to have a neurosurgical residency at that hospital so that there are always neurosurgical specialized physicians in the hospital. I'm sorry, there's a third requirement that I'm aware of, and that is you have to have a pediatric ICU so that you can take pediatric patients. And in our hospital that's defined as patients under 15 years of age. So we don't have any of those things, so we're not level two. There may be other differences between level one and level two. Honestly I'm not familiar with them because I'm not a department head.

Q: Okay. And I don't want to dwell on that too

much. Have you ever worked at a level one trauma center in your career as a trauma surgeon?

A: Yes. For four years at Cooper University Hospital in Camden.

Q: In your employment as a trauma surgeon, do you frequently interact with EMT's and paramedics?

A: Yes.

Q: How often would you say you interact with EMT's and paramedics as part of your position?

A: Every day. Every day that I'm on call.

Q: Have you had occasion to observe the various skill levels of certified nationally registered paramedics?

A: Yes.

Q: Have you ever been a paramedic yourself?

A: No.

Q: Have you ever ridden any emergency calls with a paramedic crew?

A: No.

Q: Have you ever served as a Medical Control Physician for a rescue squad or ambulance or sort of supervising EMT's and paramedics?

A: No.

Q: Have you ever treated trauma patients that have

been brought into the emergency department with a penetrating knife wound or multiple knife wounds?

A: Yes.

Q: Okay. How frequently would you say you see knife wound patients in Atlantic City?

A: I would guess once a week.

Q: Have you ever treated a patient with a knife wound where the knife is actually left in place or reined in place when that patient was brought to the emergency department?

A: Last time that I recall was several years ago at Cooper.

Q: Have you ever treated patients with a knife wound specifically to the abdomen?

A: Yes.

Q: Have you ever treated patients with other types of penetrating wounds to the abdomen caused by other mechanisms of injury?

A: Yes.

Q: Could you give The Court some examples of other penetrating type injuries to the abdomen that you've worked on?

A: The other big category is gunshot wounds.

Q: Have you ever had any experience in treating

patients with self inflicted knife wounds?
A: Yes.
Q: How common or rare is it to see a self inflicted knife wound where the blade actually makes it past the subcutaneous tissue and fat?
A: It's not common.
Q: Okay. Do you know why that's a fairly rare occurrence?
A: Once the blade gets through the fat and muscle, it encounters the peritoneum, a thin layer of tissue that surrounds the abdominal contents. And it's very, very highly innervated and it hurts a lot. We find that self inflicted stab wounds often, the blade doesn't get much past that because of the pain.
Q: Have you written any publications or made any presentations on the subject of penetrating trauma?
A: No, I've not.
MR. ROTHSTEIN: Your Honor, at this point I'd like to move to certify Dr. DeAngelo as an expert witness in the area of general principle of trauma surgery as well as the area of diagnosing and treating patients with penetrating knife wounds to the abdomen.

MR. WICEVIC: Your Honor, if I could voir dire Dr. DeAngelo.

THE COURT: Yes.

DR. DEANGELO - VOIR DIRE BY MR. WICEVIC:

Q: Dr. DeAngelo, first of all, my name's Vito Wicevic, I represent the DHEC. I introduced myself a little bit earlier. I just a have a couple questions about your resume and your involvement in surgery. And some of these might just be mistakes. I was doing a Google search and following up with various licensing bodies you listed on your resume. And again, you said this CV is up to date, correct.

A: Yes.

Q: Do you currently have licensor with Pennsylvania?

A: It's on hold. I have renewed it. They now require that you do an online CME and three credits on, I believe it's recognizing child abuse. I did the online CME, but somehow it didn't cross over to Pennsylvania. CME's are sitting on my desk and I haven't had time to work it out. So yes, my Pennsylvania license is on hold.

Q: Okay. And CME is just like continuing

education?
A: Yes, yes.
Q: Okay. New York, it appeared -- and again I'm just operating off of my search on the New York Public Health website, that you're no longer licensed in New York. Is that correct?
A: To my knowledge I am unless the renewal came to my house and I haven't seen it yet.
Q: Okay. Pennsylvania, it appeared that your license expired at the end of 2016?
A: Yes. I renewed it, but as I said, it's on hold.
Q: Okay.
A: I paid the fee and so on.
Q: Okay. And New Jersey, is it correct you renewed this past June?
A: Yes, yes.
Q: Okay. And, question. Throughout your military experience, have you maintained your licensor in these various states?
A: For the most part, yes.
Q: And can you explain that?
A: During my time in the military -- when I joined the military I was only licensed in Pennsylvania. Later on I became licensed in in

New York. Later after that I became licensed in New Jersey. So I can't say that the whole time that I was in the military that I was licensed in all those states. But ---

Q: Okay.

A: --- when I first joined I was only licensed in Pennsylvania because I was in medical school when I first joined.

Q: Okay. One other thing about your certification and licensor. You're listed as a diplomat of the American Board of Surgery.

A: Yes.

Q: And again, this might just be an online mistake, but it appeared when I did a search of American Board of Surgeries certificate look up, your name wasn't listed. Are you currently certified?

A: Yes. I'm board certified in general surgery and trauma critical care.

Q: Okay. Now have you had any malpractice or negligence verdicts against you?

A: I have, to my knowledge, I have not. I've been deposed about three times in my career, and in all cases I never heard anything else about it.

Q: Okay.

A: And I was told that I had been released from the case.
Q: Okay. So there was no settlements?
A: No. I've never been informed of any money that's been paid out in my name.
Q: Okay. Any disciplinary action by your previous employers, hospitals?
A: No.
Q: The military?
A: No.
Q: I wouldn't think. Looks like you're a Colonel. You also talked about your specialization surgery. Now you specialize in thoracic surgery, is that correct?
A: I trained in cardio-thoracic but I haven't completed the board certification.
Q: Okay.
A: I don't practice it. I practice trauma surgery.
Q: Okay. And thoracic surgery, that means the injury is somewhere between the -- the surgery is somewhere between the neck and the abdomen?
A: Yes. Cardio-thoracic is everything in the chest.
Q: Okay. Am I correct that emergency medicine and

trauma surgery are -- I mean, they're related but they're separate, correct?

A: Yes.

Q: Okay. And the emergency department is to stabilize and cure the patient, is that correct?

A: Yes.

Q: And then if they require surgery ---

MR. ROTHSTEIN: Your Honor, this is getting beyond voir dire. I mean I think voir dire is limited to the credentials and qualifications of the expert witness. I have not moved to have Dr. DeAngelo qualified as an emergency room physician or an emergency department physician. I think Mr. Wicevic's getting a little far off.

MR. WICEVIC: Well, Your Honor, my basis for that line of questioning was that there was reference through the direct about his relation to civilian paramedics, civilian EMT's. This case is about civilian EMT's, emergency medicine. So I was pointing out the distinction between that and the relevancy of -- I mean this case isn't about inappropriate traumatic or trauma care, trauma surgery. This is about the care of an EMT. So my questioning

was directed at showing the ---

THE COURT: Mr. Wicevic, you can proceed with your questioning.

Q: So, Dr. DeAngelo, am I correct that emergency room and the OR, the Operating Room, they're distinct parts of the hospital, is that correct?

A: Yes.

Q: And how often is a paramedic in the Operating Room?

A: Not very often.

Q: Okay. And that's generally where you're at, correct? The Operating Room?

A: Not all the time. I'd say maybe 40 percent of the time. The rest of the time in the trauma bay.

Q: Okay. And the trauma bay is kind of where you learn if someone is going to require some kind of trauma surgery?

A: Yes.

Q: Okay. And you have general communications with the ER doctor and ER staff, correct?

A: Yes.

Q: Okay. So I mean the contacts with EMT's generally pretty limited?

A: Well, when a patient ---

THE COURT: Mr. Wicevic, you're getting into a line of questioning that's ---

MR. WICEVIC: More cross?

THE COURT: Yeah. That goes more into cross.

MR. WICEVIC: Okay. There's no further questions, Your Honor.

THE COURT: Okay. Now, Mr. Rothstein, you're seeking to have this witness ---

MR. ROTHSTEIN: Qualified as an expert witness in the area of general principles of trauma surgery as well as the area of diagnosing and treating patients with penetrating knife wounds to the abdomen.

THE COURT: Based upon his training and the experience that I've heard, I think that he's qualified in those areas.

MR. ROTHSTEIN: Thank you, Your Honor.

THE COURT: And I will allow him to testify as an expert.

DR. DEANGELO - DIRECT EXAMINATION BY MR. ROTHSTEIN (CONT.):

Q: Dr. DeAngelo, have you had a chance to review some of the medical records relating to the self inflicted stabbing incident in Iva, South

Carolina on March 19th, 2016, where Mr. James Davenport responded to a 9-1-1 call as a paramedic?

A: Yes.

Q: Have you reviewed other documents other than the medical records from the hospital? Have you reviewed other documents relating to this call?

A: I saw the body cam footage.

Q: Okay. Have you seen the patient care report that was prepared by the civilian EMT crew?

A: I saw the chart when the patient came into the ER.

Q: Is that notebook still up there? I'm going to ask you to look at Exhibit 11b.

A: Okay. I did see this.

Q: Okay. And can, for the record, you identify what Exhibit 11b is?

A: this is the records kept by the ambulance crew.

Q: Okay. And I think you mentioned you viewed the body worn camera video footage taken by an Iva police officer who was on the scene at that incident?

A: Yes.

Q: Okay. Now I'd like to turn your attention to

that specific report that you were just looking at. Can you tell from looking at the patient care report whether or not the patient was stable from the time Mr. Davenport and his partner arrived on the scene until they delivered the patient to the ED at AnMed hospital?

A: Yes, I can tell.

Q: Okay. And do you have an opinion to a reasonable degree of medical certainty about whether that particular patient was stable during that time period?

A: Yes, I would say stable.

Q: Okay. What were the patient's vital signs en route to the hospital as reported in that patient care report?

A: A blood pressure of 129 over 83, and a second blood pressure of 128 over 88, with a pulse of 88 on both those blood pressures.

Q: Okay. Are the blood pressures and pulses within normal limits for a stable patient?

A: Yes.

Q: And do you recall when you looked at the medical records from the AnMed hospital, were the patient's vital signs similar once he

arrived at the ED?
A: Yes.
Q: And what was the patient's O2 saturation during his trip from the scene to the hospital?
A: 98 percent.
Q: Okay. Can you explain to The Court what an O2 saturation is?
A: That's how much oxygen is bound to the hemoglobin in your blood.
Q: How is that measured, or what type of device is used to measure the ---
A: You use a pulse oximeter. It's a device that's put on the finger and it shines a little light through your nail bed, and it comes up with a reading in a percent.
Q: Okay. What can you tell from a pulse ox reading?
A: You can tell if the patient's oxygenating normally or, either normally or is oxygenating enough to stay alive.
Q: Are readings between 95 and 99 percent within the normal range?
A: Yes.
Q: Okay. Did there appear to be any appreciable change in the vital signs during the transport

of this patient from the scene to the hospital?
A: No.
Q: Do you have an opinion to a reasonable degree of medical certainty about whether this patient needed supplemental oxygen during the pre-hospital care?
A: My opinion is he didn't need it.
Q: What is that opinion based on?
A: The fact that he's 98 percent on what we say room air. In other words he's breathing air is 98 percent which is a completely normal saturation.
Q: Do you know whether this patient received supplemental oxygen after the ambulance crew dropped him off at the ED?
A: I don't know.
Q: Do you have an opinion -- or let me ask you this. When you were viewing the body cam video footage, did you have an opportunity to observe the patient, see the color of his skin and listen to the tone of his voice?
A: I probably couldn't see the color of his skin too well on the body cam, but I could observe his face and his -- I could get a good idea of how he looked.

Q: Okay. Did the patient appear to be in any type of respiratory distress as you saw the video?
A: No.
MR. ROTHSTEIN: You have the photograph, Exhibit 25?
Q: Dr. DeAngelo, I'm going to hand you a photograph that's already in evidence and it's been marked as Exhibit 25. Do you recognize that gentleman as the person that you saw in the body cam video?
A: Yes.
Q: Okay. I'll represent to you that that photograph was taken in the ambulance shortly after the patient was put into the ambulance on the scene. Can you tell looking at that photograph whether the patient appears to be having any type of respiratory distress?
A: No. From the photograph I would say he doesn't look like he's having respiratory distress.
Q: Can you tell the color and condition, or at least the color of his skin by looking at it?
A: Yes. Yes, I can tell it doesn't look like he's pale.
Q: In your experience and training as a physician, what do patients look like when they're either not getting sufficient oxygen or having some

type of respiratory distress?
A: They're breathing like they just ran a marathon even though they're lying on a stretched.
Q: Okay. Is there sometime some change in the color and sort of appearance of their skin?
A: They'll be sweating and cool to touch.
Q: Okay. Based on your review of the records that you looked at, do you have an opinion to a reasonable degree of medical certainty about whether this patient needed any type of intravenous therapy during his pre-hospital care provided by Mr. Davenport and his partner?
A: I don't think he absolutely needed it.
Q: What concerns would be present in your mind given your experience and training in deciding whether or not to start an IV on a psych patient in the pre-hospital setting where the patient had a knife in the belly?
A: Well I know from -- from what I know about the case, that obviously the patient stabbed himself. I know that the was known to the EMS crew as a psychiatric patient. And I think often patients, especially psychiatric patients really don't like having an IV started. They get kind of agitated, they'll pull away from

you, they won't let you put it in and so forth. I think that since his vital signs are stable, you know, you weight the benefits versus the risks. I don't think -- in my opinion is it was a good judgement call to forego IV's and just get him to the hospital.

Q: And I've had IV's before. I imagine the -- just for the record, an IV involves sticking a needle through somebody's skin and into a vein?

A: Yes.

Q: Can that be a painful procedure?

A: Yes.

Q: Okay. And have you had experience or observed a patient that being stuck with an IV, sort of pulled away from it for flinched?

A: Yes.

Q: Is that a potentially dangerous situation where you have a patient with a knife impaled in their belly?

A: Yes. You don't want them to really make any sudden movements.

Q: Do you have an opinion to a reasonable degree of medical certainty about whether this particular patient needed any type of medication during the pre-hospital setting?

A: I would say he didn't need anything.
Q: Do patients with mild distress typically need pain medication?
A: No.
Q: Do patients with a pain assessment of four out of ten generally need pain medication to be administered by a paramedic?
A: No.
Q: If this particular patient had nicked his small bowel when the knife went in and caused some type of potential infection. Is there any medication that the paramedic could administer to treat that condition?
A: No.
Q: How does that type of a condition need to be treated?
A: The patient needs to go to surgery.
Q: Okay. Can a patient with a knife impaled in his abdomen still be considered a stable patient?
A: Yes.
Q: Now if you'll look back at Exhibit 25, does that patient appear to be in pain?
A: No.
Q: Okay. I'm sure you have patients or observe

patients come to the ED a lot that are complaining of pain and are either drug seeking or sort of faking pain, is that right?

A: Yes.

Q: And do you have any sort of telltale signs about when you see a patient laying on a stretcher whether he's truly in pain or not?

A: They would have their ankles crossed.

Q: Okay. Does this patient in photograph 25 appear to be fairly relaxed?

A: Yeah. He has his hands resting on his abdomen across -- not so much across, but sort of just holding them. He even looks relaxed.

Q: Let me show you another photograph.

MR. ROTHSTEIN: Let me see the stack.

Q: I'm going to show you what's been marked, it was actually introduced as Exhibit 24. And I'll represent to you that's a close up of the same patient that was in Exhibit 25. I know you can't see his face but ...

A: Yes.

Q: Now focusing on the stabilization or the dressing around the knife, does that appear to be appropriately stabilized in place?

A: Yes.

Q: What do you believe was the most important sort of critical component or the first thing that needed to be done when emergency crew came to this scene and saw a patient with a knife impaled in his belly?

A: Most important thing would be -- my opinion would be the most important thing would be to get him into the ambulance and to the hospital.

Q: Is it important to keep the knife from moving any further?

A: Yes.

Q: Okay. What would happen if the EMT just pulled the knife out of the patient's abdomen? Or what could happen?

A: If the knife was sitting in an organ or a structure such as the aorta or the spleen that had the potential to bleed a lot, the feeling to my knowledge is that with the knife sitting in there, it may actually have penetrated that structure. The fact that it's still in there is keeping that structure from just, you know, bleeding explosively. So it's felt that the knife should be left in place until the patient gets to the hospital. And even then, to my knowledge, these type of injuries the knife is

not taken out until you're actually in the Operating Room in case removing the knife causes some change structurally inside, such as the patient suddenly starts to bleed a lot. You're in the Operating Room, you can take care of it.

Q: If an EMS crew in Atlantic City delivered a patient with a similar self inflicted stabbing wound to the trauma bay that you work at in the condition that this patient appears to have been left at AnMed in South Carolina, would you think that the paramedic crew had done their job appropriately?

A: Yes.

Q: Now you mentioned the body cam video. In your observations of Mr. Davenport's interactions with this stabbing patient, did you see anything in the footage to support an accusation that Mr. Davenport treated this patient below the standard of care?

A: No.

Q: In your experience with trauma patients, specifically with those with impaled objects in their abdomen that had been stabilized first, is allowing such a patient to walk at his own

pace with assistance for a short distance an unreasonably dangerous manner of moving that patient?

A: Can you say that again please?

Q: Yeah. That was a long one. In your experience with trauma patients, specifically those with impaled objects in their abdomen that have been stabilized, is allowing that patient to walk with slight assistance under their own power from the scene to the ambulance an unreasonably dangerous risk?

A: In this case I would say no because I know from discussions that the patient was known to the EMS services, he was known to have psychiatric history, and he may not have liked being laid down on the stretcher and might have put up a fuss. So in that case I think having him slowly walk out of the house with support, supporting him as he slowly walks out of the house down the steps I think is very acceptable in order to keep him from making any jerky or sudden movements. And then I know that when they got him into the ambulance they then laid him down. I think all of that is sound judgement in my opinion.

Q: Okay. Let's talk a little bit about your military experience. Are you currently in the military?
A: Yes.
Q: And I know Mr. Wicevic asked you some questions about sort of administrative type suspensions of your licenses. How often do you get assigned to military duty since you've been actively in the military?
A: Well I drill every month for two to four days. Sometimes longer. We do a two or three week AT every year, and I've had three deployments.
Q: How long have those deployments actually been?
A: the first one was about 11 months. The second one was I think 8 months, and the last one was I think 6 months.
Q: In the Army, do you have a lot of control over when and where you're deployed?
A: No. None.
Q: Okay. And I didn't ask the question, but you're currently in the United States Army?
A: Yes.
Q: Okay. And what is your current rank in the Army?
A: Colonel.

Q: Okay. How long have you been a Colonel?
A: I actually don't remember. I think it's about two years.
Q: I think it may be on your CV.
A: Yeah.
Q: Are you familiar with the United States Army Special Forces or Green Berets?
A: Yes.
Q: Okay. Have you ever worked with any United States Army Special Forces groups?
A: Yes.
Q: Are you familiar with the training that Special Forces Medics receive?
A: Yes.
Q: Can you describe sort of generally the training that Special Forces Medics have to undergo before they actually become Special Forces Medics, or 18-Deltas?
A: Yes. They undergo, I think about a year long instruction in which they learn the basic physiology and then they advance to learn about pharmacy and medications. They get a lot of instruction in surgical technique. I think more so than most other branches of the military. They can do a lot of surgical

procedures independently. Many other practitioners don't. They get instructions on placing chest tubes, on intubating patients, on doing surgical airways, on doing suturing, and amputations, completions of amputations. They go through a long medical course in order to become Special Forces Medic or an 18-Delta as they're called. And then after that they have to maintain their qualifications through regularly attending a course in combat trauma management which I assist in. They also do rotations in local ER's and trauma centers. They do several training events every year in order to maintain their proficiency.

Q: How does the training that an SF Medic receives, or the education in anatomy and physiology compare to say your training for medical school?

A: It's very close to what we receive.

Q: And you mention these various rotations. How do those rotations that Special Forces Medics go through as part of their training compare to say an internship or a first year out of medical school?

A: I would say a Special Forces Medic is easily

the equivalent of a civilian, what we call a physician's assistant. And the experience Special Forces Medic, just in my opinion, this is just my opinion, can be as well trained and experienced as a surgical intern.

Q: How does the skill set and scope of practice of a Special Forces Medic compare to other types of medical professionals in the civilian world? I think you mentioned a physician's assistant.

A: Yes. A physician's assistant can do surgical procedures, but directly under, you know in a civilian hospital and a physician has to always be supervising them. A Special Forces Medic is trained to do surgical procedures such as chest tubes, surgical airways, and amputations. That medic is trained to do those procedures independently because obviously if you're deployed in a austere hostile environment, there's not going to be a physician nearby to supervise you. You have to be trained to do it on your own.

Q: Are Special Forces Medics trained on critical thinking skills?

A: Yes.

Q: Are Special Forces Medics trained on patient

assessments?
A: Yes.
Q: Are you aware of sort of the wash out rate is in training to become a Special Forces Medic?
A: I can't give you a number, but -- I can't give you a number. But I would think that it's pretty high?
Q: You think it's higher than a general surgery residency?
A: Yes.
Q: Can one make it thought the Special Forces training and become a Special Forces Medic or an 18-Delta without possessing substantial skill in critical thinking and patient assessment?
A: No.
Q: How do you know James Davenport?
A: We've served together in the 20th Group for a couple years.
Q: Okay. And what is the 20th Group?
A: The 20th Special Forces Group is one of two National Guard Special Forces Groups. 19th and 20th Group.
Q: And what is the sort of the mission of the 20th Group generally?

A: Well we're a Special Forces Group, so we carry out special operations type deployments throughout the world.
Q: Have you ever served in active duty with Mr. Davenport with the 20th Group?
A: I believe that we have been deployed at the same time. We haven't actually been side by side.
Q: Have you had an opportunity to observe Mr. Davenport's medical knowledge and clinical skills as an SF Medic?
A: Yes.
Q: How would you describe Mr. Davenport's performance and abilities as a Special Forces Medic?
A: Excellent.
Q: Would you have any hesitancy at all about allowing Mr. Davenport to provide emergency medical care to you if you were injured in some type of significant emergency?
A: I would absolutely no problem with it.
Q: Would you have any hesitancy in allowing Mr. Davenport to provide emergency medical attention to one of your family members if they were similarly injured?

A: No. I would have no issue.
Q: Do you believe that Mr. Davenport is a compassionate health care provider?
A: Yes.
Q: Have you ever witnessed Mr. Davenport provide medical care to people that he was not particularly fond of?
A: I don't think that he really dislikes anyone.
Q: Are you aware of Special Forces Medics, including Mr. Davenport, providing medical attention to enemy combatants in hostile ---
A: Yes.
Q: --- territory?
A: Yes. I am aware of that.
Q: Do you believe that Mr. Davenport is a dedicated medic?
A: Yes.

MR. ROTHSTEIN: I don't have any further questions, Your Honor.

THE COURT: Okay. Mr. Wicevic.

MR. WICEVIC: Thank you, Your Honor.

DR. DEANGELO - CROSS-EXAMINATION BY MR. WICEVIC:

Q: Okay. Dr. DeAngelo, how were you retained to be an expert in this matter?
A: I am friends with James Davenport.

Q: Okay. Are you being compensated for this testimony?
A: No.
Q: No? I think you mentioned there were -- you are in the National Guard with Mr. Davenport -- -
A: Yes.
Q: --- and have been deployed at the same time. What about Mr. Leo Deason? Any relationship with him? Do you know who Leo Deason is?
A: No.
Q: Okay. Is it accurate to say that you and Mr. Davenport maintain a friendship?
A: Yes.
Q: Do you communicate often?
A: Yes.
Q: About how often?
A: About once a month.
Q: Okay.
A: At most once a month. Sometimes more. I'm sorry.
Q: Sure. Do you ever visit Mr. Davenport?
A: No.
Q: Have you met Mr. Davenport's family?
A: No.

Q: Okay. You mentioned you were deployed at the same time, but in a different battalion? I'm not sure if I'm using the ---
A: Well when you're deployed, especially in Special Forces you spread out throughout the country. So I can't say that I actually was side by side with James.
Q: You testified that you worked with the Special Forces Medics ---
A: Yes.
Q: --- on a regular basis?
A: Yes.
Q: Now while serving in the military, you develop close bonds with your fellow service members, correct?
A: Yes.
Q: That' especially true if you're begin deployed?
A: Yes.
Q: Okay. You become almost like family?
A: Yes.
Q: Now you did some equivalence to a Special Forces Medic to a physician's assistant and surgical intern. Now you understand that when you come back to The States there's licensor for such professions, correct?

A: Yes.
Q: Okay. Now I understand you're very familiar with the practice of trauma surgery and various wounds. But you're not familiar with general EMS practice, civilian EMS practice, correct?
A: No.
Q: Okay. Now your work on this case, about how many hours do you think you've taken in reviewing this matter?
A: I'm going to say five hours.
Q: Okay. You read the patient care reports, you reviewed the body cam footage?
A: Yes.
Q: The medical records?
A: Yes.
Q: Did you review the witness statement?
A: Witness statement? I'd have to say no.
Q: Okay. And I imagine you consulted with Mr. Davenport, correct?
A: Yes.
Q: Okay. And just to clarify again, you mentioned that you're not familiar with generally accepted emergency medical treatment standards, is that correct?
A: I'm not a paramedic. I don't supervise

paramedics. But I do, you know -- our patients get brought to us by paramedics, so I do have some contact with them.

Q: Okay. I mean do you review reports from paramedics?

A: I don't -- I review them because they become part of my patient's charts, but I don't review them in the respect that I look at them to see if they -- that I evaluate them and decide whether anything was done right or wrong.

Q: Right. Well that's important, right? I mean you're looking for full documentation of the continuum of care?

A: Yes.

Q: So any kind of care provided by an EMT, you'd expect that to be documented, correct?

A: Yes.

Q: Okay. So, I mean, generally your testimony here is limited to medical judgement of this particular injury of the patient, correct?

A: Yes.

Q: Again, you're not testifying about -- you're not familiar with civilian paramedicine?

A: No

Q: All right. You've never practiced here in

South Carolina as a physician, correct?
A: No.
Q: You never practiced as a Medical Control Physician?
A: No, I haven't.
Q: Are you aware of the types of orders and protocols that Med. Control Physician has for the paramedics?
A: No.
Q: Okay. Do you know what the National Registry of EMT's is?
A: Yes.
Q: Okay. Is it your understanding that that's the accrediting body?
A: Yes.
Q: Okay. And you're mostly familiar, based upon experience, with the Special Forces Medics, correct?
A: Yes.
Q: And I think you mentioned in your direct testimony that Special Forces Paramedics have much more skills than civilian paramedics. Is that correct?
A: Yes.
Q: They receive much more training and education?

A: Yes.
Q: And they see some pretty gruesome injuries in the battlefield, correct?
A: Yes.
Q: Okay. And they're often left on their own to treat those types of injuries, correct?
A: Yes.
Q: I mean, you even said they're akin to a physician's assistant, and that would be in respect to their decision making authority?
A: Their level of training, their skill level with procedures they can do.
Q: Would you say the decision making authority for a Special Forces Medic because of the environment and the injuries that they confront, I mean they have pretty much unlimited discretion?
A: I wouldn't -- I'm uncomfortable with the word unlimited. But they do have a lot of desecration to make their own decision. They kind of have to.
Q: Check the injury, assess the environment, and they make their own decisions based upon their training and education?
A: Yes.

Q: Okay. Now there's no standing orders in Special Forces Medicine, is that correct?
A: There's no what?
Q: Standing orders?
A: In Special Forces Medicine?
Q: Yes, sir.
A: I'd have to say I don't know.
Q: Okay. I mean would it be fair to say that after you have a lengthy career as a Special Forces Medic, it'd be difficult to return to the civilian paramedic practice?
MR. ROTHSTEIN: Object, Your Honor. Calls for speculation.
THE COURT: Sustained.
MR. WICEVIC: Okay.
Q: Well as a physician, if you were no longer allowed to -- I'll move on. Dr. DeAngelo, the patient I question, what kind of surgery did he require?
A: He was taken to the Operating Room by the trauma surgeon at that hospital. He did a -- that surgeon did a laparoscopy, which is sort of a minimally invasive way to enter the abdomen and look around. They make a small incision below the belly button, the umbilicus.

They put a tube in there and they fill the abdomen with CO2, and it kind of puffs out. Then they make another incision nearby, and they put another sort of plastic tube in there and they put a camera and they look around and see what's going on. In this case they did that, they saw that the knife had just poked into the abdominal cavity, but they did not see that it had damaged any organs in the abdomen at all such as the colon, stomach, spleen. So they withdrew the knife under direct vision of the camera. There's some tissue in there called omentum. It's sort of fatty tissue that contains -- it's sort of an immune organ really. And it protects the abdomen from infection. They separated some of that omentum to get a good look at the colon and to confirm that the colon wasn't injured because the transverse colon is in the path of where that knife is. They looked around, they were satisfied that it hadn't hit anything and, as I said, they withdrew the knife under direct vision, and that was it. The surgery was done. The tubes that they put the camera and the CO2 in, they're called ports. They removed the

ports and that was it. The patient, as far as I know the patient went home the next day.

Q: Dr. DeAngelo, so the patient didn't have any intra-abdominal injury, but the knife did penetrate the peritoneum ---

A: Yes.

Q: --- is that correct?

A: Yes.

Q: And that's the -- is it I guess the membrane or the cavity?

A: It's a thin tissue like a skin that surrounds all the contents of your abdomen. It's like a skin. It protects the abdominal contents. It's very highly innervated. That's why as soon as the knife hits the peritoneum, these patients will stop at that point.

Q: You said it was very painful to have this kind of puncture?

A: Yes.

Q: Did you see how the patient characterized this patient in the emergency department records?

A: Yes, I did. But I have to find that.

Q: Well let me refer you. It's Exhibit 7, or excuse me 6 in the DHEC ---

MR. ROTHSTEIN: Your Honor, I'm going to object to

this exhibit. This exhibit's not in evidence and I think what Mr. Wicevic is getting ready to ask would be double or triple heresay.

MR. WICEVIC: Well I do have an affidavit record custodian for this, and I was planning on getting it into evidence. That being said, experts can rely on heresay. He relied on this document in his review of this case. So I think it's well within my authority to question him.

MR. ROTHSTEIN: Well the fact that he relied on it doesn't mean it's admissible into evidence. And the records custodian affidavit is not the ER physician that makes the statements that are in those records. Mr. Wicevic may have gotten past the first layer of heresay in terms of this was a business record of AnMed, but he can't get past the second layer of heresay, which is the statements that the doctor made in the report itself. And, Your Honor, this is getting back to the issue of DHEC doing no investigation. They didn't talk to the emergency room doctor, they didn't talk to the surgeon in this case, they only got these emergency room records and the OR records on a

subpoena that was issued in June of this year, about a month ago. And so, I object to this document actually coming into evidence.

MR. WICEVIC: Well, Your Honor, he just laid out a number of his alleged issues with this. Like I said, I was going to offer this into evidence during our case through one of DHEC's witnesses. They did obtain this during our investigation. We issued a subpoena and obtained it that way in order to establish a chain of custody. We have an affidavit record custodian. I think the business records exception applies directly here. These are observations and diagnoses and conditions that the emergency room physician who signed off on this as well as the emergency room nurse who also signed off on it observed. So I think it would fit within the business records exception. Again, my purposes of questioning Dr. DeAngelo was because he relied on this medical record.

THE COURT: Now is this the medical record that your witness has seen before?

MR. ROTHSTEIN: He's reviewed it before, Your Honor, but that still doesn't address the rule.

Evidentiary rule says that expert witnesses can rely on things that are not admissible into evidence. And the fact that he looked at it or reviewed it does not make that document admissible as a document here. And the fact that it might be a business record and that Mr. Wicevic might have an affidavit from the AnMed person saying, this is a business record only gets past the first layer of heresay. Your Honor probably recalls from evidence in law school, if you have multiple layers of heresay, every layer of heresay has to have an exception, and the doctor's statements -- this is not the patient asking the doctor something. A statement made for purposed of medical treatment is an exception to heresay rule. But what the doctor writes or what the nurse writes in the note about his or her own observations is heresay. And, Your Honor, I had no opportunity to cross-examen the emergency room doctor here. I had no opportunity to cross-examine the nurse, and that's the whole point of heresay is it's unreliable and it's inadmissible in a proceeding like this.

MR. WICEVIC: Well, Your Honor, I haven't even moved

to admit it at this point. I was asking Dr. DeAngelo about it 'cause it's something he relied in providing his testimony. Mr. Rothstein referred to the medical record a number of times in his direct testimony. I mean he asked him what kinds of surgery he had, so I think it's fully within my authority to question him.

THE COURT: Okay. So this is not a document that you at this point, you're not offering ---

MR. WICEVIC: That's correct.

THE COURT: --- it for evidence?

MR. WICEVIC: That's correct.

THE COURT: Just asking him to refer to a document that he reviewed in preparing for is testimony?

MR. WICEVIC: He testified that he reviewed it. Yes, Your Honor.

THE COURT: I'm going to allow him to refer to it.

MR. WICEVIC: Thank you, Your Honor.

THE COURT: And you can refer to it in your questioning.

Q: Dr. DeAngelo, according to the medical record, what was this particular patient's pain level on admission?

A: Can I look at it 'cause I don't have it?

Q: Yes, sir.
A: I have looked at it but I don't remember exactly.
MR. ROTHSTEIN: And, Your Honor, I object to this as well. I mean there's no -- the pain level at the hospital's irrelevant. We have the pain level until Mr. Davenport dropped the care off. Whatever happened after Mr. Davenport dropped off the care is not relevant to this proceeding.
MR. WICEVIC: I find it strange that he had him read through. He talked about O2 levels and other vital signs during his direct testimony, and now he's telling me I can't refer to the medical record? I think it is relevant. It's going to the continuation of care of this patient. Pre-hospital providers like EMT's are supposed to provide that care that will stabilize a patient and prevent further injuries. The continuation of care shows whether or not appropriate care was provided. He did refer to it during his direct testimony.
MR. ROTHSTEIN: Your Honor, it was for the limited purposes of showing that the vital signs were stable. And let me give you an example. If

Mr. Davenport's in the ambulance bay waiting for his partner to come out from dropping off the patient, they move the patient from the ambulance stretcher to the gurney and they drop the patient or they hit the knife accidentally, and we're talking about the emergency department crew, or if they go to take off the bandaging that Mr. Davenport put on, and they cause the patient some pain by ripping some skin or some hair out of his stomach, his pain level may change from a four to a higher level of pain. But that has nothing to do with Mr. Davenport's level of care that was administered to this patient in the pre-hospital setting. It also doesn't show that the patient was decompensating or that he was going into shock. I mean it just shows that he's experiencing a higher level of pain than he told the EMT's that he was experiencing on the trip to the hospital. It's completely irrelevant, Your Honor.

THE COURT: I'm not sustaining, but I'm overruling the objection. Excuse me. I'm overruling the objecting. I'm going to allow you to question him.

MR. WICEVIC: Thank you, Your Honor.

Q: Dr. DeAngelo, is Exhibit 6, do you have Exhibit 6? It's been tabbed out. Can you identify this document?

A: This is ED physician record.

Q: And is this the document that you reviewed in your preparation for this case?

A: Yes. I have seen this.

Q: Okay. And on the first page ---

A: Uh-huh.

Q: --- towards the bottom there's a vital sign box.

A: Yes.

Q: What was the pain scale of the patient?

A: Pain scale here's nine out of ten.

Q: Okay. So you talked about the knife penetrated the peritoneum?

A: Yes.

Q: Now also at this hospital, isn't it correct that their staff established these IV's? You can turn to the next one.

A: I'm not sure where it says ... Yes. It says here, yes. They did establish IV's at the hospital.

Q: Okay. And they administered a 1,000 milliliter

bolus of normal saline solution, is that correct?

A: Yes.

Q: Okay. And tell The Court what normal saline solution's for.

A: It's a salt solution that's used to expand the blood volume and to maintain the blood pressure.

Q: Okay. And it appears that according to this page 2 of Exhibit 6 ---

A: Yes.

Q: --- it was scheduled at 2157? Is that the scheduled date and time? Is that what that column refers to?

A: Schedule date time. I assume so. I'm not really sure what the ---

Q: Are you familiar with these types of ---

A: No. Our hospital doesn't use that term. But, you know, my guess common sense is, yes. Schedule date and time.

Q: Okay.

A: That's probably what it means.

Q: And if you turn back to the previous page, it looks like they arrived at 2154. Is that correct?

A: Yes.
Q: And that was a 1,000 milliliter bolus of normal saline solution. Was there another IV? It looks like ertapenem was established or ---
A: They gave antibiotics.
Q: Okay. And again, that was scheduled at 2206?
A: Yes.
Q: Okay. Are you familiar with trauma alerts?
A: Trauma alerts?
Q: Yes, sir. Do you know what a trauma alert is?
A: Trauma alert is an activation of the trauma team by the paramedics.
Q: Okay.
A: They call ahead and say, we're bringing this patient and we want him to be a trauma alert.
Q: Okay. And when did that occur for this? It looks like 2155? If you look back on that page 2, a little bit above the IV discussion.
A: Yes. Scheduled date and time, 2155.
Q: Okay. And it appears the patient was out of the emergency room in less that 30 minutes. Is that correct?
A: Yes. I'm pretty sure.
Q: I mean that's common for a trauma patient, correct?

A: Yes.
Q: Okay. 'Cause time is of the essence in caring for such a patient?
A: Yes.
Q: Have you ever heard of the golden hour?
A: Yes.
Q: And that's the principle that time is of the essence and you need to get that patient to the Operating Room and cared for?
A: Yes.
Q: Okay. Now is it your position that this patient was hemodynamically stable throughout Mr. Davenport's care?
A: Yes.
Q: Now isn't it correct that he did present with the possibility to decompensate?
A: Yes.
Q: I mean the nature of his injury created that possibility?
A: Yes.
Q: Okay. It's also correct that this injury could have involved multiple systems?
A: From the location of the knife and the fact that he's comfortable and his vital signs are stable, there is the possibility, but it's not

a high probability that anything vital was hit.
Q: Yes, sir. Well you don't know how long that knife is, correct?
A: No.
Q: I mean there's no way to know the length of the knife until you get it out during surgery, correct?
A: Not when you first encounter the patient, you don't know.
Q: And is there a reasonable way to know the path of the knife?
A: You can't be sure of it. But you have a good idea from the way it's sitting in his body what the path was.
Q: Okay.
A: But you can't really know for sure until you take him to the Operating Room what the path was.
Q: And there's no way to know with certainty at the scene of the accident whether the organs were actually punctured, correct?
A: I'll say, yeah, you're correct. You don't have any certainty. But, you know, you have probabilities.
Q: Okay. And I think you talked about this

patient in question, that he had a psycho-social history, correct?

A: Yes.

Q: He had a history of attempted suicides?

A: Yes.

Q: Overdosed, were you aware of that?

A: No, I wasn't.

Q: Okay. Were you aware that he had a self inflicted gunshot wound?

A: No. I don't recall that, but I was told that he had done a similar -- stabbed himself previously.

Q: Okay. And you talked about patients with these psychiatric conditions requiring some special attention, correct?

A: Yes.

Q: You'd agree that they need a supportive approach, is that fair?

A: Yes. Yes.

Q: Okay. Now, a principle of, I guess medicine in general, is to prevent the preventable. Is that fair?

A: Yes.

Q: Okay. Is it your position that the only time a patient should have an IV is when he or she

is hemodynamically unstable or when they need medications?

A: Can you repeat that?

Q: Under what circumstances should a patient receive an IV?

A: It's my opinion -- again we said I'm not a paramedic, but in my opinion, you would put an IV if you need to give them a medication or if their vital signs are unstable. Those are two things that come immediately to my mind.

Q: Is that even if you know they're going to get an IV at some point for surgery?

A: Can you say that one more time?

Q: Let me back up a little bit. If you're having surgery, are you going to require an IV?

A: Yes.

Q: Okay. So it makes sense if you're going to require an IV for surgery, why not establish it, correct?

A: You mean -- I don't want to put words in your mouth. Are you trying to ask me why not establish it as soon as possible, like in the field?

Q: Would that be appropriate?

A: I would say the patient doesn't need it in the

field. You shouldn't establish it at that time.

Q: So when would a patient need it, need an IV?

A: When they're going to go to the OR they'll do it either in the ER or they'll actually do it when they get to the OR.

Q: Okay. So ---

A: This is just my opinion, but in surgery in general we don't consider IV's that are placed in the field -- I'm not a nurse either but, IV's that are placed in the field, once the patient has stabilized and out of surgery and all that, the nurses kind of take that out as soon as they can 'cause that IV was put in on the roadside somewhere. We don't consider it as clean as one put in in the ER or the OR.

Q: So the only times in which a, you believe, an IV should be established is when there's some kind of hemodynamic instability?

A: Yeah. If his blood pressure is very low and you got to get it up somehow, put an IV in and give him a liter of normal saline. Or if the patient is unconscious and he's not breathing, he has some sort of an injury, usually a head injury, that's causing him to shut down his

normal reflex to breath, and you're going to need to intubate him, and in order to intubate somebody you need to give them drugs, you give them muscle relaxers. He'd need an IV to intubate. Those are just two examples that come immediately to my head. Those are, you know -- that's when you'd put an IV.

Q: Now when you become hemodynamically unstable, you start to lose access to establish an IV. Is that correct?

A: I'm not really sure what you're asking.

Q: As you become hemodynamically unstable ---

A: You mean as your blood pressure drops?

Q: Yes, sir. Doesn't it became more difficult to establish an IV?

A: Yes, it does.

Q: Okay. Now taking the approach of waiting for that instability to establish an IV, that wouldn't be using an abundance of caution, correct?

A: I would say -- the answer is yes. But your judgement comes into play. As we discussed before, this particular patient -- the judgement and I agree with it, was that that it would be better not to get him agitated with an

IV that he didn't need at that moment. All though when a patient becomes unstable and you have their blood pressure starts to fall, it's more difficult to put an IV, but a good paramedic will get an IV even if their blood pressure is very low.

Q: Do you understand that an EMT basic rode this call in?

A: Yes.

Q: Do you understand that an EMT basic is not certified to establish an IV?

A: Yes.

Q: Would that raise concerns?

A: No because, again, because the patient was stable, and also wasn't the paramedic very close by? Again, I don't ride ambulances, but I think the paramedic was driving the ambulance.

Q: That's correct.

A: Yeah.

Q: But you acknowledge that somebody's blood pressure, particular with this type of trauma, could drop rapidly?

A: Yes.

Q: And critical trauma would include this type of

penetrating abdominal injury, correct?
A: Yes.
Q: Okay. Now are you familiar the ACS's committee on trauma advanced trauma life support?
A: Yes.
Q: Okay. Is that a course?
A: Yes. I have to be certified in that for my job.
Q: Let me hand you this treatise. Now can you identify this, Dr. DeAngelo?
A: Yeah. It's the ATLS manual.
Q: Okay. And you said you were certified by the American College of Surgeons. Is that correct?
A: Yes.
Q: Is this kind of the go to guide for trauma care?
A: Yes.
MR. ROTHSTEIN: Your Honor, I object to this document. There's no evidence that this applies to paramedics. I mean this is -- I mean the cover of it has people with surgical masks on. This is the American College of Surgeons. This is not relevant to the standard of care of a pre-hospital provider, even a nationally registered paramedic.

MR. Wicevic: Well he talked -- I mean he's not a paramedic and he's providing testimony about his observations and opinions on this matter. Dr. DeAngelo can testify about whether he agrees with this. I think there's some vital points in here that are inconsistent with his testimony in Mr. Davenport's case. And we don't -- he hasn't testified to anything regarding this particular treatise not being applicable to EMT's. That's something that Mr. Rothstein purported.

THE COURT: Your claim is this treatise applies to paramedics?

MR. WICEVIC: My understanding is it's used for all types of providers. It's developed by the American College of Surgeons but that doesn't mean it's only for surgeons or physicians. I can ask him to explain -- I can ask Dr. DeAngelo to explain what this is for and who takes the ATLS courses.

THE COURT: Okay. I'm going to let you get into it. And just hold Mr. Rothstein's objection in abeyance for the time being.

MR. WICEVIC: Yes, Your Honor.

Q: Dr. DeAngelo, what types of providers attend

the ATLS courses?

A: Physicians.

Q: Is it limited to physicians?

A: I think PA's have. I honestly am not sure.

Q: So you're testimony is pre-hospital providers, EMT's do not attend this?

A: No. I believe there's a specific course for them. Again, this is out of my lane because I'm not a paramedic. But I believe there's something called PHTLS, pre-hospital ATLS that the paramedics attend.

Q: Okay.

A: This manual tells you what to do once they come through your door.

Q: Okay. But again, all of your expert testimony is based upon your understanding of that point inside the door, correct?

A: Yes.

Q: Inside the hospital door?

A: Yes.

Q: You have no experience with pre-hospital medicine?

A: No.

Q: Okay.

MR. WICEVIC: I'll move on, Your Honor.

Q: Now Mr. Davenport's behavior and verbal interactions, would you characterize him as being rude or unprofessional in your review of the body cam footage?
A: No.
Q: No? Not intimidating?
A: No.
Q: Would it raise a concern with you if you witnessed a coworker acting in a similar manner?
A: No.
Q: You've never spoken to a patient like that, have you?
A: No.
Q: Would you agree that's a way to gain the confidence of a particular patient?
A: Can you say the question again?
Q: Sure. Mr. Davenport's interactions with this particular patient, would you see that as an effective way to gain that patient's confidence?
A: From watching the body cam, I think his -- the way he conducted himself was fine. I think it was okay.
Q: So if you saw this in a hospital you won't

report it?
A: I can't answer that.
Q: Why is that?
A: I'm not sure what to say. But from looking at the body cam I think his demeanor conveyed concern for the patient.
Q: Okay. So it wasn't calming for him, was it?
A: Huh?
Q: Was it calming to the patient, were Mr. Davenport's interactions calming to the patient?
A: I think they were.
MR. ROTHSTEIN: Your Honor, I think you'd have to ask the patient that. Was it calming to the patient? That's something only the patient could answer, and they haven't asked the patient that.
MR. WICEVIC: I think he can observe. Is observations ---
THE COURT: I'm going to allow you to ask the question. The objection is overruled.
Q: Dr. DeAngelo, did Mr. Davenport's affect to this patient appear to calm him?
A: Yes. Yes.
Q: Okay.

A: Mr. Davenport was -- I think his demeanor was calming to the patient.
Q: Did his demeanor increase the verbal interactions between patient and Mr. Davenport?
A: I'm not sure what you're asking.
Q: Did the patient react well to the interactions?
A: I don't remember him reacting at all. But, you know ---
Q: He kind of shut off, didn't he?
A: I'm not sure. I would say yes, but I'm not sure if you would call it shut off. I just, from what I can recall, he didn't say anything. He didn't reply to anything that Mr. Davenport said.
Q: Am I correct that -- I'll move on. Ambulation of the patient. That's something you testified about. Now you have no experience transferring patients from the scenes of accidents or illnesses to transport vehicle, correct?
A: No.
Q: Okay. And at this particular scene of the injury, the patient already suffered a serious bodily injury, correct?
A: Yes.
Q: Organs in the left upper quadrant of the

abdomen include the stomach, the spleen, colon, and potentially diaphragm, is that correct?

A: Spleen and diaphragm I'm not sure are in the area where the knife is.

Q: Okay. So that would leave the stomach and colon?

A: Yes. And small bowel.

Q: And small bowel?

A: Yeah.

Q: Would puncture to one of those organs cause serious physical harm?

A: You would require surgery for it, so yes. But it wouldn't make your vital signs unstable.

Q: Okay. And, I mean, moving a patient with an impaled object would cause some level of movement, correct?

A: You mean moving them -- how do you mean ---

Q: Well, ambulating them. Walking them.

A: You know, yes. But I think in this case it was a good judgement call.

Q: Now you're not familiar with various carrying devices used by EMT's, correct?

A: I've seen them as they come through as they're brought in by the paramedics, but I don't use them.

Q: Okay. Now by walking this patient, isn't it correct that there was a possibility for further injury?
A: Yes. But there's a possibility for further injury pretty much any way you move them.
Q: Right. It's about minimizing that?
A: Yes. Yes. It's a judgement call.
Q: And that's particularly -- you know, this minimization of movement is particularly important for penetrating stab wounds, correct?
A: Yes.
Q: That are in close proximity to organs such as the stomach, colon, small bowel?
A: Yes.
Q: And you don't regularly see patients with impaled objects walking from the ER to the OR. Is that correct?
A: No.
Q: A few more questions. Oxygen, can oxygen be used to assist with a patient's pain?
A: To assist with pain? No.
Q: No? That's not one of the uses?
A: No.
Q: Okay. That's all the questions I have for you, Dr. DeAngelo. Thank you.

A: Okay.

DR. DEANGELO - RE-DIRECT EXAMINATION BY MR. ROTHSTEIN:

Q: Just a couple of follow up questions. Getting to that last point. Mr. Wicevic asked if you've ever seen a patient walk from the ER to the OR. Have you ever seen any patient walk into the OR?

A: A patient for an elective surgery, say a hernia repair will walk to the OR.

Q: Okay. In the trauma bay, have you ever seen a patient walk from the ambulance or the emergency department into the OR?

A: A trauma patient walk to the OR, no.

Q: Is your personal relationship with Mr. Davenport affect your professional opinions that you've rendered in this case in any way?

A: I'm trying to give an unprejudiced opinion, but does it affect me in some ways, probably, yes.

Q: Okay. Can you think of anyone better ---

A: I have respect for Mr. Davenport, so ...

Q: Can you think of anyone in the Special Forces that has had more experience observing Mr. Davenport's skill level, training, and experience than yourself?

A: Not many. The only other people I would say are his teammates.
Q: Now Mr. Wicevic made a point about, well when the patient got to the emergency department they started an IV, and started fluids. Do you typically start IV's and give fluids to patients shortly before they go into surgery?
A: Yes, is the simple answer.
Q: So the fact that the patient received an IV and fluids were started after the patient had arrived at the emergency department is no indication of whether the patient needed IV's on the way to the hospital, is that right?
A: Yes.
Q: Okay.
A: Yes. All trauma alerts get an IV.
Q: And to refresh your -- if you've got the book there, item number 6. Mr. Wicevic asked you some questions about the vital signs. So it appears that the patient arrives on the scene at the hospital at 2154, that's 9:54, is that right?
A: Yes.
Q: And the first set of vital signs taken in the emergency department was approximately six

minutes later ---
A: Yes.
Q: --- at 10:00 o'clock?
A: Yes.
Q: Do you have any idea what happened to the patient between the time the ambulance dropped him off in the emergency department and the time the first set of vital signs were taken?
A: I can guess based on what I do, where I am, and what I've seen done in the other places that I've worked.
Q: Are the paramedics involved in that process after the patient's dropped off at the emergency department?
A: Well they bring the patient in, they give you a detailed report on what they know about the patient, what they found, what they did. And they'll often hang around and watch the alert. They like to do that, they like to watch what we do. So they'll be there for a while. Does that answer your question.
Q: The critical vital signs, blood pressure, pulse, respiration rate, were those ---
A: They're taken immediately.
Q: Okay.

A: Yeah.
Q: And were those fairly stable compared to the readings in the patient care report?
A: Yes. I believe that systolic blood pressure was 126 in the ER. I'm pretty sure that was the first blood pressure.
Q: Okay. If you were taking this particular patient into surgery, would you do the surgery with the bandaging and the tape in place or would that have to be removed at some point, the bandaging around the knife.
A: I'll have to think about that. I haven't had -- like I said, it's been a couple years since I had someone actually come in with a knife in. I think we would probably would wait till we got to the OR to take the stabilization off because -- and then we would sterilely prepare the abdomen with an antiseptic solution. So we would have to take the stabilization off at that time. We probably would wait until the OR.
Q: This antibiotic that Mr. Wicevic mentioned that was provided to this patient prior to or once he got to the ER. Is that something you typically see paramedics starting that type of

antibiotic?
A: No.
Q: What's the purpose of that antibiotic?
A: The antibiotic is if he did damage bowel, and there's leakage of bowel contents into the abdomen, when you operate you're going to repair the hole in the organ, and then you're going to wash out the abdomen with sterile saline. So you're going to cleanse the abdomen of contamination as best as you can. But the literature shows that some antibiotics given preoperatively will significantly lower your chance of post-operative infection. But I can't recall medics giving antibiotics. I really don't remember it being done. I don't think it's done very often. The antibiotics ideally are supposed to be given just before you start the surgery.
Q: I'm going to ask you to look at page 3 of Exhibit 6. Now when you were reviewing this document, did you see the initial emergency department diagnosis that the emergency physician made of this patient?
A: Yes.
Q: And what was that diagnosis according to this

record?
A: It says, wound abdominal wall left upper quadrant open without penetration into peritoneal cavity unspecified.
Q: Okay. What does that without penetration refer to in that diagnosis?
A: That says that whoever wrote this diagnosis felt that it did not penetrate into the peritoneal cavity.
Q: If that knife penetrated into the peritoneal cavity say 40 or 45 minutes prior to the patient arriving at the emergency department, what would the condition of the patient's abdomen likely be?
A: He'd have a lot more pain. He wouldn't look as comfortable as he does here.
Q: If you palpated that patient's stomach, what would you likely ---
A: He would have -- if you pushed on his abdomen you would hurt him.
Q: Okay. If he had significant bleeding inside of his abdominal cavity, what would the stomach feel like upon palpation?
A: He would have pain because blood irritates the abdominal cavity. It hurts.

Q: Okay. I have no further questions.
THE COURT: Thank you, Dr. DeAngelo.
DR. DEANGELO: Thank you.
MR. ROTHSTEIN: Your Honor, could we take a brief recess so -- I think Mr. Davenport would like to say goodbye to the witness.
THE COURT: Yes. We're going to take a ten minute break.
(Off the record from 10:43 a.m. until 11:02 a.m.)
MR. ROTHSTEIN: Your Honor, one housekeeping, I don't know that I formally moved Dr. DeAngelo's CV into evidence.
THE COURT: You did not.
MR. ROTHSTEIN: Can I go ahead and do that? I don't know that there's a ---
MR. WICEVIC: No objection.
THE COURT: Okay, it's submitted.
(Respondent's Exhibit Number 21 was admitted into evidence.)
THE COURT: Mr. Wicevic, are you ready to call your next witness.
MR. WICEVIC: Yes, Your Honor. The Department calls Harry Dean Douglas.
THE COURT: Mr. Douglas, if you would approach the bench. Face the court reporter, raise your

right hand and he will swear you.

HARRY DEAN DOUGLAS, having been duly sworn, testifies as follows:

MR. DOUGLAS - DIRECT EXAMINATION BY MR. WICEVIC:

Q: Well good morning, Mr. Douglas. We've met on a couple of cases now. My name is Peter Wicevic and I represent DHEC. Can you please state your full name for the record, please.

A: Harry Dean Douglas.

Q: Okay. I'm gonna hand you a document, Mr. Douglas. Look on Exhibit 27 for DHEC. Can you identify Exhibit 27?

(Petitioner's Exhibit Number 27 was marked for identification purposes.)

A: Yes, it my curriculum vitae.

Q: Okay. And Mr. Douglas, can you tell us about your education beginning with high school?

A: I graduated high school from Northern Durham High School in Durham, North Carolina. I went to Western Carolina University in Cullowhee, North Carolina. Received my Bachelors Degree in Emergency Medical Care and then attended Medical University of South Carolina where I received my Master of Health Administration in 1994.

Q: Okay. Let's back up a little bit to the Western Carolina.
A: Uh-huh.
Q: When did you graduate from Western Carolina?
A: Sorry, in 1986.
Q: Okay. And what type of degree was that?
A: Emergency Medical Care.
Q: Was it a Bachelors Degree?
A: Bachelors Degree.
Q: Okay. And can you tell the Court about the curriculum for that particular degree?
A: The curriculum itself is based on the national standard for paramedic curriculum. It's just expanded a bit. There are additional courses, of course. There's general electives and English and math and that kind of thing that goes along with Bachelors Degrees. But the paramedic portion of it, the core curriculum follows the national standard curriculum but, like I said, is expanded. It goes deeper into each subject.
Q: Okay. So can you name some of the subjects?
A: Medical emergencies, traumatic emergencies, like that kind of thing. Assessment ...
Q: Okay.

A: Each module.
Q: And are those just like three hour courses, that type of ...
A: It's semester credits, so at Western Carolina where -- in my experience at Western Carolina, our courses were semester long, so for example, the patient assessment course was an entire semester course, three semester credit course. And it was physician led, physician based, so again, much deeper, much more in-depth, much more thorough than a standard paramedic assessment.
Q: Was there a clinical component to your degree?
A: Yes. Yes.
Q: What was that?
A: I don't remember the number of hours but we performed clinicals in a hospital in Asheville and we did ride time, field experience, in Buncombe County EMS as well as Medic in Charlotte.
Q: Okay. What's South Carolina institutions offer a four-year degree?
A: There are none.
Q: Okay.
A: Not in Emergency Medical Care.

Q: Right, that's what I meant. Thank you for clarifying that. Certification for an EMT, it looked like from your CV you were certified as a Basic in '83. Explain your time as an EMT Basic.

A: All right. That was part of the Western Carolina paramedic program. That was, I believe, our sophomore year. We take the EMT class, become certified as an EMT and that allows us to perform as a paramedic student. Also gives us a certification and so I worked summers and weekends and holidays as an EMT at home in Durham.

Q: Okay. And then from there were did you go in terms of your certification as an EMT provider?

A: At that point you have options. You can pursue the -- at the time -- actually there were several options at the time. In North Carolina, there were -- do you want me to go into each state or just stick with national ---

Q: Just your ---

A: national ---

Q: experience and your education.

A: Okay. In my experience, I choose to go straight from EMT to paramedic. So I did not

pursue the intermediate stage of certification but instead went straight through as a paramedic.

Q: Okay. When did you obtain your paramedic certificate?

A: In 1986, just after graduation.

Q: And for what states?

A: I got my North Carolina paramedic as well as national registry paramedic and then South Carolina paramedic as well.

Q: Okay. And then where did you go from there. Where did you begin your career?

A: I came to Greenville right after graduation as soon as I was nationally registered and started working in Greenville County, South Carolina.

Q: What made you come to Greenville?

A: At the time in 1986, Greenville County EMS pretty much led the country in EMS. They were an industry leader. Very well know throughout the EMS industry. Very aggressive, aggressive EMS service provided some of the best care in the nation.

Q: What do you mean aggressive?

A: Aggressive as far as doing things nobody else was doing at the time.

Q: Okay.
A: They were leading the industry. They were on the forefront of EMS.
Q: Okay. Has DHEC taken any enforcements against your certificate?
A: No, sir.
Q: Okay. Has any of the licensing agencies?
A: No, sir.
Q: Okay. Let's talk about your employment, and I know you mentioned some about Greenville County, and let's start about, 'cause it appears you have been practicing as an EMT and then you also have an education, kind of, career. Let's start with your practicing as an EMT. You began in Greenville County?
A: Yes, sir.
Q: And what ---
A: As a paramedic in Greenville County, yes.
Q: Okay. And what was your role as paramedic?
A: Providing care to the ill and injured citizens and visitors of Greenville County.
Q: And how long did you do that?
A: Well so as a paramedic, I moved up in the system so I was always a paramedic but then as a paramedic I took on additional administrative

responsibilities and some training responsibilities as well but continued to be a practicing paramedic. So I did that for 21 years there at Greenville County.

Q: Okay. And I see you were also the COO, Chief Operations Officer?

A: Yes, sir.

Q: What were your responsibilities as a COO?

A: I oversaw the daily operation.

Q: And how big was Greenville County at the time as far as ...

A: We had approximately 150 employees or so, full-time employees.

Q: And then where did you go?

A: I went to Medshore for a brief period and then to Pickens County EMS full-time and remained there part-time and continue to work there part-time. And then moved into education and have been in education since that point.

Q: Okay.

A: And continue to work in the field at Pickens County EMS.

Q: About how often do you get in the field?

A: Not as often as I would like to, but generally one to two half shifts a month.

Q: So about 31 years as an EMT, EMT slash paramedic, is that accurate?
A: 31 as paramedic, I guess 34 as an EMT, yeah.
Q: Now your education curriculum. Can you explain where that began?
A: Well I've always been involved in education. I think about -- I could check the dates, but I believe about two years after I graduated, the program Director at Western Carolina University asked me to come back and fill in a little bit for a couple of classes as an instructor and while she filled a full-time role, while they were doing a national search for an educator. So that kind of sparked my interest in education.
Q: What did you teach at Western Carolina?
A: I taught a rescue course and there was another class. I don't remember what it was right at the moment. But rescue -- there was another one but I don't remember. So that, kind of, peaked my interest in education. I enjoyed it so I got involved in training which is an informal position within Greenville County EMS. And I enjoyed that as well. I did not get -- and continued that throughout my career and

didn't get formally involved in education until I left Pickens County EMS for a full-time position at Greenville Technical College.

Q: Okay. Now I think you made the distinction between the education you provide to the providers of a service and then the education you provide at training institutions or universities.

A: Right.

Q: Can you explain that distinction for the Court?

A: At the institutions that's primary education. That's someone who is first time, their seeking that paramedic education. Persons who are working in the field of EMS, either as EMT's or paramedics are required to attend ongoing education and continued education and so training personnel within a service would provide that continued education at Greenville Technical College and then where I am now at the USC School of Medicine and Greenville Health System, we provide primary education. We also assist with some continuing education as well, but my primary responsibilities are primary education.

Q: Okay. So what types of courses do you teach at

Greenville Tech?

A: I just started back there part-time. When I was there full-time, is that what you're referring to?

Q: Sure.

A: When I was there full-time, I did my primary responsibility when I was at Greenville Technical College full-time was clinical coordination. So I taught some of the clinical, I attended clinical with the paramedics students in the emergency departments and then coordinated all that. But also taught as well, usually most of the time, in the final semester of their training. And that's, kind of, the bringing it all together semester. And we provide what we call all the alphabet classes, all the -- you've heard reference to PHTLS, a Pre-hospital Trauma Life Support. There's an American Heart Association Advanced Cardiac Life Support. We provide all of those courses in that final semester. So I was rather busy during that semester as well.

Q: Okay. And you also worked at T-2 Trauma Training. What is that?

A: That was some time ago before, and you would

probably have to be in EMS to understand PCCC. It's a tactical combat casualty care. Before tactical combat casualty care was really a thing, it was actually, kind of, invented by the military but before it was a formal course, there was a gentleman out of Virginia, a former Seal, Navy Seal, who contracted with the Navy to provide training to, not to corpsman, but to Seabees and just everybody but the corpsman basically for how to handle life saving emergencies. And so I helped teach that with him and several other people as well. So we provided that training for the Navy.

Q: Okay.

A: Then it became a formal course and I don't know if the name was trade marked but we quit offering it.

Q: Okay. Are your teaching responsibilities with USC School of Medicine Greenville similar to what you've explained with Greenville Tech teaching roles?

A: More or less, only at the EMT level. We do not provide paramedic level training at the USC School of Medicine or with the Greenville Health System. We provide EMT level training

for the first year medical students. We remain involved in their education throughout the four years. We teach them ACLS, the American, I'm sorry, the Advanced Cardiac Life Support. We also assist with some of their skills in preparing them for the things that we're most familiar with.

Q: Okay. And that's a good point. So Greenville Tech has all different levels of EMT certificate, certification training?

A: Well they do. EMT and paramedic.

Q: Okay.

A: Most, I think I'm pretty safe in saying this, most educational institutions do not provide the intermediate level. It's not a popular certification and it frankly, it's redundant. So ...

Q: Okay.

A: There's not a lot of calls for it.

Q: Either through your teaching responsibilities and your care providing responsibilities, have you been sued for negligence or malpractice or ---

A: No, sir.

Q: Professional memberships, and that begins on

the second page. Can you explain to the Court your various professional memberships?

A: I'm with National Association of Emergency Medical Technicians. My membership there affords me, or has afforded me, the opportunity to serve as our state's advocacy coordinator. I honestly could not tell you how I stepped into that position. I just happened to be in the right place at the right time, I think, many years ago. And I have served in that position for several years and, kind of, coordinate or promote legislation within our state at the national level. I'm also a member of the advocacy oversight committee and that oversees all of the other state advocacy coordinators. I was on the membership committee for several years and was involved in actively seeking members and coming up with ways to promote membership and designed the challenge coin and things like that. With the National Association of EMS Educators, which is a fairly large and active association that provides education for educators. It's a very strong educational program and actually counts in our state toward the basic educator course

in order to get your instructor certification. I'm with the South Carolina EMS training committee, which meets monthly and, kind of, provides input and recommendations for various issues regarding training and certification throughout the state. South Carolina EMS Association, I am a non-voting member but I attend some meetings, not all meetings, but the South Carolina EMS Association is made up of really anybody, there aren't any restrictions about who can belong to that association. But the goal of the EMS Association is obviously to promote the needs and welfare of EMS throughout the state. Through my association with the National Association of EMT, it makes sense to belong to the state association as well. I was on the Upstate EMS Counsel Board of Directors for a long time, was the Chair for 11 years.

Q: What is the Upstate EMS Counsel?

A: Upstate EMS Counsel is one of the -- the State of South Carolina is divided into four regional counsels. And the four regions provide -- have a regional counsel that provide paramedic, certified paramedic education for those counties within that region. It is not --

there are additionally -- in addition to that, there are some college programs, like Greenville Technical College, for example, that falls within the Upstate region but the Upstate Regional Counsel provides paramedic training that does not come with a college degree.

Q: Okay.

A: It is accredited. They are associated with a university but they do not provide college credit.

Q: Okay. So moving on to your licenses and certifications.

A: Yes, sir.

Q: What's your -- third one down, the name N-A-E-M ---

A: NAEMSE, that's the, you know, they have acronyms. NAEMSE is the National Association of EMS Educators that I mentioned in professional memberships.

Q: And what do you have to do to obtain those, I guess, instructor certifications?

A: Each of those instructor certifications comes after successfully passing a rather difficult exam following a 40-hour course.

Q: Okay. And when did you obtain that?

A: Both of those classes I took in 2014.
Q: Okay. What about your South Carolina paramedic instructor. Who do you obtain that from?
A: Who? From DHEC, Department of Health and Environmental Control.
Q: Okay. And how do you obtain that?
A: Now or then?
Q: Then.
A: So then, I had to come to Columbia and sit with Mr. Whitely for about three or four hours and he explained -- he, kind of, went through the policy manual and told me what to do and what not to do. And then, there's a list of objectives you have to meet. There's a list of requirements, including advanced cardiac life support instructor. You have to be an instructor in at least one of the trauma courses. There are basically two generally accepted trauma courses, ITLS, which is International Trauma Life Support and PHTLS, which is Pre-hospital Trauma Life Support. What else is there. That's all I can think of.
Q: Well you mentioned those, so let's move to Pre-hospital Trauma Life Support.
A: Yes, sir.

Q: And International Trauma Life Support.
A: Yes, sir.
Q: What are -- let's start with PHTLS, what is that?
A: Pre-hospital Trauma Life Support is a course designed by the National Association of EMT's. It started in, I think, 1996 or so. The class that I took in 1998 was the first class offered in South Carolina and we took the course and then -- which was a 16-hour course and then the next day, had the instructor course. So it was, kind of, a big deal at the time. It was brand new at that point, but it's become, pretty much, the industry standard and is a very strong course to this day. ITLS, International Trauma Life Support, is what use to be preferred to as BTLS or Basic Trauma Life Support, which is, I believe, and I'm not certain about this, I believe it's written by the same American College of Surgeons that writes the ATLS, which was the book you just had, the Advanced Trauma Life Support.
Q: Okay. Any other licenses or certificates related to the subject matter of this dispute?
A: No, sir.

Q: Okay.
A: No, sir.
Q: Okay. Honors and awards, are most of these honors and awards, you know, awards that you based upon your, I guess, general service to the public?
A: Yes, sir.
Q: As a paramedic?
A: Kind of all combined as a paramedic, I also -- I'm very active in various honor guards with regard to police, fire and EMS.
Q: Okay.
A: I attend a lot of funerals.
Q: And then your scholarly activity, publications, presentations ---
A: Yes, sir.
Q: Any particular area of concentration for these matters?
A: No, sir. Not particularly, most of them were tied to one class or another. They were class projects, not especially.
Q: Okay. All right. Your Honor, the department would like to move this Exhibit 27, Mr. Douglas' CV into evidence.
MR. ROTHSTEIN: No objection, Your Honor.

THE COURT: It's admitted.

(Petitioner's Exhibit Number 27 was admitted into evidence.)

MR. WICEVIC: Thank you. And Your Honor, pursuant to Rule 702, I am tendering Mr. Douglas as an expert in the fields of pre-hospital medical care and education.

MR. DOUGLAS - VOIR DIRE BY MR. ROTHSTEIN:

MR. ROTHSTEIN: Your Honor, I would like to Voir Dire the witness just briefly. Mr. Douglas, I think you testified that you currently work at Pickens, is that right?

A: Yes, sir, part-time.

Q: Part-time? And you said, one to two and a half shifts per month, is that right?

A: Yes, sir. Yes, sir.

Q: So you currently work in the field 12-24 hours a month? Does that sound about right?

A: That's about right.

Q: How many calls would you say you ran on average when you worked as the COO for Greenville County EMS?

A: Quite a lot. A lot more than I do now. In what period of time?

Q: I guess any. You were there for a long time as

the COO, isn't that right?
A: Yes, sir.
Q: Okay. And was that primarily an administrative role?
A: It was daily operations, so I was heavily involved in the operations every day.
Q: Were you routinely assigned to work shifts ---
A: No, sir.
Q: --- as a paramedic?
A: No, sir.
Q: And how often would you actually work on a truck as a paramedic, clinically paramedic?
A: At that point, I was not working on a truck often. I did run a lot of call though.
Q: And you're talking about a quick response vehicle ---
A: Yes, sir.
Q: --- like an QRV?
A: Yes, sir. I had my own response vehicle, so. I ended up running a lot of the -- a lot of calls. But it was part of my responsibilities as the operations officer.
Q: Now as I understand your CV, your training as an EMS bachelors training was in 1986?
A: Yes, sir.

Q: 31 years ago, is that right?
A: Yes, sir.
Q: And when you were trained as a paramedic, did they drill into you to monitor O2-IV and monitor?
A: Absolutely.
Q: Okay. What do you do to keep up your knowledge and clinical skills in EMS?
A: Quite a bit of research, I teach daily. Again, a lot of research. I work in a simulation center, so I'm constantly reinforcing the skills with students and doing them myself. And then, of course, working part-time as well.
Q: Okay. Do you still teach the mantra O2-IV monitor for paramedics?
A: No, sir. It's, kind of, outdated.
Q: And that's been outdated for a while, hasn't it?
A: Yes, sir, it has.
Q: How many knife wounds have you run in your career where the knife was still impaled in a patient's abdomen upon arrival at the scene?
A: I can't give you a firm number, but ...
Q: One or two?
A: Yes, sir.

Q: Where were you at the time? What happened, agency?
A: How -- agency, Greenville County. I don't recall having run any in Pickens County. I'm not sure. But Greenville County, I know I've run a number of them.
Q: Was that on a QRV or as an actual paramedic responding on a truck?
A: Both.
Q: You recall ---
A: And, I'm sorry, go ahead.
Q: You recall what year the last impaled stabbing patient you saw with the knife was still in the wound at the time you arrived on the scene?
A: I don't recall.
Q: Was it within the last 10 years?
A: Probably not.
MR. ROTHSTEIN: Your Honor, I'd object to this witness, his ability to testify about current standards of EMT practice. Although he currently teaches and I don't have a problem with qualifying him as an expert in education, I don't believe he's qualified to testify about the clinical care that was provided in this case.

MR. WICEVIC: And Your Honor, he has 31 years -- over 34 years between being an EMT and a paramedic. Yeah, he's held other responsibilities but he's continuously been in the field whether it's part-time or full-time. He does simulations as part of his education responsibilities. I think he's well capable and well qualified, experienced and skilled to be an expert in pre-hospital care.

THE COURT: I'm qualifying him as an expert.

MR. WICEVIC: Thank you, Your Honor.

MR. DOUGLAS - DIRECT EXAMINATION BY MR. WICEVIC (CONT.):

Q: All right, Mr. Douglas, when did the Department contact you regarding retaining you as an expert?

A: I believe that would have been Thursday.

Q: And what were you provided as part of your review of this matter?

A: Not this particular notebook but a similar notebook.

Q: And you're referring to DHEC's proposed trial exhibits?

A: Yes, sir.

Q: Okay. Do you know Mr. Davenport?

A: No, sir.
Q: How much time did you spend reviewing this matter?
A: At this point, approximately 60 hours.
Q: 60 hours?
A: Yes, sir.
Q: Okay. Have you been in attendance this evening?
A: Yes, sir.
Q: How did you become aware of the Department's decision to revoke Mr. Davenport's paramedic certificate?
A: Subsequent to being asked on Thursday to certify as a witness.
Q: Okay. Do you know Scott Stoller?
A: I do.
Q: Okay. How do you know him?
A: Scott worked at Greenville County EMS at the same time I did. We've never worked together. We've never worked on the same shift. I known him for many years.
Q: Okay. Other than previously working for Medshore, do you have any other connections to Anderson County?
A: No, sir.

Q: Do you know Arnold Alier ---
A: I'm sorry. I did work for Belton EMS part-time early, early in my career.
Q: Okay. Do you know Arnold Alier?
A: I do.
Q: Who's he?
A: Dr. Alier is the bow-tie.
Q: Okay and ---
A: Asked me, how do I know him?
Q: Is he a DHEC staff person?
A: Yes, he's the Director of EMS for the state, I'm sorry.
Q: And how do you know Dr. Alier?
A: Again, he worked at Greenville County EMS the same time I did. I don't recall -- I don't know that we ever worked the same shift together. I know we have worked a couple of shifts together. I don't think we were ever assigned to the same shift.
Q: Okay. Do you know Mr. Wronski?
A: Yes.
Q: How do you know Mr. Wronski?
A: Just through his association with DHEC.
Q: No friendship?
A: No, sir.

Q: Okay. Protocols and order of compliance and standards of care. In your education of EMT's, how do you educate providing protocol and order of compliance?

A: From the very beginning of EMT education, EMT's are taught that basically everything the do falls under medical control. So there's the scope, there's a national curriculum which teaches a wide variety of skills and knowledge and then the state may pair that down some. So the state tells you what out of what the national curriculum teaches, the state tells you what you can do according to the state. And then the service wherever you work has a medical control physician and then that physician takes the state list and can pair that down and can dictate what you can or can not do ultimately.

Q: Okay. Would you consider compliance with protocols a kin to monkey medicine, cookbook medicine?

A: No. I mean, it depends on how the protocols or standing orders are written, of course. But no, generally not. Generally speaking, there's plenty of room for thought. So, no I would

not.

Q: Are there terms used in protocols that you get an understanding through education?

A: I'm not sure where you are going with that.

Q: Are there -- is terminology within protocols something that you have learn --

A: Yes. Yes.

Q: Okay. Could you explain?

A: Give me a term to explain.

Q: Trauma.

A: Okay. So everything depends on your reference. The term trauma when you're talking about the difference between trauma and medical, anything, any insult to the body is trauma. Meaning, if I pull a hair follicle out, that's a trauma. So then, when you talk about significant trauma, or critical trauma, then there are qualifiers. That's a more defined area of trauma.

Q: Okay.

A: So there's trauma and then there's trauma.

Q: So, I mean, you said protocol compliance isn't kin to monkey medicine. Explain the decisions EMT's have to make in the course of their care.

A: I mean, there are an infinite number of

decisions they have to make. I mean, there are safety decisions, there are patient care decisions, there are transport decisions, there are -- I mean, everything is a decision. And you follow certain decision trees and you have to insert some level of knowledge into that tree and decide which path to go down.

Q: Okay. Are you familiar with generally accepted standards of care for EMT's?

A: Yes.

Q: Is that what you teach at your training institutions?

A: Yes.

Q: Under generally accepted EMS practices, when is it appropriate for an EMT to deviate from an order of protocol?

A: There certainly are times when one may need to either expand upon a protocol or deviate. I mean, basically with EMS, if you can imagine it, it can happen. So there may be times where you may need to give an increased amount of medication that goes beyond what has been prescribed by standing order or protocol. There may be times where you need to withhold a medication. There are just a, like I said,

an infinite number of possibilities.

Q: What are some of the guiding principles behind pre-hospital care?

A: There are many. Do no harm, of course, is the probably the most referred to, most well known.

Q: I mean, what are the goals does EMT and the pre-hospital care.

A: Well the goals of EMS -- EMS is a very rapidly expanding field. I'll try to keep this geared toward this case, but the goal of a pre-hospital 9-1-1 provider is to, not only get the patient to the hospital, sometimes it's to make the patient better. Certainly to not make them any worse and to protect the patient. To be the patient advocate. To protect oneself and ones partner, many goals. And to protect the public as well.

Q: Okay. So this patient in question, based upon your review and using those generally accepted EMS standards, how would you characterize the injuries of this patient?

A: I would say that would be a significant trauma.

Q: Okay. And why?

A: Because he had what was reported to be a seven inch blade within his belly.

Q: Okay. And we went over this a little bit already, I mean, trauma, what does critical trauma mean?
A: Again, you know, that is open to interpretation. What is critical, what is -- there's critical, there's -- it depends on the definition that is written within the order that you are following.
Q: What's taught as far as EMS curriculum?
A: In every EMS textbook in every speciality course, PHTLS, everything that I've found dictates that penetrating trauma to the torso, and there are no qualifiers there, penetrating injuries to the torso is a critical trauma.
Q: Okay. I mean, how are EMT's to make this distinction between critical trauma and regular trauma, I suppose? I mean, is that based upon their education?
A: In large part, yes. Yes.
Q: When there is a possibility of something becoming critical, do you treat it as critical?
A: Yes.
Q: Why?
A: So, in EMS we don't have the luxury of some of the testing and things that the hospital has.

We don't have x-ray, we don't have CT, we don't have a lot of those things. At this point, we don't have ultrasound on an ambulance. Given ultrasound or some of the other testing modes, we may be able to rule out some things. Until that point, we have what we call a differential diagnosis. And we have to go with what the worst possible outcome and we have to assume the worse.

Q: I'm sorry. What's a differential diagnosis?

A: It's basically a list of what could be wrong.

Q: Okay.

A: Yeah.

Q: Okay. So this particular patient in question, protocol, how would you characterize the status of this patient?

A: Stable.

Q: Okay. And what do you mean stable?

A: He appears to be alert. He appears to be oriented. I will say that as far as mentation goes, he is alert and oriented and therefore stable, but he does appear to be -- I think it's worthy to note ---

MR. ROTHSTEIN: Your Honor, I'm gonna object to this speculation. I mean, he said the patient was

alert and oriented. Now he's getting into speculation about whether the patient has some sort of diminished mental capacity or is -- I think that's improper.

MR. DOUGLAS: I didn't even say that.

THE COURT: Mr. Douglas, let your -- your attorney will respond to ---

MR. DOUGLAS: Sorry. My apologizes.

MR. WICEVIC: I don't think he was finished with his answer. I'm not sure what he was going to say.

THE COURT: Let's let him finish. I wasn't sure what he was going to say either so at this point I'm overruling your objection.

MR. DOUGLAS: What I was going to say was, he -- there appears to be some sort of developmental disability or something. He appears to be somewhat obtundent, however he appears to be alert. He ---

MR. ROTHSTEIN: Your Honor, that's ---

MR. DOUGLAS: --- appears to be oriented to person, place and time.

MR. ROTHSTEIN: Your Honor, that's not what I'm objecting to. It's his speculation that there's some sort of developmental disability. This patient -- he's not qualified to make that

type of assessment. He's not been qualified as an expert to make that type of assessment and he's only seen the patient through a video. I just -- I think that's complete speculation.

MR. WICEVIC: I don't think he was diagnosing him, he was just making an observation based upon his review of the video and that's what EMT's do.

THE COURT: I understand that but Mr. Rothstein's objection ...

MR. WICEVIC: We'll move on.

THE COURT: Yeah. I am sustaining his objection. I don't think he's qualified to make that observation.

MR. WICEVIC: Sure.

Q: Okay Mr. Douglas, where was this injury?

A: Left, upper quadrant of the abdomen.

Q: Now what organs are near that left upper quadrant of the abdomen?

A: Contained within left upper quadrant would be the spleen, part of the liver, the stomach. Those are the organs that what additionally, in addition to that, there's a great deal of vasculature. There are a lot of vessels within the belly. The lumbar vessels come around the

gut. There are splenic vessels. There are a lot of vessels within the abdomen.

Q: When you're sitting down, are your organs in a different place than if you were standing up like me?

A: All right. So everything within the abdominal cavity is, kind of, suspended. It's not firmly rooted in place, and it moves. A good example of that is the reason we don't do what was called -- when we use to lift the feet of the backboard in a patient that was going into shock in order to shunt all of the blood into the core of the body. And one of the reasons we don't do that anymore is because, research found that the organs would lay upon the diaphragm in that position and would restrict the motion of the diaphragm and breathing. So I say that to exemplify that the organs are not firmly rooted. They do move when we move.

Q: Okay. And if these organs that you mentioned were punctured, would that cause some kind of significant injury to the patient?

A: Yes.

Q: Death possibly?

A: Possibly. Depending on the organ, of course.

Q: Okay. Despite this patient's stability during the transport, would this particular patient present a potential, significant potential, for serious bodily harm?
A: yes.
Q: Okay. How would you characterize this patient's possibility of decompensating?
A: I would say there is a great potential.
Q: And why?
A: Because, so the knife was reported to be seven inches long, the blade of the knife rather, was reported to be seven inches long. So we can not assume that the knife was inserted straight into the abdomen at a 90 degree angle. When you talk about penetrating trauma with a stab wound, the wound pattern typically referred to as a conical pattern, the potential wound pattern. So it comes out as a -- or it comes in rather as a cone and it could have gone in any direction. This was a self inflicted stab wound. The patient was by all accounts had a psychiatric history, regardless of any other thing that was going on. He obviously has a psychiatric history so we don't know what he did. So again, you have to err to the side of

caution and you have to make some assumptions.
Q: Okay. You talked about the length of the knife. I mean, were there any uncertainties with this protocol?
A: Yes.
Q: Okay. What were they?
A: Where the knife was, or where the blade was. Where the blade was, what it may have entered, what it may have -- if it had entered a vessel or an organ it may have occluded something. There may be a clot formed. It could be the finger in the dike so to speak. It may be lying beside an organ or a vessel. There's no way to know that.
Q: How do uncertainties play into your decision making as a pre-hospital provider?
A: Again, I would say that the standard is to err to caution and treat it as such.
Q: Okay. What type of care did this particular patient require?
A: Standard would have been he should have had an IV, no fluids and close monitoring.
Q: Okay. Now would that be ALS or BLS care?
A: ALS.
Q: Okay. And what's the decision -- how did you

make that determination?
A: It's based on my experience. It's based on my education. It's also based on every resource available.
Q: Okay.
A: Every generally accepted practice.
Q: I mean, do all trauma patients require ALS care?
A: No. Most do not.
Q: Okay. Well let's move on with this case. I mean, what were your general concerns as far as meeting that generally accepted EMS care in this particular matter?
A: I had concerns about the affect ---
Q: Okay.
A: --- toward the patient.
Q: Well do the generally accepted standards of care prescribe anything regarding the providers affect?
A: Yes. Yes. Affect has become, unlike when I was in school, -- when I was in school 30 years ago, there was no mention of affect other than treat people kindly. Affect has become a large part of the education. We now educate by the principles of education and the principles of

education provide us with three domains of learning. They are cognitive, which is the knowledge base. Psychomotor, which is the skills. And then, affective, which is probably the most difficult to teach, the most difficult to assess but perhaps the most important skill that we have.

Q: Why is it so important?

A: Well for one thing, it's the one that we use the most. It's the one that allows us to enter a patient's home, to capture the trust of a patient. It's vitally important.

Q: Did Mr. Davenport meet this standard of care regarding professional affect?

A: No, sir.

Q: Why?

A: His affect was not acceptable.

Q: Okay.

A: The statements that were made were derogatory and just not acceptable.

Q: Did you see dangers in failing to meet that standard?

A: Dangers in what way?

Q: Patient safety, health dangers.

A: I don't know. I don't know the patient. The

patient did not respond to the remarks so I don't know.

Q: Okay.

A: I really can't respond to that. I wasn't there. I can't really -- my expertise extend to that. I don't know.

Q: Okay. Would you consider this patient abuse?

A: Yes.

Q: Would that be something that would be reportable to ---

A: Well yes.

Q: Okay. What other concerns with this particular call? We've talked about affect.

A: I guess the failure to appreciate the potential for the patient to become unstable at any given time. And then to not get ahead of that as has been discussed previously. Once a patient, not he, but once a patient's blood pressure begins to drop, you loose your opportunity to achieve IV access and thereby losing your opportunity to provide fluids that could expand the volume and at least keep a somewhat of a blood pressure until we get to the hospital and get them into the surgical suite.

Q: Were there any concerns with the assessment?

You can start from the beginning in terms of the assessment?

A: Yeah. So where the knife was, there was a potential for it to have perforated the diaphragm. The diaphragm moves while we breathe and it's a dome shaped muscle. A sheet of muscle that separates the chest cavity from the abdominal cavity and as we breathe, it flattens and comes down into the abdominal cavity. Depending on where he was in his breathing pattern when he inserted this knife, it could easily have perforated the diaphragm. So I would like to have seen lung sounds assessed. Not I would like to, lung sounds should have been assessed.

Q: Okay.

A: I would like to have seen abdominal sounds assessed. Not belly sounds but to listen for air movement in the belly. That would not be required. That would not be a critical fail on a check-off but that certainly would be a good idea. That's all of the essential ...

Q: How would you take those?

A: Stethoscope.

Q: Okay. And would those be generally accepted

EMS standards per ---

A: Yes.

Q: Can you explain then, I guess, the assessment continuum. I understand there are differences between initial primary assessment all the way to ongoing assessments. Could you explain that to the Court?

A: Sure. So primary assessment is at the first encounter with the patient you -- as you approach the patient you form a general impression and then the intention of the primary assessment is to identify any life threatening conditions. So you would evaluate the airway, determine if the airway is patent or not, is open or not and then determine the quality of the breathing, whether the breathing was sufficient or not. Whether it was of a sufficient rate and of a sufficient quality, meaning the rise and fall of the chest and generally lung sounds to make sure that both sides are inflating equally. And then circulation so we would check a pulse to make sure the pulse was within a normal range. At that point you don't necessarily have to have a number, it just either to fast or to slow or

something else. Looking for exsanguinating hemorrhage or massive bleeding. And then move into a skin condition, color and temperature while you're checking the pulse as well. Then move into, what's called a secondary assessment. You would make your transport decision at that point and then move into the secondary assessment where you would ask things like medications, allergies, medical history, things like that. And then explore -- there are a couple of different avenues you can go down. This is where it takes judgment with a patient who is alert and oriented, you can do a focused exam, focused on the area of the injury and then explore that injury. If there are concerns about other injuries, you might do a more broad exam and do a head to toe looking for other injuries or other conditions. And then there's reassessment. You have vital signs, blood pressure and then forced pulse, an actual number, respirations a number again. Vitals signs to include pulse oximetry and things like that. And then reassessment would be just a ongoing on the way to the hospital, ongoing monitoring of the heart rate, the

respirations and the patient condition generally.

Q: What are the documentation parameters with regards to these various assessments?

A: Document all of them.

Q: Okay. Talk about the initial primary, I mean, explain the importance of or the level of detail that's required by the generally accepted standards.

A: I'm not sure what you're asking.

Q: What level of detail is required when you're doing an initial primary assessment?

A: Okay. So like I said as far as the primary assessment, the specific number of a pulse and a respiratory rate is not necessary. It's just, is the pulse adequate. Is the respiration rate adequate. So one would estimate that and that is absolutely acceptable.

Q: Okay. Still a documentation requirement?

A: Yes.

Q: Okay. And explain the purpose of documentation for the various assessments.

A: It's for the continuum of care so that once we get to the next level, they know what EMS has

done. They know what was done in the pre-hospital environment and can continue that care.

Q: Any other concerns with the assessments in this matter?

A: I don't think so.

Q: Okay. So they do the assessment, did some bandaging of the wound, any concerns with the ambulation of the patient?

A: Yes.

Q: What were they?

A: As I said earlier, the organs in the body can move when we move. The appropriate way to move him would be to keep him in a seated position, whatever that took. Stair chair would have been the ideal piece of equipment but there are plenty other ways to move him and keep him in a seated position. He appeared to be fairly comfortable in the seated position. He did not, from what I could gather, he did not appear to be in significant pain until he stood up and then he obviously winced with pain.

Q: Okay. Explain the generally accepted standards in the EMS community for ambulation.

A: So there are few absolutes but -- well I

shouldn't say -- this isn't an absolute, there are a few exceptions to this rule but just about everybody gets the stretcher. Every patient deserves a stretcher. If the patient meets you as you're walking towards the house and they're coming out of the house walking toward you, it's a little different story but generally speaking, when you're in a house or residence or a building or any distance away from the unit, pretty much everybody gets the stretcher.

Q: Did Mr. Davenport meet this standard?

A: Certainly.

Q: Did he meet the standard?

A: Certainly, yes.

Q: Mr. Davenport ---

A: Oh, I'm sorry. I thought you were talking about the patient. No.

Q: Okay. We talked about the dangers of ambulation, what other kind of carrying devices, I know you mentioned stair chair, are there any other acceptable carrying devices?

A: Sure. The backboard has been mentioned. So to clarify, if I might, the long spine board is a useful tool just for patient movement. It is

not absolutely necessary to immobilize ones spine every time you put somebody on a spine board. We frequently use the long spine board just to move someone from point A to point B. If I was going -- I think if the long spine board were to be used in this case, you would have to be very careful to use a lot of something, padding, behind him to keep him in a seated position. I would not -- it would not be prudent to lay him supine.

Q: From your review, were there any obstacles to using any of those carrying devices?

A: I did not see any. It's really difficult to tell in the video but I did not see any.

Q: Did you review the photos?

A: Yes.

Q: Okay. Do those indicate any obstacles?

A: Not that I could see.

Q: Do you want to allow the patient to have a relative position of comfort?

A: Can I go back just a little bit?

Q: Sure.

A: Those aren't the only two ways to move a patient, short of the stretcher. I mean, there are improvised methods to move a patient. A

kitchen chair, a table, chair and table. Just take the chair, move the patient to the chair and carry the chair. There have been some concerns expressed with the strapping on the KED. There are alternate methods to strap a KED going across as opposed to crossing. A sheet, just a simple sheet can be placed under the patient and carried in a seated position. And then there's a carry, just a simple carry under the knees, under the arms and just to carry them in a seated position. So that there are a number of ways to move a patient from point A to point B in a seated position without having him walk.

Q: I think you said, KED. Were you meaning stair chair when you were talking about the straps?

A: Yes, I'm sorry.

Q: What's a KED?

A: I'm sorry. I KED has no relevance in this.

Q: Okay.

A: My apologies.

Q: Sure.

A: My intent was the stair chair, sorry.

Q: Is it important to allow the patient to maintain some position of comfort in transport?

A: Yes.
Q: Okay. Is the goal to minimize movement?
A: Yes, certainly.
Q: All right. Next consideration initiate oxygen administration. I think during the voir dire, you mentioned oxygen administration is not recognized as an accepted practice anymore. Can you explain that?
A: The statement as you quoted it, is not true.
Q: Okay.
A: It's not oxygen is not an accepted treatment, it absolutely is. There has been some -- we've learned a lot about oxygen administration in certain cases. So EMS is moving towards evidence based medicine where we use to do things because we saw it worked and so that's why we do it. Now, everything we do, once it's proven is based upon patient outcome. It's not did we get them to the hospital alive, it's did they leave the hospital functional. So the deal with oxygen is it was long thought to be a benign medication. And oxygen is a medication. But it was thought to be a benign medication. There were no contraindications, everybody got oxygen as you alluded. It was

IV-O2 monitor. Everybody got oxygen. If a little bit of oxygen was good, a lot of oxygen was better. We have since learned that is not the case, especially with certain situations like cerebral vascular accidents or strokes. We've learned that to much oxygen with a stroke can be a bad thing. To much oxygen in a cardiac event, a myocardial infarction, can be a bad thing. To much oxygen with a traumatic brain injury can be a bad thing. That is the extent of the research thus far. In a case where you're talking about the shock, nothing has -- there is no evidence linking oxygen administration to poor outcomes in cases of shock or potential shock. However, I will say many services standards are going to the oxygen saturation level as the indicator for the need for oxygen.

Q: Okay.

A: So, there's that.

Q: Well thank you for clarifying me. Did you see this as a concern, the failure to administer oxygen in this matter?

A: I would say a concern, yes. A requirement, no.

Q: Okay. Would it be more characterized as a best

practice?
A: Yes.
Q: Okay. You've spoken some about the lack of IV access. Do the generally accepted standards of care for EMT's prescribe IV access for this particular ---
A: Yes.
Q: --- type of patient?
A: Yes.
Q: Okay.
A: IV access, understanding that does not necessarily imply the administration of fluids.
Q: Okay. I think you've explained that. What's an EMT's thought process as far as making that determination?
A: I'm sorry, what?
Q: What's an EMT's thought process as far as making that determination of whether you need IV access or you don't need IV access?
A: And you're referring to EMT as the EMT or paramedic?
Q: Paramedic. Because obviously an EMT basic ---
A: Yeah, okay. Again, it goes to the potential. It goes to the potential and in getting ahead of the shock. Because once -- the goal is to

prevent shock. Once his blood pressure begins to fall, which could be the first indicator. Not likely, but it could be, then it's to late and you've lost your vasculature and especially that's why it's vitally important to have a well trained paramedic assessing the patient constantly that would pick up on those small signs that a relatively inexperienced EMT might not pick up on.

Q: What's a saline mock?

A: It's basically the way to start an IV without administering fluids.

Q: Would that be appropriate in this case?

A: Yes.

Q: Can you explain the concept of a load and go?

A: Load and go is, kind of, it's a slang term but it's in many of the textbooks. But it's -- load and go is where you find a patient who is either decompensating or common slang is crashing, or about to or potentially could. It would fall under the critical category and there's nothing that we in the pre-hospital environment can do to help them except get them to definitive care.

Q: I know you mentioned critical trauma as an

indicator for load and go. Are there other, kind of, indicators that were justified having this load and go approach?

A: Not as it relates to this call. I mean ---

Q: Okay.

A: --- unsafe scenes.

Q: Okay. Just jumping back a little bit, what's permissive hypotension?

A: Permissive hypotension, it goes by several different names but the thought process behind permissive hypotension is that when a patient is in shock as opposed to bringing the blood pressure back to normal, you want to bring it back to less than normal. There are many reasons behind it and gets deep but essentially you don't want to fill the container up all the way because the container has a leak in it and you don't want to increase the pressure. It does a lot of things, it hampers the body's ability to clot. The volume that you're putting in there, the fluid that you're putting in there doesn't transport oxygen. It's just a filler to create pressure so permissive hypotension just means that you're limiting the amount of fluid to a less than normal blood

pressure.

Q: Is there a conscience on this permissive hypotension?

A: There is not. It was introduced some time ago. It was introduced several years ago and I mean, it's, kind of, -- a lot of people know about it. I mean, it's fairly well known it just hasn't really caught traction among trauma surgeons, which is who pushes it, so. There have been several research studies done on it that the two biggest research studies that were done were flawed. They were known to be flawed, so.

MR. ROTHSTEIN: Your Honor, I'm not trying to be difficult but permissive hypotension has nothing to do with this case and I know we're getting close to lunch. I don't think this is relevant to anything.

MR. WICEVIC: I believe it was one of their theories about not having the IV access, so that's why I brought it up. Mr. Douglas ---

THE COURT: It has very limited ---

MR. WICEVIC: Okay.

THE COURT: Yeah. So, let's move on.

Q: Speaking of the IV topic, are there any

antibiotics that the paramedic can administer?
A: Yes.
Q: What would they be?
A: Yes, in South Carolina paramedics can administer antibiotics. It would not be germane to this case.
Q: Okay. Applicability of trauma protocols. Did you feel they were applicable to this particular man?
A: Yes.
Q: Okay. Why is that?
A: They are within generally accepted practice.
Q: Okay. And was the injury in question, patient in question, did he present conditions that would warrant compliance with those protocols and orders?
A: Yes.
Q: And we talked about trauma and your determination of critical trauma. Any concerns with the EMT riding the call?
A: Yes.
Q: What are they?
A: That patient should have had an IV so it should have had a paramedic tending and should have had an ongoing advanced assessment looking for

those small signs. I would have like to have seen a very experienced paramedic that would catch those signs.

Q: Are there any, kind of, generally accepted EMS standards about who was to ride a call?

A: Yes. Anytime there is an advanced life support skill, the paramedic has to be in attendance.

Q: Okay. Aside from establishing the IV and the reassessments, I think that you spoke about, are there any other ALS requirements, procedures that should have been performed for this patient?

A: Requirements, no.

Q: Okay. So kind of a converse question I asked earlier, I mean, under these generally accepted standards, the only circumstances under which an EMT basic can ride is when the patient requires BLS care?

A: Yes.

Q: Okay. If you had this body cam footage to show in your classes, how would you use it?

A: Of course, if I could redact all the faces, it would be -- you could apply this -- it's applicable to many different chapters of the EMT text, starting very early with patient

lifting and moving. This is a good way not to do it. Communication, therapeutic communication. There are two different chapters. There's communication and then there's therapeutic communication. How to talk to a patient. Again, affect is a very important part of education now. So it would be again, proportionally a negative example. It would apply to, of course, the abdominal trauma section as well. It's a very good example of a potentially unstable stab wound, yeah. Abdominal impalement.

Q: Any other concerns or conclusions regarding your review of this particular case?

A: No, sir.

Q: That's all I have. Please answer any questions Mr. Rothstein has.

MR. ROTHSTEIN: It will be a while, Your Honor. Can we break for lunch?

THE COURT: Okay. Well it's afternoon so we'll take a one hour break so we should reconvene -- my watch says it's 15 after 12:00 now, so why don't we reconvene at a quarter after 1:00.

MR. WICEVIC: Sounds good. Thank you.

(Off the record from 12:15 p.m. until 1:26 p.m.)

THE COURT: Mr. Rothstein.

MR. ROTHSTEIN: Thank you, Your Honor.

MR. DOUGLAS - CROSS-EXAMINATION BY MR. ROTHSTEIN:

Q: Mr. Douglas ---

A: Yes, sir.

Q: I'm David Rothstein. You and I have not met or had the pleasure to meet. It's nice to see you this afternoon. Have you been at the hearing the whole week?

A: Yes, sir.

Q: I'm sorry?

A: Yes, sir.

Q: Okay. So you were here yesterday when Keith Eudy testified?

A: Yes, sir.

Q: Okay. And it's almost like Greenville County EMS home week, wasn't it?

A: It's a small world, small EMS industry.

Q: Mr. Eudy was here, you were here, Dr. Alier was here, and Scott Stoller was mentioned but he wasn't actually visible here. Y'all all sort of work together back in the day in Greenville County EMS, right?

A: I'm trying to think if we were all there at -- I believe we were all there at the same time,

yes.
Q: And I notice in your CV that you graduated from paramedic school in 1986.
A: Yes, sir.
Q: Okay. The reason that stuck out in my mind is that's the same year I graduated from high school, and that was a good year, wasn't it?
A: Thank you. I appreciate that. I think you just called me old.
Q: In your 31 years of practice, I think you testified that a lot has changed in emergency medical pre-hospital practice, right?
A: Yes, sir.
Q: I think you testified -- I was asking a few questions during Mr. Vito's examination that the mantra O2, IV, and monitor has been gone for a long time, right?
A: Yes, sir.
Q: A lot of the advances in EMS, sort of cutting edge technology or what's sort of the best thing for the patient has come from the military. Wouldn't you agree with that?
A: Yes, sir.
Q: In fact the military's probably several years ahead of civilian EMS in terms of effective

care of pre-hospital casualties or patients. Wouldn't you agree with that?

A: Yes, sir.

Q: Okay. The one thing that hasn't changed since you were here, or since you went through your paramedic training, is the definition of the word protocol. I think you talked about it as sort of a decision tree, right?

A: Yes, sir.

Q: Have you seen the protocols referred to as algorithms before, a flow chart?

A: Yes, sir. Sometimes the terms become blurry. A lot of the terms are used interchangeable, so yeah. People use different terms for them.

Q: Okay. Has the definition of the term protocol changed in the last 30 years? At least that term as you understand it, paramedics?

A: No, sir.

Q: Okay. What about the term physician order, or the phrase physician order? Do you understand what that means?

A: Yes, sir.

Q: Has that changed at all in the last, I mean in the time you went to paramedic school until today?

A: No, sir.
Q: Okay. I'm kind of a visual learner, so I put a little -- I don't know if you were taught like I was in science. This is called a Venn diagram. You seen those before?
A: Yes, sir.
Q: Okay. And I want you to see, I've drawn a big green circle here. And I'm just going to put protocol, okay? All right. So that's, in a visual sense that's sort of the scope of what either a paramedic can do or what an EMT basic can do, or what an EMT intermediate can do is spelled out sort of in the protocols that are handed out by each rescue squad or whoever the Medical Control Physician is, right?
A: Yes, sir. It's basically if then statement. If certain criteria are met, then one should fill in the blank. And then it depends on what fill in the blank ---
Q: Okay.
A: --- is to what lies after that. And if it's will or shall, then that must be followed. If it's may or consider then there are things to consider or things to think about. So it depends on how it's written.

Q: Okay. Now the smaller circle I have down here to the bottom right, I'm going to use that to represent orders, physician orders, okay?
A: Uh-huh.
Q: And the reason I have it in red is because you can't violate a physician order. You understand that?
A: Sure.
Q: You agree with that?
A: Sure. An order implies there's a prescriptive authority to it.
Q: Okay.
A: Yes, sir.
Q: And you see how I've drawn a little bit of overlap here? I've got some of the red is overlapping with the green.
A: Right.
Q: Some of the red is outside of the green, right?
A: Yes, sir. I assume you mean that that is because some protocols have prescriptive authority by being signed by a physician.
Q: Okay. I'm going to put an SO inside this little overlap
A: Uh-huh.
Q: For standing order, okay? Do you agree with me

that within protocols, there are standing orders sometimes?

A: Yes, sir.

Q: Okay. But there are sometimes when a paramedic encounters a situation that's outside of the protocols and has to call for online medical control, right? So they call say the ER doctor on duty and say, hey how do I handle this, or you know this patient took pain medication this morning when they woke up and I don't know how much to give her now.

A: Yes, sir.

Q: So that's called a -- what do you call that? Online medical control?

A: Yes, sir.

Q: Okay. So I'm going to put OL here for online. And the reason it's outside the protocols, again, is 'cause the protocols or the standing orders don't tell you what to you, you have to go and get online medical control, right?

A: Yes, sir.

Q: Okay. Would you agree with me that that's a fair representation of sort of -- I mean, I know it's a little rudimentary, but would you agree with me that that's sort of a fair

representation of the relationship between protocols and physician orders?

A: More or less. Again, the terms sometimes are used interchangeable. For example, CMS, the Center for Medicare Services uses them interchangeably. They see no difference between the term protocol, or physician's orders, or order sets, or several other terms that are used. So there are times where the terms are interchangeable.

Q: Okay. Well there are certain times when they're not interchangeable, right? So let me give you an example.

A: Right. If a protocol does not have a physician's signature, then it does not have prescriptive authority.

Q: Okay. Let me ask you this. Have you seen -- did you review the Anderson County protocols as part of your 60 hours or so of getting ready for this case?

A: Yes, sir.

Q: Did you read the introductory paragraph that said these are guidelines?

A: Yes, sir.

Q: Okay. You understand that guidelines are

different than orders?
A: Yes, sir.
Q: Okay. So, did you also see in the introductory where it says that if you deviate from the protocols, you have to be able to explain why you deviated and you have to potentially document at some point why you deviated? Do you agree with that?
A: Say that again.
Q: In the introductory -- if you want to look at it, it's Exhibit 1.
A: Right. Introduction? Okay.
Q: Yeah. And it says -- I'll point you to the exact paragraph, give me a second.
A: The third paragraph, is that the one you're referring to?
Q: Well we'll get to that third paragraph in a second. Let me ask you to skip down to the fifth paragraph.
A: Okay.
Q: The last sentence in that paragraph says ---
A: Yes, sir.
Q: --- all providers are responsible for their own individual actions with regards to protocol compliance, right?

A: That is what it says.
Q: Okay. And then the sentence goes on, it says, and any deviation from the standards stated herein, meaning in the protocols, must be documented and explained, right?
A: That is what it says.
Q: So that introduction says paramedics and EMT's can deviate from the protocols as long as they can explain why they did what they did, right?
A: I will not try to interpret the procedures and protocols.
Q: Okay. Now what about physician orders. As a paramedic are you allowed to disregard a physician order?
A: No, sir.
Q: Okay. So ---
A: Not without permission of course.
Q: Okay. So if there's a standing order and unless you get permission from the online medical control to change the standing order, you have to comply with the physician order, right?
A: That is correct.
Q: Okay. And if you disregard a physician order as a paramedic, that's a bit problem, isn't it?

A: Yes, sir.
Q: Because, you know, your supervisor is that medical control physician and the emergency doctor in the ER right?
A: Yes, sir.
Q: And if they're telling you to do something, either through standing orders or online, and you disregard it, you're operating outside of this -- I mean, you're way out here (indicating) somewhere, right?
A: It's called practicing medicine.
Q: Okay. Now a lot of your testimony you talked about the -- I think you talked about a lot of your determinations were based on the physician's report, I mean the patient's report in the stabbing that the knife blade was seven inches long. Do you recall that?
A: It was not just the patient's report. By all accounts the knife was -- I heard two numbers. I heard six and seven. So six to seven. And given six and seven I would go with the longest, so seven inches long.
Q: Do you recall in the -- you watched the video, right?
A: Yes, sir.

Q: How many times did you watch the video?
A: I don't know. Five, six, seven.
Q: Okay. Do you remember toward the end of the video when the Officer Burns with the camera comes in and he says, how long was the knife blade. Do you remember that conversation?
A: Yes, sir.
Q: And the patient said, oh about seven inches long, and he held his hand up like that?
A: I recall it more like (indicating).
Q: You think it was like that (indicating)?
A: I remember him doing this (indicating), but again, I'm not going to -- again, given any numbers or any estimation, I'm going with the greater estimation.
Q: I'll show you the Exhibit 23. Do you recognize Exhibit 23?
A: Yes, sir.
Q: Okay. There's a bit of handle of the knife sticking out.
A: Yes, sir.
Q: How big would you say the handle of that knife is?
A: I honestly could not estimate that.
Q: Maybe four or five inches? I mean you've seen

a ---.
A: I would not venture to estimate that.
Q: How big would you say it is?
A: I would not venture to estimate that based on this photograph.
Q: It's hard to estimate the size of something sometimes and be accurate, would you agree with that?
A: Certainly from this photograph, yes.
Q: Okay. But if that knife was seven inches long -- I'm going to hold it right there (indicating). That's the blade.
A: Uh-huh.
Q: A lot of your opinions are based on the fact that that whole blade is inside that patient's body, right?
A: Yes, sir.
Q: And then that handle looks like it's -- well you estimate it. If I'm holding a knife, it's about there (indicating)? Would you agree with that?
A: If you're asking ---
Q: That look like ---
A: --- if you're asking me if ---
Q: --- about the size of the handle ---

A: --- that extends beyond ---
Q: --- if this is the blade?
A: --- seven inches, then the answer is that appears to be correct.
Q: Okay. So I'm now down at 11 and a half inches, you see that?
A: Okay.
Q: You ever seen a steak knife that big?
A: I don't know.
Q: You also mentioned that you had some concerns about the knife possibly hitting the diaphragm I think. You recall testifying about that?
A: Potentially, yes.
Q: Okay. If that knife hit the diaphragm, what's that going to cause in a patient?
A: Well it depends. It depends on how badly, if it perforated the diaphragm it could cause a rupture of the diaphragm, if it punctured the lung it could cause air to enter the abdominal cavity. It could cause bowel or organ to enter the lung space. I mean it just depends on how badly it was perforated. Or it could be very minimal. It just, you know, it just depends. Again, all of my testimony has been based on the potential for the injury. And given the

potential, I can't say to what extent the injury might have occurred.

Q: Okay. Well let's just assume for a second that that patient had that knife in and it hit the diaphragm. What exactly is the diaphragm.

A: It is a muscle.

Q: Okay. And the muscle that controls the breathing in your lungs, right?

A: Yes, sir.

Q: I get this backwards a lot. When you inhale -- -

A: It seems converse. It goes against logic. But as you inhale, the diaphragm contracts meaning it flattens, and then as you exhale it relaxes and comes back into a dome.

Q: Okay. So if that knife was inside the -- was in the diaphragm, every time you breathed in and that collapsed, and every time you breathed out it expanded, you would expect to see that knife kind of move up and down every time you breath. Would you agree with that?

A: I do not actually. If that had happened, what I would have expected is for the knife to have perforated the diaphragm and the diaphragm come away from the knife.

Q: All right.
A: Most likely. Especially if he was still holding onto the knife.
Q: Okay. If that happened, that patient probably would be in some respiratory distress. If that knife perforated the diaphragm, that patient would probably have some breathing problems. Would you agree with that?
A: Potentially. Again depending on the extent of the injury.
Q: Okay. And the patient might have even a collapsed lung if he hit the diaphragm. Do you agree with that?
A: Yes.
Q: Okay.
A: Potentially.
Q: I mean is that something that's pretty easy to tell if a patient's having breathing difficulty when you walk into a scene. I mean I'm sure as a paramedic, you've seen patients that have had respiratory distress ---
A: Sure.
Q: --- right?
A: Sure. And there again. It depends on many variables here. It depends on the extent of

the injury. It also depends on how long it had been since the injury occurred. So the lung space would fill with air with every breath, but then depending on the size of the injury how much air would enter that lung space with each breath. So it may develop over ten minutes, it may develop over two hours. It just depends on the extent of the injury.

Q: Well the patient had been sitting there for 20 minutes before the EMT's arrived, actually before he even called 9-1-1. And there was some perforation of the diaphragm, you would expect it to manifest itself in 20 minutes or so, wouldn't you? At least to some degree?

A: Not necessarily to the point of being visual, no. Not necessarily. Again, it's all based on potential.

Q: Okay. Well I think you testified earlier that you don't believe this patient needed supplemental oxygen. I think we had a discussion about too much oxygen can be a bad thing.

A: Right. I believe I stated that I felt it was best practiced to place the patient on oxygen, but I felt like it was not required.

Q: Okay.
A: I felt like it was not --- I'll leave at that.
Q: Okay. Where on this diagram is the term best practice show up?
A: You didn't write it up there.
Q: Okay. Would it be like somewhere up here?
A: I don't know that best practice applies to your diagram.
Q: Okay. Is best practice something that's beyond the protocols?
A: No, sir. Best practice is what should be done, what -- it's not necessarily a critical point. But it's probably a good idea.
Q: It's not the same thing as a standard of care. Do you agree with that? Is that fair?
A: That's fair. Yes.
Q: Okay. So if you don't comply with the best practice, you're not operating below the standard of care?
A: Right.
Q: Do I understand that?
A: Right.
Q: Okay.
A: That was my implication with it was not required. Had it been required it would have

been standard of care.

Q: Okay. So I think Mr. Wicevic asked you, sort of, what kind -- and I guess you did a fair amount of analysis in this case. You actually looked at this case for, I think you said 60 hours?

A: Yeah. It's hard to sleep at night.

Q: Okay. Does that include the time you've been in the courtroom this week, the 60 hours?

A: Some.

Q: How much of the time are you including in the time you've been in court?

A: In the 60 hours?

Q: In the 60 hours?

A: Oh, I don't know. Probably six or so.

Q: Okay. So you got 54 hours until the case started, I mean the hearing started at 1:00 -- when did it start? 1:00 o'clock on Monday?

A: Right. So probably -- what's today?

Q: Today's Wednesday I believe.

A: All right. So probably six hours yesterday, probably -- let's see, how long were we in here yesterday?

Q: Well we -- it was my fault. I broke the courtroom.

A: I'm sorry.
Q: So we were here from about 1:00 o'clock to maybe 6:30.
A: A couple hours yesterday, a couple hours Monday. So a couple hours each day was spent doing research within the courtroom
Q: And if I understood your testimony correctly, you first became aware of this case last Thursday?
A: That's correct.
Q: Okay. How did you become aware of the case?
A: My boss and I were at the State Training Committee Meeting Thursday, and Mr. Wronski came in and said he needed to speak to us afterward. And after the meeting we met him outside, and he said that he needed an expert witness. And I told him that we had just started our medical school class like the day before that, and that we just didn't have the time. And then my boss told Mr. Wronski he could free me up for the week, so ...
Q: Now your boss, who is your boss?
A: Phil Head.
Q: What is his position?
A: He's a program manager for the division of pre-

hospital medicine.
Q: At the Greenville Health System?
A: Greenville Health system. Yes, sir.
Q: Is that a licensed EMT or paramedic provider?
A: Can you clarify the question?
Q: Well do they actually run ambulances out of Greenville Health System?
A: Yes, sir.
Q: Okay. So that's a licensed facility by DHEC Bureau of EMS and Trauma, is that right?
A: The Greenville Health System has an ambulance service, yes.
Q: And my point is that's licensed through DHEC, right?
A: Yes.
Q: Through the division that Mr. Wronski is over at DHEC?
A: Yes, sir.
Q: Okay. And if you were to lose your license, just hypothetically, you couldn't operate an ambulance service at Greenville Health System, correct?
A: I have nothing to do with the ambulance service. I don't know.
Q: No, I'm just saying Mr. Head does though,

right? Your supervisor?
A: No.
Q: No, he doesn't?
A: No.
Q: What is his ---
A: We're the education department.
Q: Okay.
A: We have nothing to do with the ambulance service.
Q: All right. Fair enough.
A: I'm sorry. I'm sorry if that was misleading.
Q: So I think Mr. Wicevic asked you if you were running this call, or what criticisms you had of Mr. Davenport. And we'll talk about the language and interaction with the patient. But from a medical clinical standpoint, you said your only -- the only thing you would have done differently from a medical standpoint is started an IV, right?
A: Not exactly what I said, but what I said was --
-
Q: Established, I'm sorry. Established an IV.
A: No. I would have done several things differently. What I said was, as far as generally accepted practice, the standard of

care would have required an IV. Other than that, as far as the care, which would have, of course required a paramedic in the back of the ambulance, lung sounds would have been required. I believe that was it ...

Q: Okay. So you wouldn't have ---

A: If I recall.

Q: --- put this patient on a heart monitor?

A: I would have.

Q: You would have?

A: Yes, sir.

Q: Well you didn't mention that in your testimony earlier. You said IV was what you would have done.

A: I don't recall being asked what I would have done. But what I recall being asked was what standard was or what would have been generally accepted practice.

Q: Would putting this patient on a heart monitor been part of the standard practice for this patient?

A: No.

Q: I mean, what's a heart monitor going to show you?

A: Right. So, the reason I would have put the

patient on a heart monitor is exactly the same reason that the EMT that was in the back ended up using it in the end anyway. It would not be necessarily to interpret the cardiac rhythm. I would have looked at it just to see if there was anything going on. But it's to listen to the heart rate rather than having to feel the pulse constantly you can -- there's an audible signal there, so you can listen to the heart rate. So if the heart rate increases, then it's a good indication that the patient may be going into shock. There are conditions where the patient could go into shock without having the heart rate increase. But having the heart rate increase would be an alert.

Q: Are you familiar with the device -- was it LIFE Pack 15?

A: Yes, sir.

Q: Okay. And tell The Court what a LIFE Pack 15 is.

A: It's a cardiac monitor that does many more things. It monitors blood pressure, depending on what additional additives you put on it it can monitor oxygen saturation. It can do, it's called catonography. It can measure the amount

of carbon dioxide that you breath out. What else. It's a defibrillator, so much akin to the public that uses an AED, and automatic external defibrillator, it has a manual defibrillator as well as a pace maker. And depending, again it's an option, it may also monitor depending on if you purchase it, it may monitor CPR while you're doing CPR. It may monitor the quality of the CPR while you're doing it.

Q: It measures pulse, doesn't it?

A: It does a lot of things.

Q: It measures pulse?

A: So it gives you a tracing of the heart beat. It does 12 lead EKG as well. So yes, it measures pulse as well. Pulse and the heart rhythm.

Q: Is the use of the Life Pack 15 a skill that only a paramedic can perform?

A: The use of it is ---

Q: In terms of vital signs, measuring, I mean seeing the blip on the screen and what the patient's heart rate ---

A: The EMT can do that.

Q: Okay. And you mentioned that it has a

defibrillator. Is that also called an AED. Is that what you called it?

A: It has an AE- -- well I don't know if the Life Pack 15 has an AED mode. My service uses a different monitor. But I don't know if that one has an AED mode. Some monitors have a manual mode and an AED, an automatic mode. An automatic mode, an EMT may administer the shock through the AED, but not manually.

Q: I've seen those new defibrillators popping up in public places all over the ---

A: Right.

Q: --- world. I mean that saves people's lives, right?

A: Yes, sir.

Q: And it doesn't take a paramedic certificate to operate one of those devices to save someone's life, right?

A: That's correct.

Q: Okay. Some first responders who are not even EMT's are trained on how to use that type of --

A: The general public is trained.

Q: Okay. So we have Ms. Aiken in the back with the blood pressure being monitored by the Life

Pack 15 pulse.
A: Yes, sir.
Q: Respiratory rate and what's the pulse ox. Does that also show sometimes the pulse?
A: Yes, sir.
Q: Okay. And looking at -- you've seen the run report I assume in your 60 some hours of looking at this case, right? If you'll turn to Exhibit, I think it's 11b in that notebook.
A: Okay.
Q: You agree that the vital signs that Ms. Aiken recorded on this first page kind of about in the middle showed blood pressure, pulse, and respiratory rate within the normal limits?
A: Yes, sir.
Q: Okay. And it also showed an SPO2 or an oxygen saturation of either 98 or 99 percent for this patient, right?
A: Yes, sir.
Q: On the way to the hospital?
A: Yes, sir.
Q: Is that also within normal limits?
A: Yes, sir.
Q: Okay. Given that O2 saturation, does that patient need oxygen?

A: Like I said earlier, no.
Q: Okay. And did you look at the emergency room record as part of your review of the case?
A: I did.
Q: Okay. Did you see whether they have the patient any supplemental oxygen once the doctors and nurses at AnMed took over the care of this patient?
A: I don't recall, but I'll take your word for it.
Q: What is the abbreviation RA mean when it's talking about oxygen.
A: Room air.
Q: Okay. So the emergency department notes that RA. That means the patient is just breathing the same air that everybody else is breathing, right? No supplemental oxygen?
A: I believe that is correct. I don't know what abbreviations the hospital uses. I believe it is room air.
Q: Okay.
A: But that is -- I'm not certain of that.
Q: In your training you've never seen the abbreviation RA refer to room air?
A: I use the abbreviation in EMS for room air. But you're supposed to use organizationally

approved abbreviations. So ...
Q: Don't know whether ---
A: And different organizations have different approved abbreviations. So my assumption is that it is room air.
Q: Okay. You don't know what AnMed's ---
A: Right.
Q: --- routine abbreviations are, is that fair?
A: Yes, sir.
Q: Okay. The other thing that's listed on the vital signs is a pain score of four. You see that a little further to the right?
A: Yes, sir.
Q: Okay. If the patient reports they've got a four out of a ten on the pain scale even considering they have a knife in their belly, does that person need pain medication in your experience?
A: Pain medication is truly a judgement call. And I'm -- and as well, pain estimation is very much a judgement call. When I teach pain estimation, I always teach to use two estimations. That is one, the patient's, and two the practitioner's. And especially in this case, considering the patient has well

documented psychiatric history as well as anything else that might be going on, I don't know that I would trust the pain evaluation as far, you know -- it's really just a very broad estimation. But again, personally I'm pretty stingy when it comes to pain medication.

Q: So if you were making this judgement call, and by the way, if this is a judgement call, we're talking about being up here (indicating) in the Venn diagram ---

A: Right.

Q: --- right? We're not down in the red ---

A: Yes, sir.

Q: --- we're in the green.

A: And additionally, I would have started -- and I understand what the physician said earlier, but it has been documented, well documented that oxygen has at least some pain relief properties. I would have started with that. Maybe it helps, maybe it doesn't. I don't know. But ---

Q: Is your testimony that oxygen is a form of pain relief?

A: It is well documented that oxygen has pain relieving qualities.

Q: Well, you mentioned about this pain score, you wouldn't necessarily trust what the patient said in terms of -- I mean 'cause a lot of times patients will inflate their pain to get drugs, isn't that right?

A: Right. Considering the psychiatric history -- I mean like I said, it's a judgement call. And additionally, you can, even in the video, there are -- it varies. There are points where the patient appears to be in significant amount of pain. And then when he relaxes, when he's not moving, he does not appear to be in pain at all. The picture I think you're about to show me probably shows him to not be in any pain at all. But when he stands, he appears to be in a great deal of pain. When he sits he appears to be in a great deal of pain. And then when he is places supine he appears to be in a great deal of pain. Beyond that ---

Q: I'm going to show you Exhibit 21 that's been in evidence. Do you see that patient in a supine position?

A: Yes, sir.

Q: Doesn't appear to be in a lot of pain in that position or in that picture, does he?

A: I could not estimate his pain level based on this picture.
Q: Okay. A lot of times when people are in pain, do they kind of grimace or tighten their facial expressions?
A: A lot of times, yes.
Q: Okay. And that patient looks like he's kind of relaxed. I mean he's laying back. He's got his hands ---
A: I would say that he is not grimacing.
Q: Okay. So in your exercise of judgement, you would not give this patient pain medication, right?
A: I don't know. It depends on -- I don't know.
Q: Okay. You have to ---
A: Again, it's a judgement call. And without more information than I have currently, I would not want to make that judgement.
Q: I think you and I are on the same wavelength on that. I agree that there are a lot of things that you, as a paramedic, have to be on the scene experiencing the same thing that that medic sees in order to judge what that medic does, right?
A: In this case, yes.

Q: You also, I think you talked about moving this patient. I mean the patient has to be moved out of the house, right?
A: Of course.
Q: Okay. I mean you can't -- a surgical team can't come into the trailer and perform surgery while he's sitting half reclined on the couch, right?
A: Right.
Q: So there's got to be some movement of this patient, right?
A: Yes, sir.
Q: And anytime you move a patient, there's some risk involved, you agree with that?
A: Sure.
Q: Especially a patient with a knife stuck in his belly, right?
A: Yes, sir.
Q: Even if that knife is bandaged into place the best anybody could ever bandage a knife in place, there's still a possibility that if you move that patient and something happens to the knife, you could further injure the inside of that guy, right?
A: You are precisely correct.

Q: Okay. So you're faced with kind of a tough situation. The protocols don't address how to get this patient out of the house, do they?
A: They do not.
Q: Okay. And what the protocols actually say is don't ambulate the patient to the ambulance, right?
A: Yes, sir.
Q: And in your mind that means what, bring the stretcher to the patient and then take the stretcher back to the ambulance?
A: Again, I'm not here to interpret the protocols. The protocols say do not ambulate the patient. Generally accepted practice would be to use some other alternative method.
Q: Okay. So, you worked for Dr. Kickham before, right? I mean he was a Med. Control Physician over Medshore when you worked at Medshore, correct?
A: Yes, sir.
Q: Did you run calls at Medshore or was that more of a training administrative type job?
A: No, I was on an ambulance.
Q: Do you know how long Dr. Kickham's had a policy that says, don't ambulate a patient?

A: I have no idea.
Q: Okay. Is that a protocol or is that an order?
A: I would have to look at it. If it's signed by him then that would give it prescriptive authority making it an order. Regardless of the title that would give it prescriptive authority.
Q: Okay. If you're on the scene trying to comply with that directive, don't ambulate the patient, how are you going to get that patient out of the house?
A: My first alternative, plan A, would be with a stair chair.
Q: Okay. And correct me if I'm wrong. A stair chair, I mean it's like a seat with wheels on the bottom that you can bump up and down the steps and strap the patient in securely, right?
A: Yes, sir. And I don't know what model Iva, Iva?
Q: Iva.
A: Iva Rescue Squad has. There are different models, there are different manufacturers.
Q: Were you here for Ms. Aiken's testimony?
A: Yes, sir.
Q: She's Iva Rescue Squad, right?

A: I believe so, yes.
Q: She talked about the stair chair having straps that go across.
A: right.
Q: You have any reason to dispute that's the chair that Iva Rescue Squad uses?
A: No, sir.
Q: Okay.
A: But that's not where I was going, but okay. Go ahead.
Q: Okay. Yeah. I'm sorry, but ---
A: That's okay.
Q: --- I'm going to -- okay. So the stair chair has some concerns with it as well, wouldn't you agree with that? How do you get the patient from the couch to the stair chair?
A: From a seated position. You take him from a seated position and move him onto the stair chair.
Q: Who does that?
A: Any number of people. The EMT and the paramedic. If you need to solicit assistance from, I believe there was another Rescue Squad member there as well, or generally speaking, law enforcement is pretty good help. There

were at least four people on that scene. There were plenty of people.

Q: So you've got the patient sitting here on the couch, like this, right?

A: Yes, sir.

Q: And you bring the stair chair in and you say, okay we're going to move you from the couch to the stair chair, okay? As the medic in charge of the scene, tell me what you're going to tell everybody in that room to do to get that patient from the couch to the stair chair.

A: Okay. So I'm going to sit the stair chair right at your knee, I guess either side would work. I'm going to get on that side and I'm going to take you by the shoulders. I want somebody to get under your knees, I want somebody to get on the other side ---

Q: Are you going to get behind me and grab my shoulders?

A: No, sir. I'm going to be on the side.

Q: Okay. You're going to be on my left side?

A: Yes, sir.

Q: Okay.

A: And I'm going to on my count, on the count of three, we're going to move you in increments

several inches at a time, and we are slowly we're going to move you this way, this way, this way, this way (indicating), and we're going to slide you right onto the stair chair. The stair chair would be right about the height of the couch. And we'd slide you right onto the chair.

Q: Well, if you're standing here to my left and the stair chair's a little in front of you, how are you going to get the body around you and into the stair chair?

A: I'm going to serve as the back of that couch. I'm going to move you right into me, so your back is going to be against me, and I'm going to move you right onto the stair chair.

Q: Okay. And how many other people are you working with?

A: This may be difficult to visualize having never done it before. But I can assure you, I mean I've done this hundreds of times.

Q: Okay. How many people are you going to have helping you move that patient?

A: At least one other. I'll take two more if we have them.

Q: Okay. And the more people you have involved I

moving that patient, the harder it is to make sure everybody's moving at the exact same time, isn't that right?

A: Again, that's why there's one person who does the count, and everybody moves on one count. That is, again, generally accepted practice that happens every day in EMS.

Q: Now, what happens if somebody slips or stumbles or drops the patient? Let's say I'm holding the knee and I drop the knee. Is that a problem?

A: Of course. That would be unexpected. That would be -- yes.

Q: Okay. What if I drop the patient, the patient falls, knife hits him in the chest off the couch, and it goes into his aorta? That guy's dead, isn't he?

A: Sure.

Q: You can't get that patient out of the house to the ambulance before he bleeds to death, right?

A: That is correct. He would be no deader than if he were to fall forward while ambulating and have the same thing happen.

Q: Okay. There's a lot of risk in getting this patient out of the house. I mean that's a

sticky wicket, isn't it?
A: Sure. There's risk anytime you move a patient.
Q: Okay. Now you said that preferably you'd want that patient to remain in the seated position throughout the whole moving process, right?
A: Yes, sir.
Q: And I think you mentioned something about possibly you could use a back board or a spine board, long spine board?
A: It would not be ideal, but it would probably be my plan D or E.
Q: Okay. And so your plan D or E where you're going to put the strap the patient's legs to the spine board?
A: I would probably -- were I to use a spine board, I would strap him across his waist ---
Q: Okay.
A: Similar to a two point seat belt.
Q: Okay. What would you do with the upper part of the body? I think you said something about putting a pad on ---
A: Yeah ---
Q: --- the back.
A: --- somehow I'd have to use whatever was available to have something to prop him

against.
Q: Okay. How are you going to secure either the thing you're propping him up against to the patient, and or how are you going to secure that to the back board?
A: However necessary, tape, straps, by whatever means necessary.
Q: Okay. Where in the protocols does it say to use ---
A: It doesn't.
Q: --- spine board, tape, and some sort of pillow type object to prop the ---
A: As you stated ---
Q: --- patient up?
A: --- earlier, it doesn't tell you in protocol how to move someone to the ambulance.
Q: Okay. You ---
A: It says don't ambulate.
Q: --- also suggested -- I think you also suggested maybe they could just get a chair from the kitchen and use as sort of a ---
A: That is one method to use improvised -- an improvised method to move a patient. Yes.
Q: What if you're picking that patient up, you don't know it, it's not your chair, the chair's

got a crack in it. You lift the patient up and ---

A: Right.

Q: --- the chair breaks and the patient falls out on the floor?

A: We can what if this all day long.

Q: I agree. Fair enough. Bottom line is the way Mr. Davenport got that patient out of the house, he did it in a safe manner at the end of the day, right? The patient got up ---

A: Are you asking my opinion?

Q: Yeah.

A: In my opinion that was not safe, no.

Q: Okay. Tell me what you think is a safer way to get that patient out of the house.

A: In a seated position.

Q: Okay. What if the stair chair straps interfere with the position of the knife, and you can't use the stair chair? What are you going to do?

A: Then you alter the strapping method.

Q: Of the stair chair?

A: Yes, sir.

Q: And when you, let's say you do get the patient strapped, and you got to put the patient in pretty tight so eh doesn't fall out of the

stair chair, right?
A: You're asking me to quantify tight, but yes.
Q: Okay. 'Cause if you don't put him in tight, and you start going down the stairs, he could fall out of the stair chair, right?
A: Right.
Q: Okay.
A: Which is why you put the strap over the more stable portions of the body, the shoulder girdle, the pelvic girdle, not over the abdomen itself.
Q: Okay. Have you ever ridden on a stair chair?
A: Yes, sir.
Q: Okay. Have you ever gotten the sensation that, you know, you were going to fall out of the thing?
A: Occasionally.
Q: Okay. If this patient were walking or being bumped down the stair chair, and he's, oh I'm falling, and he reached for the rail for example. He could hit that knife couldn't he, when he does that?
A: Again, you keep saying if, if, if. Yes.
Q: Mr. Wicevic said if, if, if a lot.
A: Okay. But if, then yes. I mean if he fell

forward while walking, the same thing would happen.

Q: You also said I think, that you as a paramedic would want to be the back of that couch right? So you'd be kind of behind the patient?

A: It is general accepted practice that whoever is at the head of the patient and that person would be at the head, is the one that directs the movement. So, the most experienced person would be calling the shots.

Q: Okay. So again, visual learner. So I'm sitting here on the couch ---

A: Yes, sir.

Q: And you're going to take the back position. You want to be behind me or do you want to be ---

A: No. As I said earlier, I would be to your side.

Q: Okay. Do you know how wide that couch was?

A: It appeared to be pretty wide.

Q: Okay. So if he's sitting in the middle of the couch, and you've got to be to the side of him, I mean there could be one and a half, two feet between you and the patient, right?

A: I'm not getting where you're coming from.

Q: Why don't you lift the couch up and take the whole damn couch out? Excuse my ...
A: Because it would be impractical.
Q: You know if that couch would fit through the door ---
A: I don't know.
Q: --- of that trailer? Would it be appropriate to bring the whole stretcher inside the house, up the stairs?
A: Yes.
Q: Okay. Are you aware of any standards that say you should never bring a stretcher up and down stairs?
A: There's usually -- there are some services will define that. Usually there's a cap or a limit on the number of stairs that they want you to climb. So, it depends on the number that's set by the department.
Q: Okay.
A: You know, I don't know see anything in the protocols for Anderson County, and I don't know if Iva Rescue Squad has one specific to them. I don't know.
Q: Now I think Mr. Wicevic asked you whether you'd consider this particular patient a critical

trauma.
A: Yes, sir.
Q: Do you recall that?
A: Yes, sir.
Q: And I think you also said something about there's a potential for this patient to go into shock, right?
A: Yes, sir.
Q: And do you agree with me that was a pretty significant mechanism of injury?
A: It is a significant mechanism of injury, yes.
Q: Okay. Have you reviewed the Anderson County protocol to see what's required with a critical trauma significant mechanism of injury?
A: I looked through the protocols briefly assuming that my testimony was more based on my opinion rather than on the protocols themselves.
Q: Okay. Would it surprise you to know that the way you described how you would treat the patient would violate the protocols in Anderson County?
A: Yes, sir.
Q: Okay. I'm going to ask you to look in the notebook you got there, Exhibit 1. And there's some little numbers on the bottom right-hand

corner. Those are called Bates numbers. If you'll turn to page 42. Actually before we get to 42 let's go to 43. Would you agree that T-3, the multiple trauma shock protocol applies to this situation?

A: In so much as there were multiple body systems involved. Or that there was a potential for shock. I haven't read the policy for that purpose, so I'm looking at it now.

Q: You recall Dr. Kickham testifying yesterday that he thought T-3 applied in this situation?

A: I don't remember his testimony specifically, no.

Q: I'll give you a second to look at that.

A: Okay. So what was your question again?

Q: My question is do you believe that T-3 applied in this situation, multi system shock protocol?

A: I would not apply T-3. I would not have done anything to this patient based on T-3. How's that? Is that a fair statement?

Q: Okay. If you took that position as a medic on this call, you would have violated what Dr. Kickham said was applicable here, right?

A: I don't think so.

Q: Okay. 'Cause I thought there was a long

discussion yesterday with Mr. Wicevic and Dr. Kickham about whether this patient met this criteria for a T-3.

A: Well again, I'm not here to debate the protocols. I'm here to establish standard of care and education. So ---

Q: Would you agree with me that it's ---

A: I don't work in Anderson. I have read through these. I am not expert in Anderson County policy. Ask me anything you want about Pickens County policy. But I'm not expert in Anderson County policy or procedure.

Q: All right ---

A: Although, understand, when the procedures and protocols are written like they are, you don't have to apply every procedure to a patient. For example, if I want to start an IV on a patient, all I need to do is fine one procedure that allows me to start an IV on a patient.

Q: Okay. You agree with me the blind adherence to a protocol can lead to bad medicine. Would you agree with that?

A: I think doing anything in EMS blind is -- yes.

Q: Okay. And would you agree with me that at least on your review of this T-3 protocol, you

got some -- there's some ambiguity about whether this particular protocol applies, right?

A: Yes, sir.

Q: Okay.

A: If the man that wrote it says so then, yes.

Q: All right. Turn back to 42.

A: Yes, sir.

Q: You believe that the general trauma standard or the general trauma protocol applied to this situation?

A: Yes.

Q: Okay. No question this was a trauma, that a knife to the belly was a trauma.

A: Yes, sir.

Q: You defined a trauma could even be pulling a hair out ---

A: Yes, sir.

Q: --- of your ---

A: I was trying to figure out how you were tricking me.

Q: I'm not trying to trick you. Okay, so you agree that it's a trauma.

A: Yes, sir.

Q: I think you said it, in your mind, it's a

critical trauma or a serious trauma or major trauma?

A: By national standard, that's a critical trauma.

Q: Even if the patient's perfectly stable?

A: Yes, sir. Penetrating abdominal trauma, or penetrating trauma to the torso without qualifier.

Q: What do you mean without qualifier?

A: It doesn't matter how long the blade is, it doesn't matter if they're stable or unstable. It's still a critical patient. Now them being unstable, being hemodynamically compromised changes what you do to them. It's still a critical patient regardless.

Q: Well you would agree with me under the protocols that one, you've got a trauma, and two you have a significant mechanism of injury, right?

A: Yes, sir.

Q: Okay. So if we go to the protocol to match up the flow chart on T-1 under other trauma, we have a trauma, we have a significant mechanism of injury, right? Look down about half way down the page, you see other trauma and there's a colon? The first bullet says, all patients

complaining of neck or back pain or patients with a significant mechanism of injury, right?

A: Yes, sir. And again -- yes, sir. Go ahead. Sorry.

Q: Then it continues with, will receive full spinal immobilization, right?

A: Yes, sir.

Q: Okay. So if you didn't put a c-collar on this patient, bring the back board in, strap him down to the back board, that would be a violation of the protocol, wouldn't it?

A: No. No, sir. So going to your phrase about following something blindly, I agree you have to read into this. Mechanism of injury, when you refer to a mechanism of injury, it refers to -- there's not one single mechanism of injury. The mechanism of injury is what happened to the patient, what caused the injury. So, in this line, patients complaining of neck or back pain, patients with significant mechanism of injury, the reference is a significant mechanism of injury to indicate neck or back pain. So it's referring to automobile accidents or something that would cause neck or back pain. It is not referring

to, as you alluded to yesterday, a gunshot wound to the finger or -- which would be a mechanism of injury. The gunshot wound is a mechanism of injury. A gunshot wound to a finger is not necessarily a significant mechanism of injury.

Q: That's something you have to rely on the paramedic's training and experience, right?

A: As far as the significance?

Q: Yes.

A: Yes, sir. It goes to training and education as well as to some degree of experience. It has to do with kinematics or the study of the transfer of energy.

Q: I'm going to ask you to look at GP-3. It's on page 6 of that exhibit. It's called the intravenous access protocol. You see that?

A: Yes, sir.

Q: Okay. Now the first, under patient assessment, the first thing it says is it says, assess patient for indication's, right? You see where I'm talking about?

A: Yes, sir.

Q: That's the first, sort of, in the decision tree, that would be your first intersection

where you need to make a decision. I'm assessing this patient. Does he need IV, does he not need IV, right?

A: Yes, sir.

Q: Okay. So with this patient you made the decision he needs IV, right?

A: Yes, sir.

Q: So then you go down to the protocol. And that first step is part of the protocol, right? And then look down under management. You see under paramedic management?

A: Yes, sir.

Q: So that's where we're getting into orders, right? So if you made the decision to administer IV to this patient, then you drop down to the order, you see the distinction between that -- this is a good example of a protocol that has an order in it, right? A standing order?

A: Okay.

Q: And the standing order tells you that if you have a trauma patient, you're supposed to use the largest catheter possible, two sites preferred, and use y blood sets. Do you see where I'm talking about? It's under normal

saline.

A: I see use y blood sets, but I don't see where it says to do that if it's a trauma patient.

Q: Okay. Trauma patient is listed under normal saline, do you see?

A: Okay. Yes.

Q: Do you read that protocol to say that if you have a trauma patient, if you made the decision that patient needs an IV, you do normal saline, right?

A: Again, I would not -- I do not consider myself an expert with Anderson County protocol. And it does not expressly state that. There is some ambiguity, and I would not venture to guess that.

Q: Okay. If you were on the scene and you saw some ambiguity, you would call the medical control and say, I'm not sure how to handle this. I got a trauma patient, I'm putting an IV in. I'm not sure whether it applies or not. Can you tell me what I need to do.

A: What I'm saying is I don't see -- there's a list there. I don't imply that it tells me that a trauma patient gets a y blood set.

Q: What else could it mean?

A: It's a list. I don't know.
Q: You said that you would put in a saline lock on that patient, right? Or a ---
A: That would be appropriate, yes.
Q: Okay. Where does it say that if you made the decision tree that you're going to do an IV, and you got a trauma patient, where does it say it's okay to put a saline lock in?
A: The paramedic or EMT. I mean under this protocol it gives the paramedic or intermediate can establish an IV access in any patient not specifically addressed. I don't see that it specifically addressed in here, and that's where -- if I was working under this protocol not knowing them intimately, that's where I would hang my hat. But again, I am not expert on Anderson County protocol.
Q: Okay. Well let me ask you this. If you give ---
A: Let me rephrase that. My knowledge of Anderson County protocol is limited.
Q: Okay. Fair enough. If you put a saline lock in this patient, I mean you wouldn't give this patient saline. If this were your patient, you wouldn't give this patient saline on the way to

the hospital?
A: It would be appropriate to have fluid hanging at a keep open rate. That would be appropriate. It would not be appropriate to load them with fluid at that point.
Q: If the patient's got uncontrolled bleeding in the abdomen, and you can't compress that -- you can't like turn a tourniquet on it or ---
A: Yes, sir.
Q: --- put pressure on it, right?
A: Yes, sir.
Q: If the blood vessels are, what's the term, tamponaded?
A: Yes, sir.
Q: If the blood vessels are tamponaded and the bleeding is temporarily halted, if you fill that patient full of fluid ---
A: Right.
Q: --- you could mess up the clotting factors in the blood, right?
A: Right. I don't think I can revisit what I said earlier, but yes. It would increase the pressure within the vessels and could potentially disrupt the clotting process or break loose ---

Q: Kind of blow the clot out, right?
A: Sure. Yes.
Q: And then all you've got is a belly full of blood with some salt water mixed into it, right? Is that helpful to the patient?
A: No.
Q: Okay. So you personally would not apply saline in this other than maybe at a keep open rate?
A: Right. That would be the generally accepted practice and standard of care.
Q: Okay. What's involved, if you're not going to hand a bag of fluid, you're just going to put a saline lock in this patient, tell me what's involved in at least starting that saline lock.
A: The act of starting the IV and the act of decannulation of the vein is the same. It's just there's a small short tube that is filled with saline that attaches to the hub of the catheter.
Q: Okay.
A: And it's capped on one end as opposed to if you are hanging -- I'm trying not to use industry lingo. If you were to have a bag of normal saline, it would have a longer tube with a stop cock or an adjustment valve that would allow

the flow of fluid.
Q: What's on the business end of that device?
A: That goes into the hub?
Q: No, into the body. What goes into the body?
A: The IV cannula, the IV catheter.
Q: And how do you start that into the vein?
A: With a needle.
Q: Okay. How big is that needle?
A: It varies.
Q: Okay. If you had to estimate the length of that needle, is it a seven inch needle that you put in there?
A: No, sir. And again, the length of the needles vary as well. It depends on purchase practices. But they're usually anywhere from inch and a quarter to two, two and a half.
Q: Okay. Have you ever had an IV started on you personally?
A: Yes, sir.
Q: Okay. Is there some pain involved when that needle goes into the vein?
A: Minimal.
Q: Okay. What if the patient was deathly afraid of needles and he sees you opening up and you're getting ready to stick him in the arm

with a needle? Have you ever had a patient balk at receiving an IV before?

A: Have I ever, yes. I have never encountered that that I haven't been able to overcome.

Q: Okay. And what are your available techniques for overcoming that. You know, if somebody says, don't stick me with that needle, what are your available techniques to sort of solve that situation.

A: Therapeutic communication.

Q: Okay. What if that doesn't work?

A: If they absolutely refuse then you can't start an IV. That would be battery.

Q: Okay. So you have to get the consent of the patient before you start the IV?

A: Yes, sir.

Q: Okay. So if you say to this gentleman, I'm getting ready to stick you with a needle, and he says, no you're not. You can't stick him with a needle, right?

A: That's correct.

Q: Okay. What if the patient's a schizophrenic? Does that matter?

A: As far as if they refuse it or what?

Q: Well yeah. If they refuse the IV and they're

schizophrenic. Is that a concern to you?
A: A concern, yes. It depends. It depends on the patient's condition, it depends on their -- infinite number of variables there.
Q: Okay. Have you ever had a patient say, okay go ahead and give me an IV, and then as the needle gets ready to go into the skin they say, no don't do it, and move in kind of like a reflexive action. Try and stop you from doing it?
A: I've had them move. I don't know that I've ever had them tell me to stop in the middle of the ---
Q: Okay. If the patient moves like that suddenly with a knife in their chest, that could be a problem, couldn't it?
A: Sure it could.
Q: Okay. So there's a risk involved in starting an IV just to start an IV, I mean a port, just to leave it open, right?
A: Can you say that again?
Q: I mean there's a risk involved in starting an IV just to have a cap so if the patient someday needed or sometime needed fluids it'd be available to you. You agree there's a risk

involved in that?
A: I would restate that. I would say that there is a risk involved in starting an IV. There is always a risk involved in starting an IV. And I would further add that the risk in starting the IV is outweighed by the potential for the patient to decompensate in this case.
Q: Are you charging DHEC for your time in reviewing this case and testimony today?
A: Yes, sir.
Q: I'm sorry?
A: Yes, sir.
Q: Okay. You charge them by the hour?
A: Obviously not for all of it.
Q: You charge them by the hour?
A: For some if it, yes.
Q: Okay. How much of it are you charging them for?
A: Ten hours I believe.
Q: Okay. What's your hourly rate?
A: $250.00 an hour I believe for review.
Q: So you're charging DHEC $2,500.00 for this case?
A: I believe that's correct.
Q: For ten hours of time?

A: I believe that's correct.
Q: Okay. So the other 50 hours that you spent getting ready for today and the, I don't know how long we've been here today, six hours or so that you've been here today, you're just giving ---
A: Well there's a different charge for testifying. But ...
Q: How much is the testifying charge?
A: It's a little embarrassing. To be honest with you, I don't remember.
Q: Okay. Higher that 250 an hour?
A: Yes. I don't remember what it is.
Q: How much does a Pickens County -- how much do you charge them, or how much do they pay you for your time as a part time paramedic?
A: I don't know ---
MR. WICEVIC: Your Honor, I'm going to object. What's it matter his pay part time job? I'm not sure how that relates to his testimony.
MR. ROTHSTEIN: I imagine he makes about maybe 30, $35.00 an hour as a paramedic.
Q: Does that sound about right?
THE COURT: It's not relevant.
A: Closer to half.

Q: Is that an overestimation of what you make?
A: Yeah.
Q: So you're charging DHEC more than ten times your normal rate than you'd run a paramedic call to review this case. Is that right?
A: Yes, sir.
Q: Okay.
A: Based on industry standards.
Q: Who did you speak with from DHEC about this matter on -- let's say you talked to Wronski at some meeting Thursday afternoon, right?
A: Yes, sir.
Q: Now what time did that meeting end?
A: It would have been right at lunch time, so around noon.
Q: Have you spoken with anyone else at DHEC other than Mr. Wronski about this case?
A: Can you qualify that? I mean in here, yes.
Q: About the substance of your testimony?
A: No. Well, Mr. last name who I can't pronounce. I'm sorry.
Q: Vito.
A: Sorry.
Q: You've spoken with Vito?
A: Yes, sir.

Q: Okay. Anyone else at DHEC other than Wronski and Mr. Wicevic?
A: No, sir.
Q: Now what did Mr. Wronski tell you about the case?
A: Virtually nothing. He said that, what he told us, because at the time Phil was standing there, Phil Head, Mr. Head. He said that there was a case that was initiated at some point before and that the other party had called an expert witness, and so now he had an opportunity to call an expert witness, and it was very last minute. And then that was the extent of it. There was virtually nothing else.
Q: And he offered you $2,500.00, and you said I'll take it. Is that right?
A: Not at that point. No.
Q: When did you discuss what your charges would be for that type of testimony?
A: After I viewed the video and made sure that I did not know anybody that was involved in it, and I told him I would do it. And then we talked about the money.
Q: When did you tell him you would do it?

A: That would have been Thursday afternoon.
Q: You don't remember about what time it was?
A: No.
Q: Okay. So between the time the meeting broke up around noon, spoke to Mr. Wronski, you reviewed the video, got back with Mr. Wronski, and said I'll do it. Is that a fair characterization of what happened?
A: Yes, sir.
Q: How did you get the video?
A: Okay. I stand corrected. Thank you. I apologize. It was Friday morning. It was Friday morning. Ryan was in Greenville and brought the book that, one of these books, and handed it off to me. I was actually on the phone with Mr. Wronski at the time. So I said not one word to Ryan. He handed me the book, and I waved and went back into my office. So it was Friday. I apologize for that.
Q: So it wasn't Thursday it was Friday?
A: Yes, sir. I misspoke.
Q: All right. So where was the meeting that you were at with Mr. Wronski?
A: That was here in Columbia.
Q: Here in Columbia?

A: Yes, sir. That was Thursday.
Q: Okay. I'm getting a little confused.
A: I apologize for that. I misspoke.
Q: Okay. So Thursday said we may need you to be an expert. You didn't do anything on Thursday in terms of looking at documents or ---
A: Right.
Q: Friday's the first time you ever laid eyes or heard about this case, right?
A: Right.
Q: What time did the gentleman from DHEC drop off the notebook?
A: It was early to midmorning I believe.
Q: So you look at the video, call Mr. Wronski up and said I'll take it. I'll do this case for you, is that right?
A: Yes, sir.
Q: Okay. How many times have you viewed the video?
A: As I said earlier, it's probably five or six or seven. I don't have a precise number. Also, my estimation of 60 hours again was an estimation. I don't know exactly the number of hours. I stopped keeping track after two days ago.

Q: Okay, so if you estimated 60 hours minus the six I think you said, we're at 54 hours from Friday a little before noon or right around 2:00 when you called Mr. Wronski until Monday you spent 56 hours on the case?
A: I had spent a lot of time. I don't know.
Q: I'd venture to say you spent more time over the weekend preparing for the case than I did if you spent that much time on the case.
A: I have spent a great deal of time.
Q: What is it about -- I mean what have you been looking at for 56 hours in connection with this case?
A: Everything I can find.
Q: Did you read any of the depositions?
A: Yes, sir.
Q: Okay. Whose depositions did you read?
A: Everything that was in this book. I take that back. I don't think it was a deposition that was in this book. It was the -- I forget what it's called. The IRC. Is that what it's called? The IRC?
Q: Let me make sure I'm clear. Everything you reviewed is in the notebook that's in front of you?

A: I honestly haven't looked through this notebook. But I got a notebook that is similar to this. So ...
Q: Let me ask it this way, did you look at anything other than that notebook in preparing for your testimony today?
A: Sure.
Q: What else did you look at besides that notebook?
A: Textbooks, research, a lot of research.
Q: Research about what?
A: Everything that's mentioned.
Q: Okay. Have you ever served in the military? I didn't see that on your CV?
A: No.
Q: Okay. Are you familiar with the training that Special Forces medics receive?
A: Somewhat. Not as much the initial training. Where I teach at the University of South Carolina School of Medicine, we host a course for Special Forces medics from all branches, not just Army, but all branches that's kind of an extended care course. Physician lead. I don't teach in the class. I don't think I'm qualified to teach in that class. But it's an

extended care course taught by our physicians. But I assist with the class. And so I'm somewhat familiar with some of their training. But as far as their primary education, no I'm not.

Q: And I noticed in your resume there was something about some courses you taught up in Virginia for a contractor for the military, is that right?

A: Yes, sir. That was the tactical combat casualty care.

Q: I think you said you teach that to CV's. What is a CV?

A: CB?

Q: CB.

A: Navy, they build stuff, build bridges and stuff.

Q: I think you testified you don't ---

A: I mean that was one of the groups we talked to.

Q: Corpsmen. I think your testimony you don't teach corpsmen. What does that mean?

A: That class -- I apologize if that was confusing. That class is not designed for medical personnel. It's a course much like TECC, which is the tactical emergency casualty

care course is now, which I know if you're not in EMS, you have no idea what I'm saying. But it's a course that's designed for non-medical personnel that teaches some very simple life saving procedures like tourniquet application, chest seals, like covering holes in the chest, things like that.

Q: What do you do to keep up your knowledge and skills in pre-hospital care? I know you testified earlier about it's a rapidly evolving field. What do you do to keep up your knowledge and skills?

A: So you alluded to that earlier. As far as my qualifications, I can say that as an educator, I feel infinitely better prepared as far as keeping up with the rapidly changing pace of EMS, and the changing research and all that that goes into it. Much more so than when I was on an ambulance full time. That doesn't mean I feel like I'm a better paramedic, but it feels like I'm much more able to keep up with the changes. I teach paramedics, I teach EMT's, I teach critical care. I'm constantly pushing my own knowledge. Last year I completed the flight paramedic course and exam.

I'm not a flight paramedic. I have not served as a flight paramedic, but I'm a certified flight paramedic only because I needed new information. I needed more knowledge. So I'm pushing myself with knowledge, I took and passed the community paramedic course a year or two ago. Again, that's an expanded scope, kind of beyond paramedic. And so now I'm teaching those critical care courses as well. So there's that. Because of my position with the hospital and with the school of medicine I have unbelievable resources available to me. As far as research, I mean we have an entire research department. So I'm constantly in the books, constantly renewing. Every time I do a lecture on whatever topic it is, I prepare for that by looking up the most current research.

Q: And that's keeping up with cutting edge stuff's important in ---

A: Right.

Q: --- providing good quality medicine, isn't that right?

A: Yes, sir.

Q: Would you agree with me that outmoded treatment protocols can lead to bad medicine?

A: Yes, sir.
Q: And I think you also used the phrase err on the side of caution. Do you remember using that phrase in your testimony with Mr. Wicevic?
A: Yes, sir.
Q: Okay. Doesn't that practice erring on the side of caution presume that you're going to make an error?
A: No, sir. It's err, not error.
Q: Err ---
A: Err.
Q: --- meaning to err, meaning to commit an error?
A: No, sir.
Q: Is it A-I-R or E-R-R?
A: I'm going to fall to the side of caution. I'm going to ensure that given a risk of or a potential, that I'm going to explore that potential.
Q: Okay. And I -- we may be talking past each other, but the word err, is that E-R-R or A-I-R?
A: I'm not making an error. It is not a mistake.
Q: No. Listen to my question. When you say err on the side of caution, are you saying err A-I-R like breath air?

A: It is E-R-R.
Q: Or E-R-R?
A: it's E-R-R.
Q: Okay. And do you know what the word err means?
A: Yes, sir.
Q: It means to make a mistake, right?
A: Yes, sir.
Q: Okay. So why not just treat the patient for what the patient needs rather than erring when treating the patient?
A: Because the patient has a potential need, and I'm treating based on the potential need.
Q: Okay. What is needs ---
A: Not only am I treating based on the potential need, that is the standard of care.
Q: You used the phrase either needs based medicine or evidence based medicine. What does that mean?
A: The entire EMS industry is getting on board with the rest of the medical industry. We're a little late and we are moving towards evidence based medicine. There's not as much research in EMS as there is in the rest of medicine. Frankly there aren't as many educated EMS personnel as there are in other

forms of medicine. So it takes education in order to do research. So ---

Q: Let me just ask you this ---

A: --- evidence based medicine requires us to do research to prove that what we are doing is working.

Q: Okay. And let me just paraphrase my understanding. Either needs based medicine or evidence based medicine, you treat the patient according to what the patient -- you assess the patient's needs to be or what the evidence is at the call. That's not right?

A: No, sir. Evidence based medicine refers to doing what is best for the patient's outcome. It's based on patient outcome. It's strictly based on patient outcome. What is the ultimate outcome. And that's what evidence based medicine looks at.

Q: Let me ask you this. I think one of your, sort of -- I guess when you viewed the video one of your concerns when viewing the video was the language and the demeanor. I think you called if affect that ---

A: Yes, sir.

Q: --- Mr. Davenport displayed, right?

A: Yes, sir.
Q: And what specifically about the video is inappropriate in your mind? Is it the first interaction where Mr. Davenport says to the gentleman, did anybody ever tell you you're an idiot?
A: That was the first one, yes.
Q: Okay. And did you see in the video that Mr. Davenport was kind of smiling at the guy?
A: I did not see that. And I have looked at it specifically for that, and I do not see a smile.
Q: Did you look at the video on an iphone or did you look at it on a big screen?
A: I looked at it on a screen about this size (indicating).
Q: You recall Mr. Davenport's partner at the time, the very beginning of the video when the EMT's first get to the house, the partner Ms. Aiken says, what'd you do now Johnny. You remember hearing that?
A: I believe I remember what did you do Johnny. I don't remember the specific wording, but something like that, yes.
Q: Okay. Now yesterday, again I apologize to

everybody for breaking the courtroom. So we come back at 1:00 o'clock, and Judge Robinson says to me something about, Mr. Rothstein, you didn't touch anything did you? She was sort of joking with me. If she came out and said to me, Mr. Rothstein did anybody ever tell you you're an idiot, well you're being called one now. Okay. I mean would you view that in sort of a joking manner?

A: That would have made me very uncomfortable.

Q: Would you have thought that was abuse of me?

A: That would have made me very uncomfortable.

Q: You got to know the relationship between the person who's making the statement and the person who's hearing the statement before you can tell whether it's offensive or not, right? Do you agree with that?

A: Depending on the statements, to some degree, yes.

Q: Okay. So like, if I said -- my brother falls down from doing something stupid, and I say, well that was a bonehead move. Bet you won't do that again. Is that a denigrating or disparaging comment to him in your opinion?

A: And this is who, your brother?

Q: Brother.
A: Your brother, no. But there's not a patient clinician relationship there.
Q: In your experience in emergency medicine about 30 something years, right? Have you ever heard an EMT or paramedic say something, that if you just took out of context you'd think man that would be offensive for somebody to hear it. But in the context of your comradery in the EMT profession, or whatever, you've heard some inappropriate things said?
A: An EMT to an EMT?
Q: Or an EMT to a law enforcement officer, or and EMT to a patient?
A: Yes.
Q: Okay.
A: But again, there's not a clinician patient relationship even.
Q: So you really in order to know if something's received as offensive, you need to talk to the person who heard it and say, did you have a problem with the way that was conveyed to you, or did you have a problem with ---
A: When there's a clinician patient relationship, the dynamics change all together. That's not

a friendly relationship, that's not a buddy, that's a professional relationship.

Q: And do you think that was abuse what you saw on the video?

A: Yes, sir. Let me rephrase that. I thought it was abusive.

Q: Okay. And I actually wrote this down. Mr. Wicevic was talking. You said, I don't know the patient. I don't know this patient, right?

A: Yes, sir.

Q: Okay. So you don't know whether Mr. Davenport had seen this patient around the town of Iva since he'd been a paramedic?

A: No, sir.

Q: Okay. I think you also said I wasn't there, right?

A: Yes, sir.

MR. ROTHSTEIN: I don't have any further questions, Your Honor. Thank you.

THE COURT: Mr. Wicevic, before you get into redirect, we're going to take a ten minute break.

MR. WICEVIC: Yes, Your Honor.

(Off the record from 2:53 p.m. until 3:18 p.m.)

THE COURT: Okay. We're calling hearing back to

order. Mr. Wicevic, you ready?

MR. WICEVIC: Yes, Your Honor.

THE COURT: Okay.

MR. DOUGLAS - RE-DIRECT EXAMINATION BY MR. WICEVIC:

Q: Just a few follow up questions, Mr. Douglas. There was some discussion about the potential of hitting the diaphragm. How would you have checked to see if there was some kind of injury to the diaphragm?

A: By listening to lung sounds to see that they were equal on both sides, and by listening to the abdomen to see if you could hear gurgling or lung sounds in the belly.

Q: From your review of this matter, did you see anything that indicated Mr. Davenport checked for lung sounds?

A: I did not. I did not witness a lung sound assessment, no.

Q: There was a lot of discussion about the stair chair, Mr. Rothstein got in the chair. How do EMT's once they get a patient in the stair chair, move the stair chair?

A: So this chair is on wheels but there is also a track on the back of the chair that is friction based, and the track travels down a stairway

and evenly distributes the weight across the ledge of the stairs to reduce the movement. There's no bumping, it's just a straight travel.

Q: Okay. Is it a team effort to use the ---

A: Oh, yes.

Q: Okay. How many people do you need?

A: Two. At least two. Two is sufficient.

Q: Okay. And just to clarify, your testimony during direct concerned the generally accepted standards of care in the EMS. They were not talking about the compliance with orders and protocols?

A: That's correct.

Q: Okay.

MR. WICEVIC: That's all I have for him. Thank you, Mr. Douglas.

THE COURT: Thank you, Mr. Douglas.

MR. DOUGLAS: Thank you.

MR. WICEVIC: All right. The Department's next witness is Dr. Edgar Deschamps.

THE COURT: Dr. Deschamps, if you'll face the court reporter, raise your right hand, he'll swear you.

DR. EDGAR DESCHAMPS, having been duly sworn,

testifies as follows:

THE COURT: Mr. Wicevic, how many additional witnesses do you have after this witness?

MR. WICEVIC: Dr. Deschamps and then Mr. Wronski, and that's DHEC's case.

THE COURT: All right. One second. Mr. Rothstein, how many witnesses are you calling?

MR. ROTHSTEIN: Your Honor, we can kind of shorten it up a little bit. I think that some of the witnesses that we have are -- I'll certainly try and cut out some of the redundancy. Mr. Davenport's going to testify, we have Sheilah Kaiser the training officer, Craig Lawless, I was going to call Dr. Alier and Mr. Naugler. And we have Leo Deason, another expert witness on paramedic, and we have two gentlemen here from Mr. Davenport's Special Forces team. I think only one of them really needs to testify.

THE COURT: Okay. If we continue to go at this rate, we'll be here into next week. Go ahead.

DR. DESCHAMPS - DIRECT EXAMINATION BY MR. WICEVIC:

Q: Dr. Deschamps, could you state your name for the record please?

A: Sure, it's Edgar Green Deschamps. D-E-S-C-H-A-M-P-S.

Q: You have an exhibit packet up there in front of you?
A: I have this proposed trial exhibits.
Q: For DHEC.
A: Yes, sir.
Q: Can you turn to tab 12 please?
A: Correct.
Q: Can you identify this document please?
A: This is a curriculum vitae for me.
Q: Okay, is it up to date?
A: I believe it's currently up to date. Let's see. It was revised last year. I don't think that there was any significant change.
Q: Okay. Can you explain to the court your education.
A: I attended the University of South Carolina here in Columbia for my undergraduate degree where I received a degree in biology with a cognate in math and chemistry. And that was from '78 to '82, and then attended -- I'm sorry, '75 to '78, and then attended the University of South Carolina School of Medicine '78 to '82 here in Columbia, where I received Doctor of Medicine. And then attended what's called a categorical internal medicine

residency at the VA Hospital and Palmetto Health Richland here in Columbia, from 1982 through 1985 and received my medical licensor.

Q: Okay. You licensed in other states?

A: No.

Q: Any disciplinary action against your license -- -

A: No.

Q: --- in South Carolina? Could you explain your employment from graduation until now?

A: Could I explain my ---

Q: Employment jobs.

A: Employment, okay. When I finished my residency, I went back to my home town Bishopville, which was in 1985, and I practiced there with my partner John Pate until about mid 2003. At which point I came over to Columbia and joined a group of physicians, two of whom were in my medical school class. It's the Columbia Medical Group, and I have been employed there since June of 2003 here in Columbia. I also did work at Palmetto Baptist Emergency Department as an Emergency Room physician from 1999 to 2012. And starting in about 2012 I have worked in addition to my private practice

as a hospitalist for a group here called the Landmark Medical Group, and continue to do so.

Q: Any professional organizations that you're apart of?

A: Yes. I'm a member of the American College of Physicians, American College of Emergency Physicians, The National Association of EMS Physicians, and National Association of State EMS Officials. Those are the big ones.

Q: Okay. Can you explain to The Court your role as a State Medical Control Physician? Let's begin, when did you begin in that role?

A: As State Medical Director?

Q: Yes, sir.

A: That started in '95. Prior to that I was associated with DHEC from 1985 on to 1995 as a Regional Medical Director. And so in that capacity we served on the Medical Control Committee and the EMS Advisory Council. In 1995, I was asked by the Department to take over as State Medical Director, and I've served in that position from '95 until currently.

Q: Okay. You mentioned a few committees there. The Med. Control Committee. What's their roles?

A: The Medical Control Committee is a sub-committee, a standing sub-committee of the EMS Advisory Council and it's role is comprised of 11 physicians of varying specialties including surgery, internal medicine, emergency medicine, pediatrics, and their role is to recommend to the Department the scope of practice and appropriate medical care for pre-hospital EMS in South Carolina.

Q: Okay. And is the EMS Advisory Council just kind of a broader advisory body?

A: It is. It is comprised not only of members of the Medical Control Committee, but also of EMS agency Directors, EMS trainers, EMS medical Directors, so it's a much broader composite. And that council is defined in legislation.

Q: You mentioned the Trauma Advisory Council?

A: Correct.

Q: What is that?

A: The Trauma Advisory Council is also an advisory council for the Department, also defined in regulation and statute, comprised of members from medical control, trauma surgeons from all verified level trauma hospitals in South Carolina, trauma nurse coordinators, rehab

therapists and so forth. And it's purpose is to define appropriate trauma care, both pre-hospital, but also at the hospital level. And through that committee we verify and designate hospitals as trauma centers and their level within South Carolina.

Q: Okay. Have you served as a Medical Control Physician for any of licensed South Carolina EMS services?

A: Yes. I served for a couple. I served for the Bishopville Rescue Squad from 1985 until about 2003. During that time the Bishopville Rescue Squad was actually folded into what was developed as Lee County EMS. So I served as that Medical Director. I served as Medical Director for Sumter County EMS for a while, and then there have been a couple of other places, Lynchburg EMS for a while, and a couple of other places that have needed some coverage, and I stepped in to help.

Q: Okay.

MR. WICEVIC: Your Honor, the Department would like to admit Exhibit 12 into evidence please?

MR. ROTHSTEIN: No objections to the CV, Your Honor.

THE COURT: And also at this point I feel I do need

to disclose that looking at his CV I realize that he practices with my primary care physician. They're at the same medical practice. That doesn't impede my ability to be fair and impartial, but I wanted to disclose that to you all.

MR. ROTHSTEIN: If you're fine with it, Your Honor, I'm fine with it.

MR. WICEVIC: Yes, ma'am. Okay, Exhibit 12's admitted?

THE COURT: Yes. It's admitted.

(Petitioner's Exhibit Number 12 was admitted into evidence.)

MR. WICEVIC: Thank you, Your Honor.

Q: Dr. Deschamps, how many times have you given expert testimony in the area of emergency medicine?

A: In the ALJ setting?

Q: Any setting.

A: Any setting? I've served as expert witness on multiple med-mal cases. I've done, I think for the Department, I've had one other ALJ many years ago that I participated in.

Q: Was it the Stuart Platt case?

A: Yes.

Q: Okay. What about being qualified as an expert in internal medicine? Have you been qualified in that regard?

A: I have.

Q: Okay. Can you explain to The Court what internal medicine is?

A: Internal Medicine is basically defined as the medicine for adults. You can break down the global picture of medicine into medicine and surgery, surgery having to do with operative techniques, medicine having to do with the care of patients non-operatively. And within medicine there are things like pediatrics, obstetrics, gynecology, and internal medicine. Internal medicine has to do with the care of the adult patient generally accepted to be 16 to 18 and greater.

Q: And what about emergency medicine?

A: I did emergency medicine for years when I was back in Lee County. I was an Emergency Room physician there. And then served at Palmetto Health Baptist's emergency Department. I'm technically able to be grandfathered in as a fellow of the American College of Emergency Physicians. I've just never done that, I've

never taken that certification. But basically that has to do with care of persons who present with emergency medical or traumatic injuries.

MR. WICEVIC: All right, Your Honor. The Department would like to tender Dr. Deschamps as an expert in both emergency medicine and internal medicine.

MR. ROTHSTEIN: Your Honor, I do want to voir dire the witness, but I think a qualification in internal medicine would be irrelevant to this case. I mean there's no -- it's not a medical malpractice case. There's no issue about whether my client complied with the standards of care of an internal medicine doctor. So I've got two parts to the objection. I mean one is internal medicine's irrelevant, and I would like to voir dire him on emergency.

THE COURT: Okay. Mr. Wicevic, why are you including the internal medicine?

MR. WICEVIC: That is an area of his expertise. If he used that area if his expertise in his review of this matter, I think he should be able to give an opinion on it.

THE COURT: The issue in this case is solely has to do with the emergency care.

MR. WICEVIC: They had a trauma surgeon. Trauma is distinct from emergency medicine. I made an objection to that. I think if Dr. Deschamps used his expertise in internal medicine in reviewing this -- I understand the majority of his testimony will concern his expertise in emergency medicine. I'm just saying if he had to use his expertise, skills, knowledge, education in reviewing this with regards to internal medicine, he should be able to offer that testimony.

THE COURT: Okay. I'll give that some thought. Mr. Rothstein, go ahead and ask your questions.

DR. DESCHAMPS - VOIR DIRE BY MR. ROTHSTEIN:

Q: Dr. Deschamps, you're an internal medicine doctor, right?

A: That is correct.

Q: Sometimes that's referred to as a generalist?

A: No.

Q: No? It's not a specialist, right?

A: Yes.

Q: It is a specialist?

A: Yes. Internal medicine is considered a specialty. There are other sub-specialties to internal medicine such as gastroenterology or

neurology.
Q: Okay. You're not focused on any of those sub-specialties?
A: I do not do sub-specialty work.
Q: Okay. And you did, looks like, a three year residency after medical school?
A: Correct.
Q: Okay. Is that the shortest residency of any of the specialties in medicine?
A: It's the standard internal medicine residency.
Q: My question is is that the shortest residency that you can have to become a practicing board certified physician?
A: No.
Q: What's shorter than a three year ---
A: General practice.
Q: Okay. You don't have any type of fellowship or residency training in emergency medicine or trauma, do you, other than maybe the first year rotation of your internship?
A: Not formal training in an academic setting.
Q: Okay. And I noticed you're board certified only in internal medicine, is that right?
A: That is correct.
Q: Okay. Even though you said you could be

grandfathered in somehow to something else, you're not board certified in anything but internal medicine?

A: That is correct.

Q: You've never been a fellow of the American College of Emergency Physicians have you?

A: No.

Q: Okay. So when you listed your membership in your CV to that professional group, that would be like me joining the South Carolina trial workers, right? There's no -- you don't have to prove yourself to become a member of that, right?

A: No. You don't have to take a boarded test, correct.

Q: You just apply and pay some money?

A: And attend the meetings, things of that nature, yes.

Q: And you've never been board certified in any type of surgery, have you?

A: Not in a sub-specialty of surgery, no.

Q: Okay. Never been board certified in trauma surgery by the American Board of Surgery?

A: No.

Q: Have you ever been licensed as a paramedic or

an EMT?
A: Yes.
Q: When were you licensed as a paramedic or EMT?
A: Back in the '70's. '75, 6, somewhere in that range up through '82 or '83.
Q: Okay. When you were receiving your training, do you recall that mantra O2, IV, and monitor?
A: I've heard that, yes.
Q: Okay. You ever served in the military?
A: No.
Q: I beg your pardon?
A: No, sir.
Q: Okay. Are you familiar with the medical training that Special Forces Medics receive?
A: Not in specifics. Just in generalizations.
Q: And in looking at your CV, I don't see that you've offered any scholarly publications or given any type of presentations on emergency medicine or trauma, have you?
A: No.
Q: Would you have had the skill set necessary to remove that knife in the emergency department?
A: No. That knife should have been removed in the OR.
Q: Okay. Would you have had the skill set to

remove that knife in the OR?

A: No. I would not do that.

MR. ROTHSTEIN: Your Honor, I object to this witness being qualified as an expert in anything frankly. He's certainly not qualified as emergency medicine. He's not received any specialized training in emergency medicine. And I don't think he meets the qualifications to be an expert witness.

THE COURT: Okay.

MR. WICEVIC: Your Honor, if I may?

THE COURT: Yes.

MR. WICEVIC: He has significant employment in Emergency Rooms. He has significant participation in various committees that surround Emergency Room practice in EMS. I think he's wholly qualified to be an expert in emergency medicine.

THE COURT: Okay.

MR. WICEVIC: He's been qualified in several other proceedings.

THE COURT: No. I agree that he does meet the qualifications to be qualified as an expert in emergency medicine, but you're also requesting that he be qualified as expert in internal

medicine made by his training and credentialing. He is qualified but I'm just wondering the reason for it. But I find that he is qualified to testify as an expert in internal medicine.

MR. WICEVIC: And, Your Honor, I will keep Dr. Deschamps' testimony as closely related to this matter as possible.

THE COURT: Okay. Because that's what I'm thinking, that he is only going to be rendering expert opinions in the area of emergency.

MR. WICEVIC: Related to this ---

THE COURT: Yeah.

MR. WICEVIC: Yes, ma'am. All right.

DR. DESCHAMPS - DIRECT EXAMINATION BY MR. WICEVIC (CONT.):

Q: Dr. Deschamps, you were involved factually with this matter, is that correct?

A: Yes, sir. I was.

Q: Okay. So let's get to your factual involvement first. Before we do that, I'm sorry, can you explain some basic pre-hospital emergency medical principles that are particularly applicable to this matter?

A: Yeah. There are several. One is basic

medicine concept which is primum non nocere, first do no harm. The second is to be respectful and care for the patient in a respectful manner, and the third is to think ahead of the game and figure on potential problems you may have, and manage for those.

Q: Okay. Factual involvement. Did you have any involvement in this matter prior to the case going to the Investigative Review Committee, the IRC?

A: Other than I was informed of it and was asked if this should be reviewed.

Q: Okay. Did you provide any kind of guidance?

A: I said based on what I was told in a summary aspect, that yes it should be.

Q: Do you provide recommendation and guidance to staff?

A: Correct. That's part of my requirements under the statute is to provide that.

Q: Okay. And you mentioned the statute the State Med. Control Physician is a defined physician in the EMS act, is that correct?

A: Correct. 4161.

Q: Yeah. 4461.

A: 4461.

Q: And it outlines a number of responsibilities for you?
A: Correct.
Q: Can you explain those responsibilities?
A: Basically my job is to provide medical expertise and counsel to the Department in the aspect of emergency medical care pre-hospital in so much as to recommend medications, procedures, protocols, and the extent for the scope of the practice in the pre-hospital setting. In addition, I'm obliged to review cases that may come up and offer the Department recommendations for remediations, punitive actions that would occur based upon complaints and investigations. So those are the big areas that we cover.
Q: Okay. So you get the case, you recommend review by the IRC. What is the IRC?
A: The IRC is also defined in regulation, and it is the Investigative Review Committee which is comprised of the State Medical Director, at least one other emergency physician, a minimum of two paramedic trained personnel, and other personnel such as service Directors. The goal being to fairly and blindly review a case to

make recommendations. The IRC has restrictions in that no member who serves on the IRC can participate in a case of a person that they know or within the region from which they come. So if a person is in the low country -- if a case comes from the low country, no participant in the IRC may be from the defined low country area or if they know that person.

Q: So you try to recuse when there's some kind of bias?

A: Correct.

Q: Okay. What did the IRC consider in review of this Mr. Davenport matter?

A: The materials?

Q: Yes, sir.

A: Is that what you're asking? The IRC looked at the information provided by the investigator from DHEC, which included statements, medical records, a video, I believe those were the things we had at that point.

Q: I'm sorry, did you say the patient care report?

A: Correct. Yeah, medical records including the patient care report. Yes.

Q: Okay. Can you explain the general procedure with IRC as far as presenting cases?

A: Basically it is not a, what would be considered judicial proceeding. We don't swear witnesses in. We basically have the investigators come in, present the information to the members of the committee that they have gleaned, then we ask the persons who are the subject of the investigation to attend and make statements and answer questions if they wish to do so.

Q: Okay. Was Mr. Davenport asked questions or did he otherwise participate in this IRC?

A: He did. Both Mr. Davenport and Mr. Rothstein were there, and were allowed to speak, to answer questions, and to offer any information that they wish to provide to us.

Q: Okay. How many IRC matters have you been involved with?

A: It's hard to say. A lot of our investigations as previously mentioned are resolved with consent orders or with remediation. Maybe a couple a year. It seems like they kind of run in groups. We may go a year with none, and then a year that we've got several.

Q: Have there been IRC's where there's been recommendations of no disciplinary action?

A: Yes.

Q: Okay. What were the recommendations for this matter?

A: From the IRC?

Q: Yes, sir.

A: The IRC made the recommendation to the Department, and I'll have to read I tot be 100 percent sure that I ---

MR. ROTHSTEIN: Your Honor, I'm going to object to this. This is, number one, heresay. Number two, it's irrelevant. And number three, this is a de novo hearing. The law does not allow you to give any type of deference to what happened below. So I would object to the recommendations and decisions the IRC is admissible to evidence.

MR. WICEVIC: Well, Your Honor, I can ask him if he's aware of the recommendations of the IRC and his involvement in relaying those recommendations. Regarding the relevance, I think the recommendations of the committee full of unbiased, you know, various professionals around the State in this industry are certainly helpful in you making your decision.

MR. ROTHSTEIN: Your Honor, I've got a real problem with him representing to The Court this is an

unbiased panel. The IRC meeting was lead by Mr. Wronski. The meeting was chaired by Dr. Deschamps. When Dr. Deschamps said that we were allowed to provide everything at the hearing that we needed, that's not accurate. He refused to accept the grievance material that Mr. Davenport provided. We also didn't have an opportunity to participate in the first half of the IRC meeting. We were sat in a room on a different floor than the IRC meeting. So Mr. Wronski described the IRC meeting as sort of like a Grand Jury. Again, the decisions of that body are not relevant to this case. And the recommendations of the body are heresay.

THE COURT: I agree.

MR. WICEVIC: Okay. I'll move on.

THE COURT: Yes. Okay. The objection is sustained.

Q: All right. We talked about your factual involvement. Did it end right there after the IRC until this contested case came up and we contacted you?

A: Yes. To the best of my knowledge.

Q: Okay. In your expert opinion were Dr. Kickham's various orders and protocols appropriate, I mean medically appropriate?

A: Yes, they were.
Q: Now were they appropriate as far as the level of EMT certifications and the corresponding skills that those EMT's can perform?
A: As far as I can see, yes.
Q: Okay. You mentioned the State protocols earlier. Can you explain to The Court what State protocols are?
A: The Medical Control Committee develops for the State a set of protocols very similar to what you've seen in general aspects. They are different in format. And these are consensus documents developed by members of the medical control, which again include emergency physicians, pediatricians, and trauma surgeons, as well as internists, and are felt to be appropriate practice within the scope of practice for paramedics and all levels of medics within South Carolina. We revised these recently and sent them out to the field. They are not mandatory -- in general they are not mandatory. There are a couple of the protocols that we do require as mandatory protocols within our State list. But generally we set these protocols as ceiling protocols, meaning

that the local EMS agency has the ability to do anything up to the levels we have specified, but may not proceed beyond those levels. So we set what South Carolina's maximum scope of practice is for the basic, the maximum scope of practice for the intermediate, and the maximum scope of practice for the paramedic. So a local service may unitize a protocol up to those maximums but may not exceed it. Similarly they may downgrade the protocols and not utilize those protocols, or may elect to not utilize some procedure, or medication, or whatever within the protocol.

Q: Okay. Can you explain to The Court the distinctions between protocols and orders?

A: Okay. Protocols as has been stated before are representations for algorithmic or guideline processes on how to manage a given medical situation. And these protocols represent what is generally accepted as best practices and or standards of care. Within the protocols you may have directives to various levels of certification by a physician which constitutes standing orders. For example, within a protocol it may say, open the airway. That's

part of the protocol. And in another place it may say, intubate the patient. That is a standing order. In this situation, intubate, okay?

Q: Okay. Would you characterize the practice of civilian paramedicine and pre-hospital care as cookbook medicine?

A: No.

Q: Okay. Why is that?

A: Because it requires thought and integration of knowledge, and knowledge of how to integrate multiple protocols within a given scenario. They're very -- in fact I don't know of any scenarios where they are a strictly single protocol based scenario where you've got just a plain common garden variety heart attack. Usually they are protocols that involve airway, or shock, or cardiac arrest, or ventricular fibrillation. So you're proceeding down one protocol and may shift completely out of that protocol to another protocol, follow that protocol down, and then shift back into the first. And this may occur multiple times. So there's nothing cookbook about it. You got to be able to think ahead and know where you may

have to deviate from one protocol into another.
Q: And deviate, do you mean move from?
A: Yeah.
Q: Okay.
A: Right.
Q: Okay. Before we get into the protocols and orders, what did you review as part of the expert opinion you're offering today?
A: I reviewed the documents that were provided by the Department, which included the patient care records, the hospital medical records, Emergency Department records and operative record, multiple depositions and a video that we've seen earlier.
Q: Okay. I mean, did you determine whether any protocols or orders were violated by Mr. Davenport?
A: Yes.
Q: Okay. Well you're familiar with this patient, what would the first protocol you look to be this universal patient care protocol?
A: That's generally the best place to start with protocols because it applies to all patients.
Q: Okay. Well let's turn to that. It's Exhibit 1, Bates page 15.

A: Stand by just a minute.
Q: And I apologize for the small type.
A: It's all right. I have glasses.
Q: Good.
A: Bates page 15 you said?
Q: Yes, sir.
A: All right. Go ahead.
Q: can you identify this?
A: This is listed as universal patient care protocol general procedures for Anderson County EMS, signed by Thomas Kickham DO dated 9/5/13.
Q: Okay. And is that in accordance with the State protocols? Is GP-18 in accordance with the State protocols?
A: Right. Yes. It does not exceed the State protocols and generally follows in another method of presentation than the current State protocols.
Q: Okay. Did you see any concern with violations of this particular protocol?
A: Well sure. I mean there are a couple here. For example under management, bring equipment to the patient's side, demonstrate professionalism and courtesy, initial -- I wouldn't ding initial assessment particularly

bad. And then those are the biggest ones that I see there.

Q: Okay. Well are any of these an order?

A: An order? Yeah. For example, bring all equipment to a patient's side. That is a definitive statement. Do this.

Q: Okay.

A: Okay? It's not a consider or think about. It's a definitive declarative statement. Bring equipment.

Q: Okay.

A: So that would be considered a standing order. Vital signs would be considered a standing order that you would want to obtain. Now they are apart of the protocol, but they are directives to the medics in following of these.

Q: Okay. So you said bring all equipment to patient's side.

A: Correct.

Q: Which equipment was lacking?

A: Well I didn't see stretcher or a carrying device.

Q: Okay.

A: I didn't see oxygen. It may or may not have been there. It's not important whether it gets

used. If it is needed, it needs to be there.
Q: Okay. You talked about demonstrate professionalism and courtesy.
A: Well that was a big area, yes ---
Q: Okay.
A: --- that was deficient.
Q: And can you explain what your concern was with that?
A: Well I think it's fairly straight forward and simple. You just have to look at the video. You do not approach a patient in that fashion. That's just not acceptable.
Q: How might that affect patient care?
A: Well it could very easily initiate an adversarial relationship right off the bat, and what you're after is a comradery with the patient. You want to demonstrate compassion to the patient. You want the patient to feel comfortable with you. You want the patient to feel reliant upon you, and that he can rely upon what you recommend doing.
Q: Okay.
A: He or she.
Q: Any other concerns with this particular GP-18 and compliance?

A: Not particularly.
Q: Okay. Let's skip back one.
A: Okay.
Q: GP-16, patient safety protocol.
A: All right.
Q: Any concerns with compliance with that protocol? And let me back up a little bit.
A: Okay.
Q: Is it applicable?
A: The patient safety protocol? Well, sure. I mean you always want to make sure that everything you do allows for patient safety.
Q: Okay. And is this acceptable in terms of compliance with the State protocols?
A: Correct. It is.
Q: Okay. And do you have any concerns with Mr. Davenport violating this protocol?
A: I'm just looking. I don't see any large areas there where I'm particularly concerned. One thing that would concern me, and it would fall under this generally is that the patient for a period of time was left unmonitored so to speak in the back of the ambulance once they were moved from the house out. Along with that in patient safety protocol, the safety also

includes not making something worse, and ambulating the patient would violate maybe the spirit of this.

Q: Well let me ask you to look at the bullet points under paramedic. Does it state anything regarding ambulations?

MR. ROTHSTEIN: Your Honor, he's leading the witness. I'm trying to be somewhat patient, but he's leading the witness to exactly what -- he's just having him read off a bullet point. That's just nothing more than Mr. Wicevic testifying.

MR. WICEVIC: I'll try not to, Your Honor.

THE COURT: Okay.

Q: I think it might be the small text.

A: Yeah. It is and trying to get through them all.

Q: Take your time.

A: But particularly, you know, you've got to transport all patients on appropriate carrying devices, not done. That's under the EMT paramedic. Ensure that all patient restraints are utilized on each carrying device. Well no carrying device, you can't do that. Both personnel should maintain control of the

stretcher at all times. Well didn't get used until at the ambulance. Stretchers and other equipments. So those are the big ones that I would say there.

Q: Okay. Let's turn to page 16.

A: Okay.

Q: GP-19.

A: Okay.

Q: Can you identify that?

A: This is the adult assessment protocol for Dr. Kickham.

Q: Okay. And I assume this is an adult patient, it would be applicable.

A: Yeah.

Q: Did you have any concerns with violations of this protocol?

A: Well I did not see a focused history and physical based on the patient's Chief complaint. There was parts of that done, but certainly not an adequate one. Assess the need for critical interventions. And then it states that if none are anticipated, downgrade -- well certainly critical interventions could be anticipated in this situation. Perform secondary examination was not done at the

facility, or at the residence. But that's acceptable. Maintain ongoing assessment throughout the transport appears to have been done.

Q: Okay.

A: And then the documentation of findings and information associated with assessment and performed procedures, certainly there was no that I saw, no documentation of the original in-home evaluation.

Q: Are you speaking about Mr. Davenport's evaluation?

A: That's who I saw do what was done on the video.

Q: Okay. And those various procedures you just mentioned, would those be considered protocols or orders?

A: That does kind of overlap. I would -- and the way these are written, it's not clear where one stops and where another one starts. But I would say, for example, perform a focused history and physical based on patient's Chief complaint. To me that would be an order. It's a declarative statement, do this. So that's a directive from the physician. So sometimes I think we make too much of is this a protocol or

is this an order. There are times when it's very clear, give them medicine, give x amount of a medicine. That's clearly a standing order. But if you say take the stretcher to the bedside, that's an order but it falls within the protocol. So it's kind of wishy washy.

Q: Okay. Well I don't think I asked you about the orders for the patient safety protocol, GP-16. If you move back to page 14 very quickly. And you talked about these various procedures that you felt were applicable. Would they be considered orders?

A: Under GP-16 you said?

Q: Yes, sir.

A: Yeah. I would say that these are orders. But again, it's often not clear which one becomes an order and which one becomes part of the protocol. But regardless, you're supposed to follow the document. And so whether you violate the standing order or violate the protocol, it's not necessarily a difference in our eyes.

Q: And you said these. Are you referring to the ambulation and the carrying device directives?

A: Correct. I mean I would consider that a physician order. You don't ambulate the patient, you do bring the stretcher to the bedside.

Q: Okay. You've done, I think these are kind of the overlapping initial kind of assessment protocols ---

A: Right.

Q: --- and orders. Where do you go from there?

A: Well you go where the patient will lead you. In this case this patient was obviously a multi trauma patient. Penetrating abdominal wound. So you would go to a protocol that fits that. Now that may be several protocols. There was no obvious indication of an airway difficulty, which would be high on your list to look for. So you can move past that unless you see something. There's no obvious indication that the patient was in immediate circulatory collapse so you can move past that. So you can get down into a trauma, multi trauma IV protocol, that area, at this point.

Q: Okay. Well let's turn to T-1, we can start there, page 42.

A: All right.

Q: Okay. Would T-1 be applicable?
A: Sure. This is a general trauma standard of care. So certainly this falls under trauma, this is care for trauma in general. So yeah. This would be an applicable protocol.
Q: What's trauma mean?
A: Well it depends on whether you want the Oxford dictionary definition or not. But in South Carolina trauma and traumatic injury is actually defined in regulation. And it is the application of a extrinsic force to the body of a person that produces injury, which has a substantial likelihood to require either medical or surgical intervention to reduce or prevent the risk of disability or death. So that's actually a technical definition for South Carolina when we refer to trauma or traumatic injury, that's what that's based on.
Q: Okay. And I think you're referring to the trauma regulation ---
A: Correct.
Q: --- regulation 61-116.
A: Correct. And that is part of the EMS system.
Q: Okay. All right. Did this patient suffer trauma?

A: Correct. Yes.
Q: Okay. Now the first one, T-1, general trauma standards of care. Is there a more specialized trauma protocol that would be applicable for this patient?
A: Well, sure. There was a -- over on Bates 43, we see the multiple trauma slash shock protocol. And that would be certainly appropriate for this.
Q: All right. Why is that applicable?
A: Because this patient had a multiple trauma or potentially multiple trauma. And we've got to assess for potentialities. So this potentially was multiple trauma based upon systems that could be involved from the mechanism of injury.
Q: Okay. What about shock?
A: The patient had the potential for shock, but based upon the documentation I've been given, there was no indication of current shock.
Q: Okay. Now did Mr. Davenport comply with this protocol?
A: No.
Q: Okay. How did he fail to comply with it?
A: Well, so in this one it states to initiate cardiac monitor lead two, initiate intravenous

access protocol. So in that sense he failed to do those two things within this protocol.

Q: Okay. Anything else?

A: There are parts of this protocol that were not indicated. For example, initiate airway management protocol. He -- and we could clearly see the patient did not have that as an issue, so he checked it, it's not there, he can move ahead. So a couple of these things do not particularly apply in this case. Let me just see. Up at the top under general information it state that intravenous access is initiated en route to the medical facility unless extrication is required. So the fact that, by what we know, the paramedic was driving. He therefore could not follow that part of the protocol.

Q: Okay. Anything else?

A: No. That's all I see right there.

Q: Okay. Well you mentioned that the airway management protocol, and just for clarification -- excuse me, you talked about oxygen therapy.

A: Okay.

Q: Turn back to the front, page 5, GP-1

A: Bates 5.

MR. ROTHSTEIN: Your Honor, I'm not trying to interrupt Mr. Wicevic, but there own expert on paramedics said oxygen was not required for this patient. And now they're going to offer Dr. Deschamps to apparently contradict their own expert. I mean I think this is ---

MR. WICEVIC: Well he was talking about the EMS generally accepted standards. I just want The Court to know Dr. Deschamps' opinion on this matter. He's talking about protocol compliance. I just want you to understand Dr. Deschamps' opinion. I think that will be helpful with your rendering of a decision in this matter. I'll try to make this quick. I'm trying to get through this.

THE COURT: Okay. The objection is overruled.

Q: Dr. Deschamps, can you explain why or why not this oxygen therapy was required pursuant to this order?

A: Well it says initiate adult airway management protocol. And then it gives respiratory rate greater than ten, administer oxygen as indicated for mild distress, nasal cannula two to six liters per minute. And so he didn't do that. Now you know, you can make the argument

that the guy had adequate O2 stats. But the way this protocol is written, that's a violation.

Q: Okay. Is it a violation of an order or a protocol. Well it would be an order 'cause oxygen counts as a medicine, and it says, if this do that.

Q: Okay. And where are you referring to in this GP-1?

A: GP where?

Q: GP-1. Are you referring to ---

A: I was looking under EMT paramedic respiratory rate greater than ten per minute, administer oxygen as indicated, mild distress, nasal cannula two to six liters per minute, which is the second paragraph there. I mean certainly the guy -- the patient did not need his airway opened. It was clearly open, so a lot of this is really not necessary. And you can make that argument because under his pulse oximetry scale he was, if I remember right, above 95 percent. So you can make that argument.

Q: Okay. Anything else with regards to GP-1?

A: Not that I see.

Q: Okay. All right. Let's turn back to T-3, page

43. Initiate cardiac monitor lead two. You said that was an order?

A: Yes.

Q: Okay.

A: Yeah, that's not a debate. It says, do this.

Q: Okay. Did Mr. Davenport comply with that directive?

A: No. He was not in the back.

Q: Okay. Initiate intravenous access protocol.

A: That's correct. It's under the paramedic section and it says do that.

Q: Okay. Well let's turn back to GP-3, page 6.

A: Okay.

Q: Can you explain the applicability of this particular protocol?

A: Well this is just a protocol on how to initiate an IV. And under -- it lists that which is appropriate in South Carolina, only an intermediate EMT or paramedic level EMT are able to do this. And under paramedic for example it states the type of fluid to utilize and whether or not you can utilize bolus fluids or what sites to be utilized.

Q: Okay. And what would be appropriate for this particular patient?

A: Well certainly the patient needed IV access. I would have minimal difficulty if he capped it, hep-locked it or saline locked it. But the point was the patient needed the IV access.
Q: Okay. And Mr. Davenport did not comply with that?
A: No.
Q: Okay. All right. Getting back to those trauma protocols, I think you went through everything applicable in T-3 ---
A: What Bates page are you on again?
Q: I'm sorry. Page 43.
A: Okay.
Q: Any complaints with compliance with T-2 regarding transport?
A: No. I don't recall any particular issues there. They did the right thing. They got him out and gone.
Q: Okay. And I don't think I asked you this for the trauma shock protocol or the intravenous access protocols. Are those both in accordance with the state protocols?
A: Are these protocols? Yes. They're in accordance with ---
Q: Okay.

A: --- South Carolina State protocols.
Q: Okay. We've got the IV. Where does the paramedic, where does Mr. Davenport go from here?
A: In what respect?
Q: In his patient care. Are there any other applicable protocols?
A: Well, I mean I think that those are the major ones. You know, starting at the house, the walking of the patient has to do with patient safety and universal care. Then the failure to initiate an IV while in the back of the unit was a problem. So I think those are the biggest issues we've got.
Q: Any concerns with transport who was riding in the patient compartment?
A: Right. Yeah. I mean, that's what I've said all along is that the highest qualified person should have been in the back. So that's an issue but it's not necessarily a failure to do some step in a protocol. It's a failure to oversee the entire picture of the call. The higher level person should have been in the back.
Q: Okay, so thus far, you have problems with Mr.

Davenport's conduct and verbal interactions ---
A: Correct.
Q: --- the transfer from the scene of the injury to the ambulance ---
A: Correct.
Q: --- IV access, and then the transport decision as far as who rides?
A: Correct.
Q: Do these inactions and actions of Mr. Davenport create a substantial possibility of death or serious bodily harm?
A: They did.
Q: Can you explain to The Court how you made that determination?
A: Well in the absence of an adverse outcome does not indicate adequate or good medicine. And the failure to foresee and provide for such things as IV fluids for acute decompensation by having the highest trained member in the back could have lead to severe worsening of the patient's condition and or death.
Q: Okay. I mentioned a number of failures that we just discussed. Did any of them individually create a substantial possibility of death or serious harm?

A: Well sure. Yes. The walking of the patient, the failure to initiate an IV. All of those things could potentially lead to worsening of the situation. Or failure to correct a worsening situation.

MR. WICEVIC: I beg The Court's indulgence.

Q: Dr. Deschamps, that's all the questions I have for you.

A: Okay.

Q: Please answer any questions by Mr. Rothstein.

DR. DESCHAMPS - CROSS-EXAMINATION BY MR. ROTHSTEIN:

Q: Dr. Deschamps, a minute ago I think you testified that the regulations actually define the term trauma.

A: Trauma or traumatic injury.

Q: And what regulations are you talking about?

A: That's the South Carolina trauma regulation.

Q: Okay. Do you know what number of the South Carolina Trauma Regulation?

A: 61-116.

Q: 61 -.-

A: I think.

Q: --- 116.

A: I'd have to pull it up and look at it. I never can remember all the numbers. But it's the

South Carolina trauma regulation.
Q: And does that regulation apply to emergency medical services?
A: Yes.
Q: Okay. I thought regulation 61-7 was the regulation for emergency medical services.
A: It does. But we have several regulations that also impact EMS. For example, the AED legislation and regulations can affect EMS.
MR. ROTHSTEIN: At the risk of breaking this machine, Your Honor, is it possible for me to try to use the Elmo?
Q: Can you see that, Dr. Deschamps, 'cause I can zoom in a little bit.
A: Okay.
Q: Do you recognize the regulation 61-7 is the DHEC regulation for emergency medical services?
A: Yes.
Q: Okay. And if you'll look, this is for the little table of contents. You see section 200 says, definitions?
A: Correct.
Q: Okay. All right. I'll turn in the book to section 200, okay?
A: All right.

Q: And I'll represent to you I believe these definitions are in alphabetical order. See where starts advanced life support has a definition?
A: I do indeed. Yes.
Q: Okay. Then I'm going to go down to hh in the section 200, the suspension, right? It has a definition of the suspension.
A: Okay.
Q: And then it skips to the department, you see that?
A: I do.
Q: Okay. And then vocational school.
A: I do.
Q: Okay. There's no definition of the word trauma or traumatic injury in the EMS regulations, is there?
A: It's in the trauma regulations is what I said.
Q: But my question is there's not one in the EMS regulations?
A: Not in the EMS regulations.
Q: Now, Mr. Wicevic went through a bunch of policies in this notebook, okay. You now Dr. Kickham?
A: Yes. I mean not personally on a friendly

basis. But he's been at it a while and I've been at it a while.

Q: Okay. That Exhibit 1 in that big notebook there is the standards and protocols for Anderson County EMS, isn't that right?

A: It is.

Q: So that's what Dr. Kickham expects paramedics and EMT's under his medical license to abide by, isn't that right?

A: Correct.

Q: So those protocols aren't what DHEC expects paramedics and EMT's to abide by, right?

A: Yes.

Q: In terms of the standards of care that DHEC expects of a medical provider, that's not reflected in Exhibit 1, is it?

A: Yes. It is.

Q: Okay. Those are Dr. Kickham's expectations, not DHEC's expectations, right?

A: But his expectations cannot exceed our expectations. So, yes they are his expectations, but they are also the Department's expectations.

Q: Okay. The Department publishes a set of protocols as well, right?

A: Correct.
Q: And those are the standards that DHEC expects paramedics to -- it's sort of like -- I think somebody testified yesterday about floor and ceiling. I think they had it exactly backwards. You have the DHEC standards as the floor. You can't drop below the DHEC standards, right?
A: No. You're incorrect. The DHEC protocols are the ceiling. The paramedic, basic, or intermediate cannot exceed what is stated within those protocols. They may do less than that under medical order. In other words, for example, if we allowed surgical cricothyrotomies, where you cut the neck to provide an airway, the State says you may go up to that level. But if Dr. Kickham does not feel comfortable with his medics doing that, he does not have to include it. And even if his paramedics are trained in that, they cannot do it.
Q: What if the State protocol says you can do something, and Dr. Kickham says you can't do it?
A: Then you can't. End of story.

Q: Okay. But that's Dr. Kickham's expectations of his paramedics. That's not DHEC's standard for that paramedic, right?
A: If that medic does that procedure, even though we allowed it at the State and Dr. Kickham has said you can't do it, that paramedic is in violation and it would be punitive.
Q: Punitive by Dr. Kickham, right?
A: By us.
Q: Okay. Where does it say that you can enforce other -- I mean there's hundreds of EMS agencies around the state of South Carolina, right?
A: Correct.
Q: With hundreds of different Medical Control Physicians, right?
A: 147 or so, I think.
Q: And there's not a lot of uniformity in those protocols, is that right?
A: There's surprising uniformity but there is variation.
Q: Okay. For example, if Dr. Kickham says that patients should ambulate or should not ambulate to the hospital, okay? But you go from Anderson County next door to Greenville County,

and Greenville County says it's okay to walk patients in certain circumstances. DHEC doesn't have a, sort of, a dog in that fight as to whether you can walk that patient or not, does it?

A: No, but here's the thing. If you're the paramedic and you're working with Kickham and he says don't do it, and you're that same paramedic and you go to Greenville and they say you can do it, if you come back to Kickham you can't do it again.

Q: Okay, but you at DHEC are not going to discipline that or take enforcement action against that paramedic who let the patient walk ---

A: When he should not have?

Q: --- when Dr. Kickham says don't walk?

A: Yes. If he violated his services protocol, then we may do so. Now a lot of times the local service will say, you violated that protocol. We're going to reprimand you in this fashion. We may or may not know about that.

Q: That's a local problem local solution, right?

A: Correct.

Q: You've heard that phrase before, haven't you?

A: We try to abide by that. Yes.
Q: Okay. You've heard Dr. Alier say that in the IRC?
A: Sure. We ---
Q: We looked at this and we thought it was a local problem local solution, right?
A: Correct.
Q: Until we saw that video?
A: I don't remember if he added that in, but ...
MR. ROTHSTEIN: Can we switch over to my computer on here? Is that possible to do that?
Q: All right. Do you have that on your screen, Dr. Kickham -- I mean, sorry. Dr. Deschamps.
A: The DHEC, yes. I do.
Q: Okay. Do you recognize that as the DHEC homepage on their website?
A: That is the DHEC official SC Government site, it appears to be.
Q: Okay. And it's for the record it's www.dhec.sc.gov. You recognize that?
A: I do.
Q: And then under health there's a tab that says EMS training requirements and protocols, right?
A: Okay.
Q: And so if I wanted to find out what DHEC's sort

of expectations or standards for a paramedic, and I'm not talking about different, among the hundreds of different Medical Control Physicians. I want to know what DHEC's expectations and standards for paramedics and EMT's is, I can go to this website, right?

A: It may be one of the sites you could utilize.

Q: Okay. You see where it says protocols and forms?

A: I see that.

Q: All right. I'm going to click on protocols and forms.

A: Okay.

Q: And it pulls up this screen, right?

A: I see that. Yes.

Q: Okay. And if I click on this little memo here, that gives me a PDF document that sort of introduces the protocols. Have you ever seen that document before?

A: Yes.

Q: I'm going to hand -- this is not in our exhibit notebook. I've marked it as Exhibit 23. Okay. You see Exhibit 23?

A: I do.

Q: Does it look like the documents on the website?

Do you recognize that as ---
A: It does appear the document that's on the website.
Q: Okay. So this is a memorandum dated November the 1st, 2010, right?
A: Correct.
Q: Okay. Is this the set of protocols that was applicable on March 19th, 2016, on the date of the stabbing incident?
A: I would say -- well this isn't the protocols but I would say this is referencing those, yes.
Q: Okay. It references a set of 2010 EMS pre-hospital protocols for DHEC, right?
A: That is correct.
Q: Okay. Is there a more recent version of the DHEC protocols than this document?
A: Yes.
Q: Okay. When was that document published?
A: I believe it was April of this year. April of '17.
Q: Okay. So were there any versions between November 1st, 2010 and April of this year, 2017?
A: Not full versions. There may have been updates or individual changes.

Q: I'm going to turn your attention to the -- you know who Jennifer Paddock is?
A: Jennifer Paddock was a previous Director for the Bureau of EMS, division of EMS at that time.
Q: Okay. Is Mr. Wronski her successor in that position?
A: He is one of them.
Q: Okay. Maybe not immediate, but ---
A: Correct.
Q: --- that's the same position, right?
A: Right.
Q: Okay. Did you review these protocols and the memo before, I assume, Ms. Paddock sent this out?
A: Probably, but I do not have independent recollection of having reviewed it.
Q: Okay. As the State DHEC Medial Director for EMS, for the DHEC, you would expect to have reviewed this before it went out ---
A: Yes.
Q: --- is that right? Okay. And if you look at the first paragraph, the latest addition -- this is the second sentence in the first paragraph. This latest addition contains

treatment modalities for all levels of emergency medical response in accordance with the recently published national EMS education standards. You see that?

A: I see that. Yes.

Q: And then it goes on. It says, it is intended to be all inclusive of information necessary to provide the appropriate treatment and transportation to citizens and visitors of our State, right?

A: I see that. Yes.

Q: Okay. You agree that this document set's forth the standards of care that DHEC expects of its paramedics and EMT's?

A: It sets forth the protocols we expect -- these were not mandated protocols. These were given out to the services to adapt. So these were put together by the Medical Control Committee and sent out to the services for their use.

Q: Okay. Then it says, after the sort of the little index there about the difference types of protocols it says, like earlier additions it is important to remember that this document serves as a guideline only, right?

A: That is correct.

Q: So these are protocols, these are not orders?
A: These were protocols which included orders. But that document was a guideline for services to utilize.
Q: All right. Let me get back, see if I can find that website. All right. I'm going to click on the State approved protocols. You see where I am on the website?
A: I do.
Q: All right. And sections one through four are included at this link, right?
A: Correct.
Q: And you see this table of contents?
A: Correct.
Q: And the protocol number eight is the protocol for behavioral matters. Do you see that?
A: I do.
Q: Let me see if I can find that one real quick. It'll take me a second to scroll down. And this -- just as we go through this -- this is sort of the flow chart or decision tree or algorithm that we've been talking about. This is in a different format than Dr. Kickham's protocols, but this is that type of a document, correct?

A: It is.
Q: All right. So if I go down to behavioral, you see where I am?
A: I do.
Q: Okay. I'm going to scroll down here to the bottom. You know what the term pearls means?
A: Yeah. Those are little information things that help you along.
Q: Okay. And do you see -- well if you don't count the red bullet, the fourth bullet down there?
A: I do.
Q: You see where it says, do not irritate the patient with a prolonged exam?
A: I see that.
Q: Okay. Did the interaction with Mr. Davenport and the stabbing patient involve a behavioral situation that would trigger this protocol?
MR. WICEVIC: Your Honor, I'm going to object. The Department's not alleging that Mr. Davenport failed to comply with State protocols. The State protocols are there for guidance in Med. Control Physicians' development of their own respective protocols and orders. This isn't something that he has to comply with. We're

not saying he didn't comply with this. Further more, it's from 2010. If Mr. Rothstein wants to ask if the Med. Control orders of Dr. Kickham were not in accordance with the ceilings that these set, I think that's fine. But compliance with these State recommended protocols is not an issue of dispute.

THE COURT: Mr. Rothstein?

MR. ROTHSTEIN: Your Honor, Dr. Deschamps says this is the version that was in existence on March 19th, 2016, the date of the stabbing incident. The new volume for the new version didn't come out until April, 2017. So I think he established these are the applicable protocols for the State.

THE COURT: The objection is overruled.

Q: Okay. You see where it says, do not irritate the patient, right?

A: Correct.

Q: Okay. Is that an order or a protocol?

A: it is a pearl. The protocol is above that and there are orders there. For example, the 50 percent Dextrose adult 25 percent Dextrose pediatric if the blood glucose is less than 60. That is an order. This is the protocol, this

is helpful information.
Q: But it's written in mandatory language. It says, do not irritate the patient, right?
A: It is, but it's also within the pearl section.
Q: Okay. So just because something uses mandatory language doesn't make it a standing order, right?
A: For example, if it is up in the first part where you got the purple block, remove patient from stressful environment, that is a direct order as part of the protocol for the first responder level.
Q: Okay. Give me a second. I'm going to scroll down.
A: And then it said, use verbal calming techniques under that as well.
Q: Give me one minute. I'm trying to find one of the protocols. While we're getting that loaded up, let me ask you this question. Now toward the end of your testimony, you said that a paramedic is always -- or you said that you believe Dr. Kickham's protocols require the highest appropriately trained pre-hospital provider to ride in the back of the ambulance. Is that right?

A: I think what I said was that that is generally accepted in patients who have severe or significant injuries or where there's likely decompensation. If the protocol requires a procedure en route that a lower level is unable to perform, then by default you need the higher level in the back.

Q: Okay. But if that patient's stable, there's no need for the higher level.

A: Stability doesn't enter into it. Potential is what enters into it.

Q: Okay. And where does it say that in Dr. Kickham's protocols?

A: The protocol doesn't say that. That's generally accepted pre-hospital EMS medical knowledge. It's the generally accepted principle for treatment of patients.

Q: You don't have a standing order that says, all ambulance calls have to be ridden in by a paramedic, do you?

A: No.

Q: Okay. You could do that if you wanted to, right?

A: Sure. You could write that.

Q: You could say our standard is anytime an

ambulance goes out we want to have a paramedic in the back of the truck?

A: Sure.

Q: Okay. But DHEC has never taken that position?

A: No.

Q: DHEC does allow a basic paramedic to ride the back of the truck in certain circumstances, even if it's a -- I'm sorry, a basic EMT, even if it's a paramedic EMT partnership that goes out to ride that call, right?

A: In certain circumstances that could occur.

Q: Now I'm going to turn your attention to the multiple trauma protocol for DHEC. You believe this stabbing incident was a multiple trauma case?

A: Correct.

Q: So this protocol would apply, right?

A: Correct.

Q: All right. So this sets the minimum standard that DHEC would expect a paramedic to administer care in a multiple trauma situation, right?

A: No. We are not setting standards from DHEC. We are making recommendations to local services of how we think it is best to be handled. It

is up to the local service to adopt this protocol or adapt this protocol.

Q: Okay. I'm not asking whether, like Anderson County for example, has adopted that protocol ---

A: Right.

Q: --- okay. I'm looking only at DHEC's protocol, okay? And according to that memo that was at the beginning of this, you said, we developed these protocols that are in accordance with what we expect pre-hospital providers to provide the residents and visitors of our State -- or citizens and visitors of our State, right?

A: It is the information necessary to provide appropriate treatment. It is not mandated.

Q: Okay. Well let me look at this flow chart. And this isn't the pearl section. I'm talking about the actual protocol section, okay?

A: Sure.

Q: And if you'll look down as you go through the flow chart, universal patient care protocol. You work your way down to vital signs, including GCS, Glasgow Coma Score, right? You see where I am?

A: Yes. Right.
Q: And then there's a decision tree that says, if the vitals are normal you go off to the right ---
A: Correct.
Q: And if the vitals are abnormal you go off to the left, right?
A: Okay.
Q: Were the stabbing patient's normal or abnormal?
A: They were normal.
Q: Okay. So Mr. Davenport goes off to the right under normal. Is there IV access indicated for a normal vital sign ---
A: No.
Q: --- under this protocol?
A: No.
Q: Okay. So at least in DHEC's protocols, Mr. Davenport acted appropriately?
A: It is not required is what we're saying. But these again are not mandatory protocols.
Q: Do you agree with the statement -- let me make sure I get it right. I'm going to quote this. Quote, there is no single way to provide good medicine, close quote. Do you agree with that statement?

A: I agree with that.
Q: Okay. Does it sound familiar to you?
A: I may have had part of the authorship on that.
Q: Okay. I'll hand you Exhibit 24, Respondent's Exhibit 24.
A: Okay.
Q: Okay. If you'll turn -- this is the, I think, the protocols that you testified a minute ago went into effect in April of this year, right?
A: Correct.
Q: Okay. This is a pretty big undertaking by DHEC to update the protocols that were seven years old, would you agree with that?
A: It was substantial.
Q: And if you'll flip through the first little section about the table of contents, you get down to a document called Author's Statement, right?
A: Okay.
Q: And if you turn to the second statement, do you recognize your signature above the signature block, Edgar G. Deschamps, right?
A: Correct.
Q: And the last sentence above your signature says, there is no single way to provide good

medicine, right?
A: Where you reading that now?
Q: Right above your signature. Last sentence.
A: Oh, okay. Yeah. Right. There's no single way to provide good medicine.
Q: Do you agree with that?
A: Yes.
Q: Okay. All right. If you'll turn a couple more pages down, I think you'll find the introduction.
A: Okay.
Q: There's a little sort of table about levels and certainty of evidence or something. Are you on the introductory page?
A: This page, introduction?
Q: Yes. If you'll look at page one of four in that document, this is -- did you review the introductions before it was released?
A: Several times, but there can be errors still.
Q: Okay. The first part of the introduction is the definition, right? It says, a medical protocol or algorithm or guideline is a document with the aim of guiding decisions and criteria regarding diagnosis, management, and treatment in specific areas of healthcare.

A: Right.
Q: Is that an accurate definition of what a protocol is?
A: Yeah.
Q: Sometimes they're referred to as algorithms or guidelines?
A: Correct.
Q: Okay. You know what the term guideline comes from?
A: I don't know the specific.
Q: I had a case one time, I looked it up. There's the little line on the side of the highway is a guideline, okay? Sometimes you have to outside the guidelines, right?
A: Well if a deer jumps in front of you, you might.
Q: There you go. That's different, than say, a New Jersey median right, that has a big concrete thing. You can't go outside of that guideline?
A: Right.
Q: So a guideline is a little more flexible than say an order. You agree?
A: Correct.
Q: Okay. And the goal of educating paramedics is

for them to develop their own experience and knowledge base that they're not bound by the guidelines or rigidly follow the guidelines. You agree with that statement?

A: Right. And we actually say that in here somewhere.

Q: Okay. I'm glad you recognize that. So look at the second paragraph from up from the bottom. Paragraph says, medical algorithms based on best practice can assist everyone involved in delivery of standardized treatment by a wide range of clinical care providers, right?

A: Correct.

Q: Many are presented as protocols and it is a key task in training to ensure providers step outside the protocol when necessary, right?

A: Correct.

Q: Okay. So this document says that when you're training paramedics, don't make them blindly follow the protocols. If they need to step outside the protocols, they should have the judgement and assessment skills to do that, right?

A: In a sense, yes.

Q: Can you step outside an order?

A: No. Not generally. There could be exceptions.
Q: Okay. If you'll look to the next page, page two of four of the introduction about half way down the page, whereas a protocol guideline or algorithm guides decisions and criteria for diagnosis, management, and treatment of specific cases, a standing order is a specific written policy that prescribes a definitive action to be taken for a particular condition or situation, right?
A: That's what it says, yes.
Q: Okay. Standing orders include medication dosages, routes of administration, therapeutic procedures, et cetera to be implemented.
A: Correct.
Q: Okay. Then it says, standing orders are often included within protocols.
A: Correct.
Q: Okay. I know that it was a little hokey, but did you see the Venn diagram I drew?
A: See it right over there. Yes, sir.
Q: Is that an accurate sort of representation of the relationship between protocols and orders?
A: I would say it's generally an acceptable idea. The standing orders might be bigger or smaller

depending upon the protocols.
Q: Well it's not intended to be to scale but ---
A: Right.
Q: --- there's some overlap. Some orders are standing orders which are within the written protocols.
A: That's correct.
Q: But some orders are completely outside the protocols where you have to call -- like if you call a doctor and get online medical control.
A: Correct.
Q: And you're not allowed as a paramedic to step outside of that red box, right? If a doctor orders something, you can't say, well I'm just going to disregard that. I'm going to do something else, right?
A: With rare exceptions, you're correct.
Q: So there's a lot of green area within the protocols for judgements and, you know, making the right decision based on the circumstances presented at the time. Do you agree with that?
A: In that drawing, yes.
Q: Okay. If you look further down page 2, there's another highlighted sentence that says, each medical emergency must be dealt with

individually and appropriate determined accordingly, right?

A: Correct.

Q: Professional judgement is mandatory in determining treatment modalities within the parameters of these protocols. You agree with that?

A: That is correct.

Q: Okay. And have you turn over to the next page it states, professional judgement hierarchy. It's the second sentence. See where I'm reading from?

A: Gotcha.

Q: There's a colon ---

A: Right.

Q: --- says, first of all the pre-hospital provider may determine that no specific treatment is needed. So as the paramedic or EMT's going through the protocol, may not need to do a certain step, right?

A: Correct.

Q: Then it says, or the pre-hospital provider may follow the appropriate treatment protocols and then consult medical control, right?

A: Correct.

Q: And then it says, or the pre-hospital provider may consult medical control before initiating any specific treatment.
A: That's correct.
Q: Are you aware of any situation where Mr. Davenport has ever disregarded a consultation with online medical control?
A: No. I have no knowledge of any such thing.
Q: Are you aware of him violating any standing orders of Dr. Kickham?
A: Well, as we talked about earlier, within the protocols it said things such as, in this situation initiate IV. That was not done. I approach that as a standing order. Because as you pointed out back here, the standing order includes therapeutic procedures such as initiating IV.
Q: You've got that notebook in front of you, Dr. Deschamps?
A: Which now?
Q: Dr. Kickham's protocols.
A: Okay. Where do you want me?
Q: Page 6.
A: Okay.
Q: Specifically the intravenous access protocol,

right?
A: Okay.
Q: The first bullet under patient assessment says, assess patient for indications, right?
A: Correct.
Q: It doesn't say start an IV, right?
A: Correct.
Q: That's a decision tree as to whether you start the IV or not.
A: Sure.
Q: Okay. If you start the IV, then you're down into looking at those standing orders for what type of fluid that you provide to the body and that type of thing, right?
A: Correct.
Q: And this protocol has a standing order that, if you have a trauma patient, you start normal saline sodium chloride, right? .09 percent sodium chloride for a trauma patient?
A: Give me just a second. Let me locate it. Okay.
Q: And so this protocol says if you have a trauma patient and you start an IV, you have to give him saline, right?
A: You have to hang saline, yes.

Q: But the decision is whether to start the IV in the first place is the decision that's up to the paramedic, under the protocol?
A: No. It's reflected in the trauma protocol, which says start IV. So it takes you down below that first section.
Q: Okay. Are you talking about trauma 03?
A: What page was that, 43 maybe? Hang on a minute.
Q: Yes. 43.
A: Okay. Right. So you're coming down there under multiple trauma shock, and it says, initiate intravenous access protocol. So it's ---
Q: Wait a minute. That says ---
MR. WICEVIC: Your Honor, can he finish his answer?
THE COURT: Yes. Let him finish.
MR. ROTHSTEIN: Okay.
A: So it says, initiate IV access protocol utilize y blood sets. Attempt to establish two lines. Infuse at a rate to maintain systolic blood pressure greater than 90.
Q: And you think that that protocol and standing order applies to this patient?
A: Yes.

Q: Okay. It doesn't say start IV, it says initiate the protocol, right?
A: Right.
Q: So it refers you back to the protocol which says assess the patient, whether they need an IV or not.
A: Well you're kind of getting into this cyclic thing. The trauma protocol says to initiate an IV.
Q: No, no, no. Look. It says initiate the intravenous access protocol.
A: But then under that it clearly lists -- you could not go back to that IV access protocol and say, this patient doesn't need it, but I'm going to use a y blood set and infuse saline to maintain a blood pressure greater than 90.
Q: But didn't your expert testify a -- you were here when he testified, right?
A: Right.
Q: And he testified that he would have started an IV -- no start an IV, he would have initiated what do they call that? A hepwell?
A: Yeah, or saline lock, or heplock.
Q: He didn't say he was going to start two IV's, did he?

A: I didn't hear that.
Q: Okay. He also didn't say that he was going to utilize y blood sets, did he?
A: I did not hear him say that specifically.
Q: He didn't say that he would infuse at a rate to maintain the systolic blood pressure of more than 90, did he?
A: I didn't hear that.
Q: Okay. So if he had treated the patient according to what he would have recommended that would have violated an order, right?
A: Not necessarily. If you start the lines and they systolic blood pressure's 120, you don't need to infuse anything. The guidance there is what type line to start. You want to start a large bore IV, you want two if you can get them, and you want it set with a blood set which allows you to deliver large quantities of fluid or blood if you need it. It's a bigger bore.
Q: Wait. Is a hepwell a blood set?
A: No. The blood set is the connecting thing from where you plug into the cannula.
Q: Now I think you testified a little while ago about Dr. Kickham's -- Anderson County protocol

that said, should not ambulate the patient to the ambulance or something along those lines, right?

A: Correct.

Q: Okay. That phrase says, should not ambulate, right?

A: Correct.

Q: It doesn't say, do not ambulate.

A: Well, isn't should a derivative of shall, which is a declarative?

Q: To me it's a little weaker than shall, right?

A: It may be. I'm not an English major, so I don't know. But I thought should was part of shall. So if you should do this we expect it to be done. If you could do this, you may or may not.

Q: When you read, should not ambulate the patient, is that under any circumstances?

A: I would say that there may be some circumstance where you had to. For example, in Mr. Davenport's career, I'm sure that if you're under fire you're going to get those guys moving however you can. So I don't have an objections to that, to in his other career. But in civilian EMS I would have an objection

to it.
Q: Now I think that that same protocol, it may be the patient safe- -- it's one of the general ones. It says that an appropriate carrying device should be used, right?
A: Correct.
Q: Do you think a kitchen chair is an appropriate carrying device?
A: In certain circumstances it might be. It wouldn't be my first choice. I've carried people on kitchen chairs before.
Q: Did you see the video of this patient encounter before the IRC meeting?
A: Yes.
Q: Okay. Did you see the video of the patient encounter before Mr. Davenport ever saw the video?
A: I have no idea.
Q: Okay. Do you know if you saw the video before Mr. Davenport was called down to Columbia and met with Mr. Wronski, Mr. Naugler, and Mr. Wiznuski?
A: I have no idea. I don't recall specifically when I saw it, but it was prior to the IRC.
Q: Prior to the IRC did you ever tell Mr. Wronski

that you thought the video showed violations of statutes and regs of DHEC?

A: I may have. I probably did.

Q: So you were the chair of the IRC, right?

A: Correct.

Q: Okay. When you went into that meeting you already had a preconceived idea about whether Mr. Davenport based on the video had violated DHEC standards?

A: Yes.

Q: So you weren't an unbiased participant in the IRC?

A: I had an idea based on what I had seen so far. I had not spoken to Mr. Davenport for explanations.

Q: Okay. So you made the decision before you even heard from Mr. Davenport's side of the story, right?

A: No. Decisions were made after the IRC met.

Q: No. I mean I think you said after you viewed the video the first time before the IRC, you made a decision in your mind that what you saw in the video violated DHEC standards?

A: Based upon what I saw in that video, yes.

Q: And I think Mr. Wicevic asked you what you

looked at at the IRC, and you said information from the investigator. Who was the investigator in this matter?

A: Richard Naugler.

Q: Any other investigators other than Mr. Naugler?

A: I don't recall any. I think he made the presentation.

Q: And then you said you reviewed witness statements. Plural with an s on the end of it, right?

A: I may have said it that way, yes.

Q: Okay. Which witness statements, plural, did you look at?

A: Well I think we had -- by witness statements I mean to say statements. So we had, I think we had a declaration that Ms. Aiken, and we talked with Scott Stoller during the meeting.

Q: Okay. Wasn't your discussion with Mr. Stoller after the IRC meeting?

A: No. It was during. Well it was during the deliberative phase, after y'all had left.

Q: Okay. So Mr. Davenport and I had already left the building by the time you called Mr. Stoller, right.

A: I don't know when you left the building. You

had certainly left the room, I think.
Q: Okay. So when you said that Mr. Davenport and I had an opportunity to make our case and ask questions and all that stuff, that was before you even got Mr. Stoller on the phone, right?
A: Right. And I think I asked you that and Mr. Davenport if there was anything else y'all wanted to say and had we given you ample opportunity to say what you wanted.
Q: And do you recall Mr. Davenport and I wanted to hand up a grievance packet that he had submitted to ---
A: I do.
Q: --- Anderson County?
A: Yeah.
Q: Okay. And you wouldn't allow that into evidence, would you?
A: It was irrelevant to this particular call from our standpoint.
Q: I think you said you saw the PCR, patient care report, right?
A: Correct.
Q: And you said you saw medical records. Which medical records other than the PCR did you see?
A: I would have to go back and look at the minutes

from the IRC to document it, but I think at that point we saw the ER record, maybe the OR record at that point, but I'm not -- I would have to look at the IRC transcript.

Q: Okay. And you also saw the video, right?

A: Correct.

Q: How many times did you view the video, or how many times did you say you viewed the video in total?

A: Less than 10 I would think.

Q: Okay. How many of those occurred prior to the IRC meeting? How many times did you see it ---

A: Once.

Q: --- before the IRC? One time?

A: Correct.

Q: Okay. How many times did you watch it during the IRC meeting?

A: I think we watched it in its entirety once, and then I think there were a couple of questions that members had and they had to go to certain portions of the video.

Q: The first part of that meeting for about the first hour and a half of the IRC meeting, Mr. Davenport and I weren't in the room, were we?

A: No, sir.

Q: Okay. At that point Mr. Naugler and Mr. Wronski and Dr. Alier were in the room, right?
A: I don't know specifically who all was there. They may have been. Again I need to look at the transcripts. I know people, they came in and out. Mr. Naugler was there at least for part of it. Mr. Wronski was there for part of it. I'm not sure whether Dr. Alier was there or not. He may have been in and out. I don't remember.
Q: So neither Mr. Davenport nor I had an opportunity to listen to what Mr. Naugler said, right?
A: That is correct.
Q: And we didn't have an opportunity to ask Mr. Naugler any questions about his investigation?
A: That is correct.
Q: And we also didn't have an opportunity to sit through the video as you were watching it, right?
A: No.
Q: Okay. And as questions came up about the video while you were watching it, Mr. Davenport didn't have a chance to respond to any of the comments back and forth about what the video

showed, right?
A: Not during that initial viewing, no.
Q: Now when you called Mr. Davenport and me into the room after you dismissed Mr. Naugler, did you see the video again?
A: Again, we'd have to go look. I don't think we showed the entire thing while y'all were there.
Q: Okay. I don't recall seeing it, but I was just wondering if you had a different ---
A: I don't recall it either.
Q: How many medical malpractice suits have you been involved in during your medical career?
A: In what format?
Q: As a defendant.
A: A couple.
Q: Have you been sued in Lee County?
A: Yes.
Q: Okay. You recall in 1992 you were sued by a woman who was your patient, came in with bronchitis.
A: I know her well, yes.
Q: Okay. And you ---
MR. WICEVIC: Your Honor, I'm going to object to the relevance of this inquiry.
MR. ROTHSTEIN: Your Honor, if I remember correctly,

when my expert witness was on the stand, Mr. Wicevic asked about medical malpractice cases. I think it's very relevant. I mean it goes to impeach an expert witness. It goes to his medical knowledge and his medical expertise. I think it's valid cross-examination material. I mean what's good for the goose is good for the gander. He asked my witness the same questions, Your Honor.

MR. WICEVIC: But I think my questioning was during the voir dire. He's already been qualified as an expert. I'm not sure what the point of it is now. If he's questioning his qualifications, he should have done it during that period.

MR. ROTHSTEIN: I'm going to have to proffer this information anyway. I mean I think it relevant. I think the rules clearly allow impeachment of an expert witness by asking them if they've ever been sued for violating the standard of care, and whether they've actually had a jury finding that they violated the standard of care, and were ordered to pay money as a result of that finding.

THE COURT: I'm going to take this matter under

advisement and call a ten minute break at this point. I do need to use the phone anyway.

MR. ROTHSTEIN: Okay. Thank you, Your Honor.

(Off the record from 5:10 p.m. until 5:23 p.m.)

THE COURT: Okay. Mr. Wicevic, I think what we've got here is you're objecting to Mr. Rothstein's ---

MR. WICEVIC: That's correct, Your Honor. I think the inquiry into his qualifications has ended. This appears to be some attempt to impeach Dr. Deschamps. And the rules on impeachment 608-B will not allow this. Specific instances of conduct of a witness for the purpose of attacking the witness's credibility other than conviction crimes listed in rule 609 may not be proved by extrinsic evidence. It may however in the discretion of The Court if probative of truthfulness or untruthfulness be inquired into on cross-examination of the witness concerning the witness's character. Truthfulness or untruthfulness. Your Honor, this is not an inquiry to Dr. Deschamps Truthfulness. It's an inquiry into his past medical practice, and I think Mr. Rothstein even said that in his response to my objections about his

qualifications.

THE COURT: Yeah. Mr. Rothstein, I'm somewhat confused. Exactly what are you attempting to do with this line of questioning?

MR. ROTHSTEIN: Well there's two things, Your Honor. I don't have to conduct a voir dire of an expert. If I agree that the expert's qualifications allow him to be qualified as an expert, I can forego my opportunity to voir dire the witness, and I can impeach him on cross-examination with whatever is within the bounds of what I'm allowed to do under the rules of evidence. There's two points that I'm going to make here, Your Honor. One, it does go to his, sort of level of expertise. He's been qualified as an expert witness. It does tend to impact his credibility. That's the exact reason Mr. Wicevic asked my witness the same question. The only difference here is my witness had no cases reported against him. This witness does. And so that's the first point, Your honor. The second point is Dr. Deschamps is testified that he has not disciplinary actions against his medical license. And I was going to ask him if he

thinks it's fair -- or if the Board of Medical Examiners moved to take his license after that first malpractice verdict against him where he caused permanent injury to a Lee County resident. If he thought it'd be fair for the Board of Medical Examiners to yank his ability to practice medicine based on that bad outcome. And I think that is relevant.

THE COURT: A civil suit and a disciplinary action, that's different. I'm sustaining Mr. Wicevic's objection.

MR. ROTHSTEIN: Okay. Just for the record, Your Honor, I'd like to proffer this.

THE COURT: Okay. You can. Go ahead.

MR. ROTHSTEIN: Do you want me to do it just verbally to you or you want me to ask questions of the witness? It's probably quicker if I just summarize.

THE COURT: It would be quicker, yes.

MR. ROTHSTEIN: Okay. The testimony I would elicit was that there was a case brought against Dr. Deschamps in 1992 in Lee County, South Carolina. A woman went in to his practice complaining of bronchitis. She was administered an intramuscular injection into

her rear end. She was given a shot in the buttocks with some type of a steroid. The needle was improperly placed in the wrong position. It struck the patient's sciatic nerve in the back of her leg and caused her permanent nerve damage, which rendered it ver painful for her to walk, and she became disabled and was unable to work. The case ended up with a jury verdict in 1994 against Dr. Deschamps in favor of the plaintiff for $900,000.00.

THE COURT: Thank you. I'm assuming you've got additional questions for ---

MR. ROTHSTEIN: Just a few. I know it's been a long day.

Q: Now you testified earlier that you've been involved in one other ALJ matter involving a paramedic?

A: Yes.

Q: And that was the Stuart Platt case from Lexington County?

A: Correct.

Q: Okay. Do you recall what year that was?

A: I don't recall specifically. Six or seven years ago maybe.

Q: Okay. Could it have been more than 15 years ago, or about 15 years ago?
A: If it has time flies. Maybe it has, but I don't remember it.
Q: I'm going to hand you this. I don't know that we need to mark this as an exhibit. I don't intend to actually move to introduce it, but I want to ask some questions. Dr. Deschamps, in discovery in this case, you may not be aware of it, but we asked in request for production number three, for DHEC to produce any and all document related to the suspension, revokation, demotion, or other disciplinary action taken against any license or certificate of a paramedic in South Carolina from January 1st, 2011 to the present. And that is the response we got from Mr. Wicevic on behalf of DHEC.
A: I've never seen this.
Q: I did an analysis of the list of the cases here, and there were two cases where a paramedic had their suspension revoked for 48 months, for four years since January 1st of 2011. You have any reason to dispute that?
A: I have no reason to dispute it.

Q: Okay. One of those individuals is sitting to my left, Mr. Davenport. Okay. The other individual -- and I can use abbreviations. His initials are J-A-D. He's on page 4 of this document. It's the first full item on the list. You see that?

A: The second paragraph down?

Q: Second paragraph down.

A: Okay. I see that.

Q: Okay. And this particular paramedic committed misconduct, did not carry a stretcher to the cardiac patient, did not start CPR until the patient was on the stretcher, and only gave the patient one dose of epinephrin in 30 minutes. You see that?

A: I see that.

Q: Okay. Was that appropriate medical care for a cardiac patient?

A: No.

Q: Pretty clear violation of the standard of care?

A: Yes.

Q: Do you know what happened with this particular patient?

A: I have -- no, I do not.

Q: Do you know if the patient died?

A: I do not know. I'm not familiar with this particular one.
Q: Okay. And this case was actually resolved by what's called a consent order. Are you familiar with that?
A: I am.
Q: Okay. And that's where the paramedic agrees to accept the punishment and doesn't contest the punishment, right?
A: Correct.
Q: And this isn't the first time that paramedic J-A-D was before the Board. Do you recall seeing him another time?
A: You talking about the one on this page 4?
Q: Yeah.
A: Is that who you're referring to as J-A-D?
Q: Right.
A: Okay. No. I do not. I mean, it's possible. I see a bunch of these come through. I'm not familiar with this document and I often do not remember any of the names.
Q: Okay. I'm going to ask you to flip back to page 2 of this document. Look down from the second name from the bottom. You see the same paramedic J-A-D?

A: I do.

MR. WICEVIC: Your Honor, I'm going to object. Dr. Deschamps says he didn't now about this particular EMT.

THE COURT: I'm going to allow the question. I'm overruling your objection.

MR. WICEVIC: Thank you.

THE COURT: Go on, Mr. Rothstein.

Q: The first time this paramedic J-A-D came before the Board, there was another challenge to his provision of care to patients, right?

A: Give me just one second please.

Q: You see this is another consent order dated February 15th?

A: Right. Okay. I see it.

Q: Okay. And in this consent order, DHEC and the paramedic agree that the paramedic would surrender his paramedic license for nine months and sort of be bumped down to an EMT basic during that period, right?

A: Right.

Q: And in this case the paramedic failed to perform a systematic patient assessment, neurological examination, or obtain complete patient history including the patient's

medications, right?
A: Correct.
Q: This resulted in being unable to correctly assess and properly care for an 87 year old fall victim with a head injury, correct?
A: Correct.
Q: And that patient actually had to be airlifted to a different hospital because of the actions or inactions of this particular paramedic, right?
A: Okay. Correct.
Q: You agree that's a pretty bad outcome for a patient encounter?
A: Well, I mean, yes. It is. It's not what you want at all.
Q: Okay. And when the patient was airlifted, that caused further deterioration. The paramedic also failed to immobilize this patient's spine. Right? According to the fall protocol?
A: Correct.
Q: Pretty serious allegations against a paramedic. Would you agree with that?
A: Yes.
Q: Okay. And DHEC agreed in this consent on February, 2013 to suspend -- not completely

revoke his license, but suspend it for nine months and allow him to work as an EMT basic.

A: Right.

Q: Right? So I think we talked about this J-A-D fellow. The next highest -- over the 48 months, Mr. Davenport and J-A-D have been before you twice. The next highest one I can find initials G-A-L. I'm sorry, J-M. And that'll be on page 4.

A: And it's what letters again?

Q: J-M.

A: Okay.

Q: Second name from the bottom. You see that?

A: I do.

Q: And this paramedic also entered into a consent order, right?

A: Yes.

Q: He agreed with the punishment and did not challenge this through the IRC or through the administrative law process, right?

A: Correct. As far as I can tell from what's recorded here.

Q: Okay. And this is another cardiac patient where the paramedic in question disregarded the Sumter County EMS protocols for emergency

treatment, failed to perform basic cardiac life support on the patient causing the patient to suffer further injury as well as creating a substantial possibility of death. You see that?

MR. WICEVIC: Your Honor, I just wanted to object again. Dr. Deschamps makes recommendations to the Department. We wouldn't allow Dr. Deschamps' recommendations with IRC into the record. I don't know why we're going into this long inquiry into the Department's past enforcement actions. I think if he want's to ask questions about that, Mr. Wronski who will be testifying later, he makes the decisions on behalf of the Department. He'd be the person to answer those questions.

THE COURT: Okay. Mr. Rothstein, why are you ---

MR. ROTHSTEIN: Dr. Deschamps has been there since 1985 I think he testified earlier. Mr. Wronski has only been there about two or three years. So a lot of these cases predated Mr. Wronski's involvement.

THE COURT: Yeah, but you're not asking him a question. You're reading from this document. What's the question that you've got for the

witness?
Q: That was what that paramedic was accused of doing in terms of violating protocols, right?
A: What you read. I agree you read what's here, yes. Again, I want to say I don't know these people by name. I may have had some involvement in recommendations but I do not recall that. So I can't give you anymore details about it.
Q: Okay. What happens if you fail to provide CPR and AED on a cardiac arrest patient?
A: They'll certainly die.
Q: And you've got all the documents that I got from DHEC. And again I'm just going to summarize what my analysis was and see if you have a reason to dispute that. According to my case, there were a total of 50 cases that were on that list.
A: This list?
Q: That list.
A: I haven't counted them, so I can't ...
Q: And out of those cases there were 19 what they call ESO's. do you know what an ESO is?
A: I do not.
Q: Okay. Have you ever heard of an emergency

suspension order?
A: Oh, okay. Right. Yes.
Q: Emergency suspension order is when a paramedic has been arrested for a felony or serious crime of moral turpitude? Is that right?
A: Yes, that's part of it. I'm sorry. It's a little bit late.
Q: And so DHEC has the authority to act immediately to suspend that paramedic pending the outcome of the criminal charges, correct?
A: Correct.
Q: Okay. So if you take out the 19 emergency orders, there were actually 30 consent orders from DHEC at in time. Do you have any reason to dispute that?
A: I have no reason to dispute anything about what's here or how it's accounted at all, 'cause I'm not familiar with this. I'll take your word for it.
MR. WICEVIC: Your Honor, I think that's the key to our objection. He testified he doesn't know anything about this.
MR. ROTHSTEIN: Well, Your Honor, he signed off on every one of these cases. The fact that he can't remember while he's sitting here today is

not ---

A: No. I have not signed off on ... I don't sign off. I may be consulted for a recommendation, but there's no paper that I sign.

THE COURT: Okay. The objection is sustained.

Q: Would you be surprised to know that Mr. Davenport's the only paramedic who's been recommended for enforcement action against his paramedic certificate since January 1st of 2011, who's files a contested case hearing request?

A: I would not be surprised. I don't recall any.

Q: Your expert in the case, Mr. Douglas, do you recall him testifying that he's a member of a committee that looks into the, sort of, wellness of mental health issues of paramedics and EMT's?

A: I don't remember that specifically.

Q: Do you agree that begin a paramedic and an EMT can be a stressful job?

A: Absolutely.

Q: You aware that paramedics and EMT's face a higher incidence of suicide and depression and alcohol and metal health issues at a rate higher than many other occupations and

professions?
A: Generally healthcare associated professions show that, yes.
Q: Okay. When you worked as a paramedic back in the day, did you work long hours?
A: Yes.
Q: Typically did you work 24, 48 type shifts?
A: No. When I was at Bishopville, it was 24,7,365. We were volunteer service and basically I worked anytime they needed someone.
Q: Would you agree that working long hours like 24 hours on can also take a toll on a paramedic or EMT's well-being?
A: Yes, sir.
Q: Now, to your knowledge, what has DHEC done to address these types of wellness and mental health issues for paramedics and EMT's in South Carolina?
A: Well, DHEC really does not have authority that I know of to get into the work place and set hours or standards for hours. That's out of my area. We do have symposiums and meetings where health and wellness is discussed, and we bring in folks to try and help educate the people who do make those decisions, which are the service

providers. But we don't regulate how many hours somebody can work, or at least I don't think we have that authority. I've never been involved with anything like that.

Q: And I'm not talking about regulating hours. I'm talking about, sort of, wellness and concern for the paramedics and EMT's that are licensed in South Carolina. Are you aware of any efforts that you or your office, or people under your supervision have taken to promote the health and wellness and care for the paramedics and EMT's?

A: There may be some. I'm not personally familiar with them at this time.

Q: Are you familiar with something called the Code Green Campaign?

A: I am not.

Q: Okay. You've never heard of the Code Green Campaign?

A: I have not.

Q: Now I think there was some testimony earlier from one of the witnesses that talked about what a differential diagnosis was.

A: Yes, sir. I remember something about that.

Q: And a differential diagnosis is sort of

potential explanations for a certain condition, right?

A: Potential explanations or problems that may be associated with a certain condition, yes.

Q: Okay. I think you testified when you first saw the video, you had some concern about Mr. Davenport's interactions and his, sort of, demeanor toward the patient, correct?

A: I did.

Q: Okay. Did you during the IRC discussions talk about whether that was a response to stress that Mr. Davenport may have been under?

A: We discussed multiple possibilities for it and wanted to make sure that he had good care.

Q: Okay. Did you discuss the possibility that he might be burned out?

A: I think that was one of the statements that was brought up.

Q: Okay. Were you aware that Anderson County lost a paramedic to suicide in February of 2016?

A: I don't often know how folks die. I'll know that they expire. We'll be notified, but I don't specifically recall a suicide.

Q: Do you know if Mr. -- when you viewed the video, did it appear that Mr. Davenport was

having trouble getting around a little bit?
A: I don't recall. If you want to play it I can look at it, but I don't recall. I recall at some point hearing that he was having some pain. And I have no doubt that he may have.
Q: Okay. In the IRC meeting, do you recall discussions among the members of the committee about whether they thought Mr. Davenport might have been suffering from post traumatic stress disorder?
A: I remember that was brought up and discussed at some point.
Q: Okay. You recall a discussion about possibly him having a traumatic brain injury from the blast he received in Afghanistan?
A: That may have been discussed. I don't specifically recall that, but it could have been.
Q: Okay. Did you discuss the possibility that Mr. Davenport might have been having difficulty in returning to civilian life after being in active duty combat?
A: Yes.
Q: Okay. And what specifically did you and the committee members do to follow up on those

concerns and those discussions about Mr. Davenport's health or well being?

A: Well that was part of one of our recommendations to the Department was that he at least has some evaluation to see if any of that may be true. That was part of one of the recommendations. We did not say that any of it was true, only that we were concerned it might be and we'd like some professional to tell us whether -- we didn't even need to know. Just have some professional look at him. If they said, nothing is there, end of story.

Q: Okay. You never offered that to Mr. Davenport prior to the recommendations that his paramedic credentials be suspended or revoked, did you?

A: That was one of the recommendations from the IRC.

Q: Recommendation was we're going to suspend him and make him go to an evaluation, right?

A: One of the recommendations was we will take some time -- we felt that there had to be some punitive action based upon the results. Sometime, some smaller time, and at least a single evaluation with the recommendation that if something was discovered and further therapy

was recommended that he attend that. But if nothing was discovered and no therapy was recommended, end of story. Or a longer period of revokation or suspension, and those two terms kind of get mixed up as to what they mean, if he did not wish to do that. We gave options.

Q: All right. But before you made the recommendation of suspension, you didn't say, hey we need to have Mr. Davenport see if he can go to an EAP or some sort of counseling to see if he's got some mental health issue that explains the way he acted toward this patient on that night, did you?

A: Before we went through the IRC?

Q: No, no. Before you offered Mr. Davenport a consent order where he would agree to a suspension of his license for at least a year, right?

A: I think that the Department may have offered a consent order at or about the time of the IRC, which lead to the IRC. I don't remember specifically. But in the IRC we had a couple of recommendations. One was a smaller time without certification, coupled with some sort

of professional evaluation, or a longer period without certification if he declined that.

Q: Okay. Well I know this is late, but my question is before you made the suspension recommendation, you never said, hey let's have him evaluated first and consider that as part of the IRC, right?

A: No. That came out of the IRC is what I'm trying to say.

MR. ROTHSTEIN: I don't have any further questions, Your Honor.

THE COURT: Okay.

MR. WICEVIC: Your Honor, I'll make it quick.

DR. DESCHAMPS - RE-DIRECT EXAMINATION BY MR. WICEVIC:

Q: Just a few follow up questions.

MR. WICEVIC: Could we get the monitor?

Q: Now, Dr. Deschamps, I believe in your direct testimony to my questioning said there's a lot of moving parts to paramedic practice.

A: Correct.

Q: Might there be other protocols regarding IV access besides this multiple trauma shock ---

A: Oh sure. You may see IV access under cardiac arrest or under respiratory distress or under back pain. I mean, IV access may be under

multiple issues. And that's part of the formulation that the medic has to sort through.

Q: Okay. Well let's look at -- and again, these are the State recommended protocols, correct?

A: Correct.

Q: Okay. Let's look at IV access. I have it up on the screen.

A: Okay.

Q: Would that be applicable to this particular patient?

A: Sure.

Q: And why?

A: Well, I mean, first off you do universal patient care protocols. Then it says, assess need for IV. Emergent or potentially emergent medical or trauma condition. So either there's clearly an emergency or a potential emergency that could develop. And in those cases you initiate the IV.

Q: Was there an emergent or potentially emergent?

A: Sure. I mean, that's what we've said all along is that we felt, given the mechanism of injury and the findings, that the potential for injury, prolonged injury, death, disability was there.

Q: Okay.
A: And that's all you need is to check that box for potential.
MR. WICEVIC: And, Your Honor, please stop me if you don't need this, but there was some reference about DHEC not being concerned with order violations. And I was going to have Dr. Deschamps review the regulation to respond to that. But I know The Court's familiar with our laws.
Q: Dr. Deschamps, what are the various bases that the Department can take enforcement?
A: Basically any violation whatsoever of the regulations.
Q: Okay. What else?
MR. ROTHSTEIN: And, Your Honor, again this is -- he's testifying about legal matters at this point. I think it's improper for this witness to instruct you on what the law is.
THE COURT: I agree with that.
MR. WICEVIC: Okay. Fair enough. I trust The Court can figure out the legal matters in this. You mentioned that there are certain circumstances which would allow a paramedic or EMT to deviate from an order. Could you explain the meaning?

A: Okay. So, you're going down your protocol and it comes to a place where it say, start an IV. Okay? In the next section you come to says, administer epinephrin. Okay? Well if you can't get the IV started, you may not move to the second point. So you by default have to deviate from that. If you're under potentially life threatening situation such as an active shooter or something, and it says, do not ambulate the patient. Well if you're getting shot at the quickest thing may be to ambulate the patient. The goal is to protect the medic first. If the medic in injured then nobody helps the patients. So anytime where you may need to deviate to protect the provider, that's an acceptable sort of thing.

Q: Well did you observe those types of circumstances with this ---

A: I did not.

Q: Okay. Dr. Deschamps, the only reason why I bring this up is because it was brought up during your cross-examination. What's the first step according to the State protocol for caring for a behavioral patient?

A: First step is scene safety and universal

patient care.

Q: Then what's next?

A: Then after that remove the patient from the stressful environment. Use verbal calming techniques because communication is very important, reassurance, calm, establish a rapport, and then check the Glasgow Coma Scale. From there go to an appropriate protocol.

Q: Okay. Did you see compliance with that second bullet point?

A: No.

Q: Okay. No further questions. Thank you, Dr. Deschamps.

MR. ROTHSTEIN: Your Honor, there's two things. I promise I'll be less than two minutes.

THE COURT: Okay.

DR. DESCHAMPS - RECROSS-EXAMINATION BY MR. ROTHSTEIN:

Q: I think it was just on the screen. What does the pink F mean?

A: First responder, which is now referred to as rapid. We coded ours by color for level. So anybody at or above that level can fulfill that obligation. So if you see a P for paramedic, only a paramedic can do it. If you see an I for advanced, then an advanced or a paramedic

can do it. So that's the floor.
Q: So as an F, that's something that you don't even need a EMT basic to do, right?
A: Correct.
Q: Okay. The first person on the scene may be a firefighter or ---
A: Correct.
Q: --- a Police Officer who's trained in first response. Okay. And on that IV access one that Mr. -- it doesn't say administer an IV, right? In that second bullet down after universal care protocol. It says, assess need for an IV, right?
A: Right. But then it comes down under A and says, peripheral IV. That's a statement. Start the IV.
Q: Okay. But if you assess the need for the IV and there was no need for the IV 'cause the patient was stable, you don't go further down the protocol, right?
A: Stability has nothing to do with it. Potential emergent medical or trauma condition. So stability is great and we aspire for that. But that has nothing to do with the protocol. If the potential exists you treat to the

potential.

Q: Okay. I think you said you checked that box, right?

A: Yeah. Once you get there and say this, then you don't have to go any further. You know, it's like if you are assessing a patient for cardiac disease in an older man, he's got chest pain, it doesn't matter how much negative you find, that chest pain's enough positive that you got to exclude heart as an issue.

Q: I understand, but when you say check the box medicine, that's inconsistent with having the paramedic have the critical skills to think for themselves.

A: No, no, no. I figured you might ask that. But you're checking the box in the sense of once you come to this point and get an affirmative negative answer, whichever way it is, then you are obligated to do something. So if you check the box that there's a potentially emergent medical condition, if you say in your mind, in this situation there's a potentially emergent situation, then everything else is moot. You go down and start an IV.

MR. ROTHSTEIN: I don't have any further questions,

Your Honor. Thank you.

THE COURT: Okay. Thank you, Dr. Deschamps.

DR. DESCHAMPS: You're welcome. Thank you.

THE COURT: And I think it's five minutes before 6:00, so we're going to stop for today. And we'll start again -- I'm sorry. Go on.

MR. WICEVIC: I was just going to say we just have one more witness.

THE COURT: You've just got one more witness?

MR. WICEVIC: Yes, Your Honor.

THE COURT: Okay. Good. We'll start with that witness at 9:00 a.m. in the morning. Okay? Good.

(Whereupon, the hearing adjourned at 5:57 p.m. and was reconvened on Thursday, July, 27, 2017 at 9:07 a.m.)

STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT
Docket No. 17-ALJ-07-0003-CC

South Carolina Department of Health and Environmental Control,	)
Petitioner,	)
v.	)
James Davenport,	)
Respondent.	)

ADMINISTRATIVE HEARING

****

Thursday, July 27, 2017
9:07 a.m. - 5:43 p.m.

The hearing before the Honorable Shirley Canty Robinson, was taken at the Edgar A. Brown Building, 1205 Pendleton Street, Suite 224, Columbia, South Carolina, on the 27th day of July, 2017 before Travis McLeod, Court Reporter and Notary Public in and for the State of South Carolina.

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INDEX

		PAGE:
ROBERT WRONSKI:		
MR. WICEVIC	DIRECT EXAMINATION	4
MR. ROTHSTEIN	CROSS-EXAMINATION	67
MR. WICEVIC	RE-DIRECT EXAMINATION	174
LEO DEASON:		
MR. ROTHSTEIN	DIRECT EXAMINATION	0
MR. WICEVIC	VOIR DIRE	0
MR. ROTHSTEIN	DIRECT EXAMINATION (CONT.)	0
MR. WICEVIC	CROSS-EXAMINATION	0
MR. ROTHSTEIN	RE-DIRECT EXAMINATION	0
FIRST SERGEANT DERREK CRUS:		
MR. WICEVIC	DIRECT EXAMINATION	304
MR. ROTHSTEIN	CROSS-EXAMINATION	319
Certificate		321

EXHIBITS

(Petitioner's Exhibits 1-14 and Respondent's Exhibits 1-22 were marked prior to the hearing.)

Petitioner's Exhibit Number 6 36
(AnMed Emergency Department Record)
Petitioner's Exhibit Number 7 37
(AnMed Operating Room Procedure Notes)
Petitioner's Exhibit Number 9 29
(James Davenport DHEC Interview)
Petitioner's Exhibit Number 28 66
(Affidavit for Iva Police Department)
Petitioner's Exhibit Number 29 66
(Affidavit for AnMed Health)
Respondent's Exhibit Number 3 87
(DHEC Division of EMS and Trauma Investigation Log re: Davenport)
Respondent's Exhibit Number 15 317
(Davenport Military Discharge Documents and Listings of Awards/Medals)
Respondent's Exhibit Number 16 318
(Davenport Proficiency Reports from Military)
Respondent's Exhibit Number 22 220
(Curriculum Vitae of Leo Deason)

(The original exhibits were retained by Judge Robinson.)

STIPULATIONS

It is stipulated and agreed that this hearing is being taken pursuant to the rules of the Administrative Law Court and the South Carolina Rules of Civil Procedure.

THE COURT: The hearing is called to order, and do we have anything that we need to take care of before Mr. Wicevic calls his last witness?

MR. WICEVIC: I do not believe so.

THE COURT: Okay

MR. ROTHSTEIN: I'm good, Your Honor.

THE COURT: Okay. We're ready to hear your witness.

MR. WICEVIC: Yes, Your Honor. The Department calls Robert Wronski.

THE COURT: Okay. Mr. Wronski, you've been sitting here so you know the drill.

MR. WRONSKI: Yes, ma'am.

ROBERT WRONSKI, having been duly sworn, testifies as follows:

MR. WRONSKI - DIRECT EXAMINATION BY MR. WICEVIC:

Q: All right. Good morning, Mr. Wronski.

A: Good morning.

Q: Please state your full name for the record.

A: Robert Anthony Wronski.

Q: Mr. Wronski, can you state -- can you explain your education?

A: I graduated from high school in Western New York, Niagara County in 1984, directly into the U.S. Navy. 20 years in the Navy. Various submarines, submarine squadron commands. My

last four years I had some kidney stones and I was chained to a desk, so I still completed 20 years in the Navy. Beyond that I have an Associates degree from Trident Technical College, 1991, a Bachelor's degree in public health administration from Columbia Southern University, and a masters in business administration with a concentration in public administration from Columbia Southern University.

Q: What was your associate's degree in?

A: Just in general science. I was trying to get into nursing school.

Q: Okay. Your job experience. You talked about your military. What did you do after you got out of the military?

A: Out of the military directly into full-time position with a Fire Department that I had been volunteering with as a paramedic firefighter. And I stayed at the Beach Park Fire Department in Illinois outside Chicago until 2006 when I moved back to Charleston. I've been stationed in Charleston and I always wanted to come back. So I came back down to Charleston. I worked for Charleston County EMS for a bit and missed

the fire side of things, and I was hired by the Mt. Pleasant Fire Department to be their Medical Training Officer and to start an advanced life support paramedic engine program with them. Stayed there for about four years, resigned from that position, went to private EMS for about seven or eight months, and then back to the Fire Department as the training officer for the St. Andrews Fire Department, and then eventually was promoted to Assistant Chief of that Department before taking this position.

Q: Okay. Can you explain your patient care roles, I guess beginning with your Fire Department experience outside of Chicago?

A: I was the Medical Training Officer for the Beach Park Fire Department for a period of time, but I was also a shift commander, I was a Captain. Lieutenant first, sorry, promoted to Captain before I left, and I rode the ambulance early when I worked there for most shifts that I was on. I was one of the senior providers there. And then I, as a shift commander, I switched more to an engine and command role.

Q: Okay.
A: But I still provided advanced life support patient care.
Q: And then you moved down to Charleston. Can you tell about your patient care?
A: When I was in Charleston County I was strictly on an ambulance as a crew Chief, and was there for 18 months give or take before I took the position with Mt. Pleasant where I also then provided advanced life support care via quick response vehicle.
Q: Okay. And perhaps I should have gotten to this before we got to your job and experience. Explain your various certifications as a EMT.
A: So I got my EMT basic, actually the Navy put me through EMT school between duty stations. They were putting EMT's on submarines to assist the one corpsman that's on a submarine. And so in between my duty stations between South Carolina and Virginia I attended Tidewater Community College in Virginia Beach and obtained my EMT certification.
Q: When was that?
A: 1991.
Q: Okay.

A: After that I was sort of bit by the bug, so I took my CPR instructor certification relatively quickly. Joined a volunteer rescue squad in Abingdon, Virginia, which is in Glaucester County, and while I was on sea duty, and as I could I volunteered with Abingdon Rescue Squad and moved up through my cardiac technician with is just a -- there were several levels in Virginia. It's above an EMT, above an advanced EMT. And volunteered for Abingdon until I left Virginia to go to Chicago where I obtained my paramedic certificate in 2001, which is step above. I bridged up to paramedic when I got to Chicago Great Lakes.

Q: Okay. We talked about all the certifications, EMT, paramedic. When did you get your paramedic?

A: My paramedic license was 2001.

Q: Okay. Are you currently certified as ---

A: Yes.

Q: --- a paramedic in this State of South Carolina?

A: Yes, sir.

Q: Okay. What's your position now?

A: I'm the Bureau Chief for the Bureau of EMS and

Trauma at South Carolina DHEC.

Q: Okay. Can you explain your responsibilities as a Bureau Chief?

A: As Bureau Chief I oversee the operations and the personnel at the five direct reports within the agency, but we have 18, soon to be 19 on the Bureau. We handle basically everything that's related to EMS and trauma as well as athletic trainers in South Carolina. So certifications of personnel, agency licenses, ambulance permitting, education program approval, athletic trainer certification and recertificaion, and that's on the EMS side, and the ambulance inspections and all that go with that, as well as any investigations that may come up or complaints. And on the trauma side, it's all time sensitive emergencies, so it's trauma, pediatrics, stroke, stymies which are heart attacks, and sepsis is part of our time sensitive division. And we have a data division as well. It's our third division within EMS.

Q: Okay. Dr. Alier and Richard Naugler are here. What are their roles within the Bureau?

A: Dr. Alier is my division head with the division

of EMS. We've got the division of EMS, the division of trauma and time sensitive emergencies, and the division of date, the date division. He's the head of the EMS division.

Q: Okay. What about Mr. Naugler?

A: Mr. Naugler is an EMS inspector. Inspector three I believe is his level.

Q: Okay. Do you have any, I guess, paramedic or EMT teaching responsibilities?

A: I don't have any responsibilities now. We regulate every education institution. I would have to go to North Carolina, Georgia to teach. But I previously had through paramedic instructor certification. And then all the ancillary course instructorship that go with those, and I still maintain those.

Q: Have you received any kind of awards in the field of EMS?

MR. ROTHSTEIN: Your Honor, I object. I don't think any awards he's received is relevant with anything in the case.

MR. WICEVIC: I'll withdraw.

MR. ROTHSTEIN: He's trying to bolster a witness.

MR. WICEVIC: I'll move on.

Q: Mr. Wronski, we talked about the division of

EMS. Can you explain the general investigation process?

A: The investigation process is ---

Q: Of EMT's. Let's be specific.

A: Of EMT's? Specifically with EMT's? An investigation may result upon the receipt of a complaint. We like to have a written complaint with a name attached to it, but we don't always get those. Our statute regulation is pretty clear that we can act on any kind of information that we get if we feel it's necessary. Once we have that information in hand, we'll assign an investigator to it.

Q: Well let's back -- before you get into that. How do you determine whether or not to investigate some kind of information you receive?

A: It depends what we get. It truly does. Some of the information, it comes in either as a complaint of this paramedic treated me poorly or this agency was, you know -- sometimes they're even about bills. We don't handle things about bills, but up to we'll receive an entire package from an agency that says this happened to us, we investigated it, tell us

what you think. Or, you know, if you think it needs more -- if there's more that needs to be done at the DHEC level. Here's our package that we've completed.

Q: Okay. I mean are you looking for information that might fall afoul of our regulations or statutes?

A: That's what we do, that's what we look for is specifically are misconducts within the regulation and the statute.

Q: Right. I mean, you mentioned the billing of -- -

A: Uh-huh.

Q: I mean, is that something that's within the scope of our ---

A: It is not, and we get those quite frequently. But we just simply tell them that it's between them and the agency.

Q: Okay. So the determination to inves- -- or talk about whether to investigate. What's the investigation process?

A: Our investigation process is to then assign an investigator to the complaint to first check for veracity and if there's any teeth to it based on what we have and then what we can

quickly obtain. So if it's a patient care complaint, we can quickly pull patient care reports in the office. If there's any statements that have been given to us, we can you know, check the statements versus the patient care report. And then we sort of have a little huddle after that and we say, okay this is something we absolutely need to investigate and move forward and take a deep look at, or send a letter back and say we're not going to investigate it. Rarely do we not investigate stuff that comes in.

Q: Okay. Well what does -- there's something mentioned during the cross of Dr. Deschamps, local problems local solutions.

A: Right.

Q: Can you explain what that means?

A: Local problems local solutions is where we may investigate it, but we then determine that what was done at the local level is akin to what we would have done or in many cases it's more than what the agency based on when we look at what violation may have occurred to the active regulation. And we say, okay this was a training issue, that this person didn't have

any ill intent or ill will, just had a training issue or they performed a skill incorrectly and the Department is going to have them do A, B, C, and D to correct that issue, and we feel it's best handled at the local level with a local solution. We wouldn't do that much more or anymore based on the violations that we could see.

Q: Are there any other factors that you look into in making that determination to investigate, or is that generally it?

A: I mean it's generally a group decision. No one person ever really makes a decision on these. But we look at so many different things. We look at, again, whether it was a training issue, whether it was intent, you know?

Q: What do you mean intent?

A: If it was just somebody -- it's a term I don't like to use too often, but if somebody's just being lazy or somebody just forgot, or if there was just, I'm not going to do this. You know, we will occasionally see those that come in, and that's when we definitely determine we usually will bring in an investigation and start the formal interview process and

collecting more data.

Q: Okay. So you determine to initiate the investigation, do the investigation, find that there were violations. What's the enforcement process?

A: If we still feel that there may be violations -- can I back up one second?

Q: Sure.

A: There's one part of the investigation process or the enforcement process that are for emergency suspension orders. Those don't get a ton of investigation. If we get a report from SLED, all of our EMT's and paramedics are fingerprinted, and we get SLED reports for felony arrest that will come in occasionally. And if it's a felony arrest, if it's an arrest for something pertaining to moral turpitude, we will do emergency suspension orders. And it's based on the arrest report, the police report, the charges, and we'll do an emergency suspension if we feel there's a danger to public safety. So there's that side of it too. But then on to the regular investigations. What was your last question. I apologize.

Q: I was just asking if you could explain the

general enforcement process.

A: So once we determine that we may have enough to proceed forward, then we'll bring in who we think are key people we need to talk to. And a lot of times it's just the people that were involved on the call. It could be just the paramedic and the EMT, could be the supervisor if the supervisor witnessed something we might bring the supervisor in. And we bring them in to speak to them, to get their side of the story. Those are all taped. No one's sworn, but we do tape them and we inform everyone ahead of time that we're going to be taping them. And we will provide them to the people if they ask for them.

Q: Okay. And if you still believe that there's a violation after that, then what do you do?

A: If we believe there's a violation after that, then we again, reconvene the EMS Director if there's no direct relationship with him, and the investigator. We may bring in the compliance manager, to discuss so he can refresh us. I don't remember every case we ever had, but he's really good at remembering those kind of things. So he can say, yep we

had something similar to this and this is what we did. And then we'll propose that to the person. A lot of it is based on that interview and a lot is based on what they tell us, you know, where the enforcement goes from there. A vast majority of people that come in that have been alleged to have done something wrong know they've done something wrong. And they say, I did it, I'm sorry, I forgot, I blew this off, I didn't think about it, you know. And they really are remorseful and we take that into consideration as well as can this be corrected with remediation? We don't like to use punishment. We like to rememdiate as much as possible. What role does the State Medical Control Physician play in the investigation and enforcement process?

A: Investigation and enforcement process, we don't role him in to everyone that we do. But if see a potential that there's going to be a serious one, whether we think that there may be some serious action or if I just say, hey I want an outside set of eyes to look at this to see if I'm on the right track, I'll say, hey Doc can you take a look at this file or can you look at

this investigation, and it can be early on or it can be later just depending on as we gather more information because many times during an investigation, we'll think one thing and something will pop up and we'll see something else.

Q: What's the Investigative Review Committee?

A: The Investigative Review Committee is set in our statute. When we feel the need that we may need to suspend or revoke a license and we can't obtain that sort of consent order with the party, we have to convene the Investigative Review Committee to review our investigation and make a determination for us. Not for us but to make a recommendation for us based on what we provided to them and the questions they ask. The parties don't have to be there, but we always invite them if they want to come. And they may -- you know, we've had three or four different people come into an IRC for one case, not for -- we've only had two IRC's actually in the last three and a half years. But it consists of the State Med. Control Physician, one representative from the Regional EMS Council from the non-affected regions we

say. So whatever region it was, this incident was in the Upstate region, so it was Pee Dee, Midlands, and Low Country, one paramedic at large which can be anyone. We like to pick somebody with a lot of experience. And if it's a medical, we'll pick somebody with really good medical experience. If it's a trauma, we try to get someone with trauma experience. And then one other physician who is a Medical Control Physician and a practicing emergency room physician. The statute is very specific that they have to be both. There's not a lot of those but we don't have a lot of IRC's.

Q: Okay. Moving onto this particular incident, the James Davenport matter. How did we become aware of this matter?

A: The Department became aware that there was a review that was taking place by Anderson County and or Iva. I'm not sure if I was initially rolled into the review. We received it from the Director of Anderson County. And it was -- when it initially came into the office I was not aware of it. My division directors often times get these reviews or complaints and I do rely on them to make good decisions, and I

trust them implicitly to make good decisions as to, you know, whether we need to ramp one up or not. And this came in as a review I believe. I can't testify exactly the thought process of what came in, but it came in as a review on several calls with some recommended action. So one of these local solutions for local problems. That's how it came in.

Q: Okay. Who received it?

A: I believe Dr. Alier did.

Q: Okay. And what was the Department's response. At that point was there an investigation?

A: There was not an investigation that had opened at that time.

Q: Okay. Is there a reason for that?

A: Based on their review and our review of the EPCR's. It looked like there was a paramedic who was needed some remediation on protocols and needed some remediation on, you know, what maybe best practices were. And they were going to handle it at their level.

Q: Okay. Now the Department did open an investigation into this?

A: Yes we did.

Q: When was that?

A: The official investigation, I would have to look at the notes to tell you the date. I apologize. But the official -- it was the date of the day after we received the video tape.
Q: Okay.
A: Or video recording.
Q: Okay. So who was assigned to this particular investigation?
A: Richard Naugler was assigned as the lead investigator on this one.
Q: Okay. And so what ---
A: I have an Upstate inspector but she had some ties to that area, so that, because it's such a small community, that will occasionally happen. And we won't assign an investigator to something that they may or may not have some ties to.
Q: You said a small community. Could you explain that? What do you mean by a small community?
A: South Carolina EMS? As we've seen in the courtroom in the last few days, everybody knows everyone. And I know a lot of people across the State by face but not intimately familiar with. Everyone in this community has worked with somebody who's worked with somebody that

knows somebody. It's not a -- people will jump agencies in South Carolina. Some people will stay in one place for 30 years, and some people will work 30 places in 30 years.

Q: So when is a recusal amongst DHEC investigations?

A: If there's a direct relationship between the Department or the agency that we're looking at or with a particular person who has a direct relationship with someone who's being accused of doing some misconduct.

Q: Okay. So what did the Department's investigation into this matter consist of?

A: The investigation cons- ...

Q: What did the Department do as part of it's investigating?

A: Okay. Part of the investigation -- obviously the investigation was open based on the video tape.

Q: Right.

A: After we received the video tape. Dr. Alier received it one night. I saw it the next morning, and that's the day we opened the investigation. That began the investigation. Within the video tape it appeared that we had

some pretty serious violations of the active regulation. Dr. Deschamps couldn't remember yesterday when he saw the video, and I for the life of me couldn't remember at what point he saw it. But it was near the time that we then brought in Mr. Davenport for an interview. So the next step on that was to collect PCR's, I believe we got the Emergency Room report, I'm not positive when we got the OR report. We had the video tape, we had statements from Ms. Aiken I believe, a statement from Ms. Aiken, and a chart review that was included with the initial package. And that's when we brought Mr. Davenport in.

Q: Let me hand you the DHEC proposed Exhibits. Or you have a copy up there?

A: There's one up here, yeah.

Q: Perfect. See if we can identify the documents.

A: There's a copy of our reg. and act I here too.

Q: All right. Is the patient care report that you reviewed as part of this investigation in this exhibit packet? There's a table of contents.

A: I would have to verify the date. There's a bunch of PCR's in here.

Q: What was the date of the incident that prompted the Department's ---
A: The 19th.
Q: Okay. So which exhibit would that be?
A: That would be Exhibit 11b.
Q: Okay. What other documents or files do you see in this exhibit packet that you reviewed as part of your investigation?
A: Ms. Aiken's statement, the AnMed Operating Room.
Q: So wait.
A: Sorry.
Q: Ms. Aiken's statement, Exhibit 4?
A: Exhibit 4, yes. I'm sorry.
Q: Okay.
A: So I'll start at the top. Exhibit 1, Anderson County protocols, the body cam footage, eventually the AnMed OD department, the radio call, the audio file that's there, Ms. Aiken's statement. And I want to apologize. I was limiting to what we started our investigation with. But we have reviewed all these as part of the entire investigation. So I'll keep going down.
Q: And I'm really talking about before the

issuance of this.

A: Before the issuance of anything we reviewed all of these exhibits that are in here actually. Just let me -- before I commit to that let me .... Until very recently I had not seen Exhibit 14. But the rest of those, we have seen and received as part of the investigation. Yes, sir.

Q: All right. So you get all the documentation, then you brought Mr. Davenport in for an interview?

A: Yes.

Q: I want to be clear, we didn't have all of these exhibits that are here prior to bringing Mr. Davenport in.

Q: Okay.

A: But we wanted to get his side of the story. We do. So we -- like I said, that's a key, when we bring somebody in, is there recognition that something was potentially done wrong, we want to hear their side of it. There's always another side to a story. And so we wanted to make sure that we brought him in to have his side of it.

Q: Okay.

A: We had Ms. Aiken's statement, so we didn't want to bring her in. And to be quite honest, the reason we didn't bring her in for an official interview with us is watching the video tape and holding her statement, they run pretty concurrently. The run pretty accurately together as to what happened on scene. So her statement stood for us.

Q: Okay. Did you record the interview with Mr. Davenport?

A: We did.

Q: Who was present during that interview?

A: Myself, Richard Naugler, Bently White who was our Communications and Policy Director at DHEC. Mr. Rich Wiznuski, who is our Trauma Director. He's my Trauma Director and this was a trauma call so I wanted him in there on the initial interview, myself, and I cannot tell you if Mr. Nix was in there. I don't believe he was.

Q: Okay.

A: We go around the room on the recording and identify everybody who's in the room.

Q: How do you ---

A: And Mr. Davenport. I'm sorry.

Q: I'm sorry. How do you record the interview?

A: We have two digital audio recorders. We record on one of the digital audio recorders.
Q: Okay.
A: We mark the time, we mark the date, we say who's in the room, and then at the end we mark the time and the date and say if anybody has left or come or gone.
Q: Okay. And where is that recording stored?
A: It's stored on a secure drive at DHEC on a t-drive in our investigations file. Each investigation has a number assigned to it, and it's stored within that file.
Q: Okay. Who has access to that file?
A: Mr. Nix, myself, Mr. Alier, and the investigator that's assigned to it. Sorry. They have to be able to put stuff in to that investigation file.
Q: I don't want to play the whole audio recording, but let me play the file. See if you can identify it. Hopefully we won't have any technical difficulties. And this is Exhibit 9 of the DHEC proposed exhibits.

(Audio Played)

Q: Can you identify that voice?
A: That's Mr. Naugler.

Q: Okay.

(Audio Played)

A: That's myself and I'm marking the time.

(Audio Played)

Q: Is that the beginning of the audio file?

A: That's the beginning. I verify via photo ID and the credentialing information system profile to make sure we have the right person. We don't know everybody, so ...

MR. WICEVIC: All right, Your Honor. The Department would like to admit DHEC's Exhibit 9 the audio file DHEC interview with Mr. Davenport into evidence.

MR. ROTHSTEIN: Your Honor, I think if this is going to be admitted into evidence, the whole video needs to be played rather than little snip-its. I think it's misleading to cherry pick certain statement that are made in the audio without having entire context. So he's going to try and introduce parts of it, I think the whole thing needs to be played.

MR. WICEVIC: Well I was just going to insert it into evidence. I wasn't even going to play clip-its of the audio recording. I was just admitting it into the record for The Court's

consideration.

THE COURT: Just the entire audio?

MR. WICEVIC: Yes, Your Honor. And it's two hours long, and there's a lot of discussion. I don't think it's ...

THE COURT: It's admitted.

(Petitioner's Exhibit Number 9 was admitted into evidence.)

MR. WICEVIC: Thank you, Your Honor.

THE COURT: And, Mr. Rothstein I'm sure that 2 hours long, you have no objections to them not playing the entire thing.

MR. ROTHSTEIN: I have not. As long as it's in evidence we're fine.

Q: Okay. Mr. Wronski, can you explain -- let me ask, do you have strategies going in to an interview?

A: We have strategies that we employ going in. We don't claim to know everything that's going on, but we do like to have the what we think are the answers to several of the questions that we're going to ask, so that when we ask those questions we then will filter in some other questions that we maybe don't have all the answers to. And then we can sort of in our

heads check the what we think might be the truthfulness of those statements. If they're answering truthfully to five, and then number six we don't know. Then we'll probably assume that number six is truthful as well.

Q: Okay.

A: So that's a strategy we go in. I mean there's just several different strategies. Sometimes there's no strategy to it. It's that we have this complaint and we want to hear their side of the story. We just want to know what happened and what's going on.

Q: Okay. I mean what's the ultimate objective of your interview?

A: Ultimate objective of the interview is to try to get answers to our questions, find out how the person feels about whatever allegations have been brought forth by whomever. If they're readily admitting during this interview that, you know, what they did is true and it's on there, then we'll try to talk them through it and see what their mind set was and see why they did what they did, and have them explain it to us, so we can -- you know, we don't like to bring people in two and three times to do

these kinds of things. Try to get them all hammered out as much as possible. And so our, I guess, to shortly answer your question, is to get as much of the truth as we can, and to get as much of a picture from that person who was involved, that person was directly there.

Q: Okay. Well what did you learn as a result of this interview?

A: We had three patient care reports that had come in this initial complaint, I'm sorry, the initial review, and that we used for the investigation. And so we walked through the first two of those. We wanted to get a feel for patient care, patient treatment, thinking, how he felt about the protocols, how he made determinations with different patients, how he went through things in his mind, whether he was good with the protocols, didn't like the protocols, didn't know the protocols in some cases. Not saying he did or didn't. We just like to -- we walked him through those first two calls before we got to the one that we were really concerned about.

Q: Okay.

A: There were concerns with the other calls,

obviously. The Department sent them down. But upon our review of those, there were really good explanations for some of the things he did.

Q: Okay. Well with the March 19th call.

A: Uh-huh.

Q: What was your finding with regard to that?

A: We walked him through that call first before we showed the video tape. Asked him some questions about it. He gave us answers to those questions. And then I informed him that when we do these investigations we collect as much evidence as we can, and in this case we had a video tape, and I wanted to then show him the video tape. And that's when we started the video.

Q: And then what transpired?

A: Attitudes changed a little bit. I will admit mine changed a little bit. When we started the video, right when we started it, Mr. Davenport chuckled and said, yeah this is where I call him an idiot. And I said, Mr. Davenport you're the only one in here laughing right now. And it went from there. So it became slightly more adversarial at that point, after the video was

over and started to ask more poignant questions regarding what he had told us prior to that.

Q: What were the other components of the investigation?

A: The entire investigation?

Q: Yes, sir.

A: Most of these exhibits that are in here.

Q: Okay.

A: And I want to just correct that just so that I don't go offline. Some of these, Dr. Deschamps's CV, Dr. Kickham's CV, this email that's down here, the Med. Control agreement. Those weren't considered in our investigation. Those are exhibits that are here for The Court. So the majority of the things that are from Exhibit 8 up, 9 up actually and then the other calls that are there.

Q: Okay.

A: So some of those things weren't involved in our investigation but the majority of the top ones were. Yes, sir. The chart review, the DVD, the standards of care.

Q: Okay. Well you said you had medical records, is that correct?

A: Yes, sir.

Q: Okay. Let's turn to Exhibit 6. Can you identify this?
A: This is the AnMed emergency department physician record.
Q: Okay.
A: It's been redacted, but I recognize the address.
Q: How'd you obtain this?
A: I believe we asked for it first from the -- Mr. Wiznuski I think got it for us. And then we also then obtained it through subpoena I think.
Q: Okay.
MR. ROTHSTEIN: I'm sorry. Did I miss when? Did you ask him when he requested it?
MR. WICEVIC: I asked him how. The Department would like to admit Exhibit 6 into evidence.
MR. ROTHSTEIN: Your Honor, I object to this document on several grounds. For one they don't have a foundation for this document. Number two, the document's hearsay. Number three the document contains hearsay within hearsay. Number four this is not part of their investigation contrary to what Mr. Wronski just testified about. This document was obtained by a subpoena I believe in June of sometime. If

I'm not mistaking, in June of this year, probably less than two months ago.

MR. WICEVIC: And, Your Honor, I have an affidavit of the records custodian. If there's particular -- may I approach the bench?

THE COURT: Yes.

MR. WICEVIC: So we have an affidavit with the records custodian. I believe this is a business record. It contains -- if you look at rule 803, memorandum, report, record, or data compilation, or any form of acts, events, conditions, or diagnoses made at or near the time by or from information transmitted by person with knowledge kept in the normal course of business. I submit to you this was made by various persons within the emergency department. They regularly make these records. They're made by individuals with knowledge of these observations these conditions, diagnoses. If there's particular statement's within here that are hearsay, for example I believe there's something to the fact that the patient stated that -- there's a statement within the records saying the patient stated he's feeling pain or something along that line. I think that would

be hearsay within hearsay. However I think that would be satisfied by the statements made for purposes of medical diagnoses or treatment. So I think -- I mean, if there's a particular statement within here that Mr. Rothstein objects to we can talk about it, but I think, from my review, it looks like this is a business record. I think it's accepted. I did some case law research and it appears, you now, across the country, medical records are accepted as business records.

THE COURT: I accept it and I am admitting it.

(Petitioner's Exhibit Number 6 was admitted into evidence.)

MR. WICEVIC: Okay. Thank you, Your Honor.

Q: Mr. Wronski?

A: Yes, sir.

Q: Exhibit 7, can you identify that?

A: This is a procedure notes from a surgeon that performed the surgery on our patient with the abdominal stab wound.

Q: Okay.

MR. WICEVIC: Your Honor, the Department would like to admit Exhibit 7 as well for the same reasons.

MR. ROTHSTEIN: Same objections, Your Honor.

THE COURT: Okay. It's admitted.

(Petitioner's Exhibit Number 7 was admitted into evidence.)

MR. WICEVIC: Thank you, Your Honor.

Q: Mr. Wronski, can you explain why medical records are relevant to your investigation?

A: The medical records are relevant to our investigation and there's a degree of relevancy.

Q: Okay.

A: So the direct patient care report has a high degree of relevancy to what decisions we may make or to what directions we go. And other records may have less relevancy, but we like to refer to them just to see what happened after. See what kind of patient outcomes we had, and maybe occasionally there will be some notes within the notes of the medical records that say what happened. Because a paramedic will turn over a patient in the Emergency Room and they'll say, I said this. Then the nurse will say, well no they said this. And those notes will sometimes end up in that part of the record of the Emergency Room. So we like to

collect the other ancillary records as well.
Q: Okay. Any other components in your investigations that we didn't discuss? If you think of something ---
A: If I think of something I'll come back to it. I can't think of right off the top of my head. I was in the patient care records, so I'll have to clear my ...
Q: Sure. Did you seek any kind of advice for disciplinary recommendations from Dr. Deschamps for this matter?
A: Not directly from Dr. Deschamps, but from the Investigative Review Committee.
Q: Okay. So when do you convene the Investigative Review Committee?
A: As I said before, whenever we're considering taking someone's license, which we do not take lightly, we will try to reach that via consent order. And if we can't obtain an consent order with the party, then by law we have to convene the IRC if we're going to do an administrative order ---
Q: Okay.
A: --- to see if they agree.
Q: Do you recall about when you convened the IRC

for this matter?

A: There were two dates and I apologize. We attempted to convene it once and we delayed it at the request of some of the parties. And I believe it was a month after that. If I could refer to my notes I could tell you the exact date, but it was about a month after that that we convened it.

Q: Okay.

A: I apologize.

Q: Can you explain the basic procedure for these IRC meetings?

A: The procedures, I got none handed to me when I took the job at DHEC. So our first one we worked our way through. We had a really good investigation. We gave it to the IRC, and we learned from that one for our next one. So for this one we notified the regions to send us a representative on a particular day for an IRC via email. I also approached Dr. Clanton who I now because he attends Medical Control Physician Meetings and I don't have any direct relationship with him. And plus he was in, I believe he was in the Pee Dee region. And then my paramedic at large, I obtained a Training

Officer from Colleton County Fire and Rescue, but at the last minute he had to have surgery, so his Fire Chief, who was also a paramedic for 25 or 30 years in Colleton County attended as the paramedic at large.

Q: Okay. So you convened the meeting.

A: So we convened the meeting. I explained to them -- and Mr. Rothstein has said during the course that I referred to it as a Grand Jury. I watch too much television probably. But I saw it as us providing evidence to a body to make a determination as to whether there were violations or not and then to make a recommendation to us. That's not what a Grand Jury does turns out. But those are the words I used. And so I don't run the meeting. I sort of keep it on track. I don't chair it. Dr. Deschamps is the chair of the meeting. But I told them why they were there. We gave them what we had so far as far as evidence. We told them that Mr. Davenport and his attorney were here. They wanted to question them because they don't have to. It's up to them what they do, and it's up to them what evidence they accept in or don't accept or look at. And I

mentioned that several times. And then I was there for parts of it, but I wasn't there for every part. Especially during deliberations there was no one from DHEC in the room that I can recall. I wasn't there. I don't know Dr. Alier and Richard Naugler weren't in there. We had come out. I also let them know that Mr. Stoller was available by phone if they needed him. He wasn't able to attend. But if they wanted to speak to him, excuse me, they could speak to him.

Q: Okay.

A: And so I just sort of keep it on track. And if they need somebody to run and get something, that's us. We run and get them, whatever they need. And then at the end of the day, we did a transcriptionist, is that the right term? Court reporter, I'm sorry, we had a court reporter, then they transcribed it. But we had a court reporter there as well. We learned from the first one after having to transcribe that one ourselves, that we wanted a court reporter for the next one. So we had to obtain a court reporter as well. We didn't swear anyone it, but we did have a court reporter in

the room.

Q: Who presented on behalf of DHEC?

A: Richard Naugler presented the investigations since he was the lead on it.

Q: Okay. Was Mr. Davenport allowed to present?

A: After we presented to the Investigative Review Committee, I don't know if they took some time to talk first and then brought Mr. Davenport up, or if they brought Mr. Davenport right up. I cannot remember the exact how much time elapsed in there. But yes, Mr. Davenport and Mr. Rothstein came up to the IRC.

Q: Okay. Well what were the recommendations at the IRC?

A: The recommendations that came out of the IRC were a -- there were two. A one year suspension of Mr. Davenport's paramedic certificate along with they recommended an evaluation for different things, anger management, basically, I hate to use the word, but a psychiatric evaluation. It's just to see if there was something in there that was preventing him from providing good patient care.

Q: Okay.

A: He also had to maintain his other courses throughout this suspension. His advanced cardiac life support CPR, and they recommend we do that a lot in our orders, so that when somebody does come off suspension that they're ready to, you know, come off the suspension, get their license back, and we can reissue it if they fulfilled all the consent orders and administrative orders.

Q: Okay.

A: All the conditions within it.

Q: Were there other recommendations?

A: The second recommendation was if Mr. Davenport did not agree to that consent order, for a four year revokation, or a revokation which in this case would have been four years. We could at the time revoke up to -- a revokation for an EMS license is strange in the statute to me. When I think revoke I think revoke. But revoke at the time meant up to the period of certification. So in Mr. Davenport's case he had recently recertified I think. It would have been about four year revokation of his license. I asked the IRC while I was in there if there was any negotiation, that they would,

and they said there was a little with the suspension. I think that's maybe when Dr. Clanton piped up and said if there was treatment that was recommended beyond a year, as long as he was still going to that treatment you could give him his license back, but not keep it if he was in some sort of a treatment program for whatever. But there was no real negotiation. It was recommended by the IRC to us, to the Department.

Q: Did you adopt those recommendations?

A: We did. We did. I've several advisory councils that advise the Department. And the IRC is one of these that we consider. And when they give us recommendations we consider them very strongly. And so we did adopt both of those recommendations. Well we adopted the first one first. And it was rejected. And then we adopted the second.

Q: And here we are.

A: Yes, sir.

Q: There was some discussion about, on somebody's cross, about DHEC not offering mental health treatment, or not being understanding of that. Do we? Does DHEC do anything as far as mental

health treatment?

A: A couple years ago at the annual EMS bike ride that we have across the State, I was asked to speak. And that bike ride is I memory of people that have passed that are involved in EMS. Some people die in line of duty. Very few die in the line of duty, but some do. Some just pass from cancer, and unfortunately many commit suicide. I acknowledged that in that speech and I made a commitment to everyone that was there that we were going to do what we could. We're a regulatory body. There's not a lot we can do where we get involved, but I said we would do what we could do. And one of my inspectors Ms. Kristen McConnell who's in the Upstate is a huge proponent of the project that Mr. Rothstein brought up yesterday. She is a member of that organization. She has a masters in psychology.

Q: I'm sorry. What organization?

A: Is it Project Green?

MR. ROTHSTEIN: Green Code.

A: Green Code, Code Green. I'm sorry. Code Green project that focuses on first responders, not mental health, but first responders, the way

they deal with things. And so I asked her what we could do to start getting involved. She came back to me and told me, so she is now a participating member of the FAST team, which is when there's a critical incident across the State, the FAST team will deploy immediately to these agencies where recently, not recently, but a while ago we had an accident in Florence where an EMT, a paramedic had her leg amputated in an accident. Whenever in Beaufort County she had to leave her recent conference because she had to go lead a team to Beaufort County when an ambulance struck a person who was laying in the middle of the road in the middle of the night. So we go down, we sent a team out immediately. We combine with the firefighters assistance team to do that. The biggest project that we've taken on so far for responder mental health, which I think is amazing, is that we partnered with the South Carolina Firefighter's Association, SLED also got part of the grant, but our partner in this was the South Carolina Firefighters Association where if a person, whether they've gone to a critical incident stress debriefing or not,

usually this is where they come out of the critical incident stress debriefing, and they'll recommend that you go talk to someone else. If they do have to seek the help of a mental health professional, they can use their insurance if they have it. Whatever out of pocket expenses they have, this program picks up. We have a grant that pays for insurance for $15,000.00 per person per incident to pick up their cost. And if they don't have insurance it'll pick up their cost up to $15,000.00 per person per incident. So if you have two bad incidents in a year, this program this insurance will pick up $30,000.00 of that. So we are very concerned about the mental health of our professionals because too many people commit suicide.

Q: Okay. Moving on to this particular enforcement. What was the Department's decision in this matter?

A: Our final decision?

Q: Yes.

A: Our final decision was to issue an administrative order to revoke Mr. Davenport's license.

Q: Okay. And the grounds for that beginning with the disregarding an appropriate order by a physician concerning emergency medical treatment?

A: Yes, sir.

Q: Can you explain to The Court the difference between protocols and orders?

A: We've been over this quite a few times. But the difference between a protocol and an order is a protocol is -- it goes by man names in cases. It could be a protocol, it could be a guideline, it could be many different things. But a protocol is what will lead you down the path of treatment for a patient. And then within the protocols there are standing orders that must be followed for the treatment of a patient. And in some cases the full protocol is the standing order.

Q: Okay. All right. Well what is the Department's determination with regards to Mr. Davenport's compliance with the orders of Anderson County?

A: We did determine that he did violate and disregard specific orders that were given to him by Dr. Kickham in this case.

Q: Okay. Well you have Anderson County, Exhibit 1. Can you explain to The Court the violations by Mr. Davenport?

MR. ROTHSTEIN: Your Honor, this is getting kind of cumulative. He's had at least four witnesses do the exact same thing, and I'm sure he's going to do the same thing with -- and that's why we're here on the fourth day of the case.

MR. WICEVIC: Your Honor, does The Court need any additional explanation about the Department's position on compliance with these various orders?

THE COURT: You can get into testimony, but just let him very briefly explain how they -- because he is in their compliance department, how the Department viewed it.

MR. WICEVIC: Right. And that's ...

Q: Can you follow that directive?

A: If I may, I have been here through the trial, and there have been discussions about whether the intravenous access protocol was followed. We believe the protocol was not followed because it was not used, and there are orders within that protocol.

Q: Okay. And what's ---

A: I'm sorry, that's protocol number, it's page 6. Obviously the general protocols that we've discussed as well.
Q: Well can you be more specific? Mr. Wronski, can you be a little bit more specific?
A: Can you refer me to those Bates pages real quick for those particular protocols, so I can ---
Q: Tell you what, there's a table of contents.
A: Sure.
Q: Page 3.
A: Right. So GP-18 has been mentioned. That is one that definitely has violations within it. GP-16 also with the patient safety protocol. We've discussed the walking of the patient and not using proper carrying devices I believe are located within that one.
Q: What was the failure for GP-18?
A: GP-18 is the universal patient care. Can I refer to that real quick?
Q: Yeah. And that's page 15, Bates page 15.
A: So, under the EMT paramedic management, the orders in this case for this protocol, bring all equipment to the patient's side. He brought what he thought he was going to need

short of a carrying device. And that happens all too frequently where somebody will get caught not having a proper carrying device, but that's not the major concern in this one. The major concern in this one is the, demonstrate professionalism and courtesy. And Mr. Davenport I believe has stated to us that he did check the temperature measurement of the patient by feeling his skin. So that wouldn't be a violation. But the main one in this one is the adult assessment procedure. A complete adult assessment was not completed, and the Department felt also he did not demonstrate any professionalism or courtesy towards this patient or on the scene itself with other responders.

Q: Okay. Any other referring back to the table of contents?

A: My apologies. We could get into the trauma at that point.

Q: Okay.

A: The T-1.

Q: Sure. And that is on Bates page 42. Begins on page 42.

A: Okay.

Q: Okay. What were the bases for violating this protocol or these protocols?
A: As has also been discussed, the Department also felt this was a critical trauma, and the scene time wasn't horrible, so they did okay with the scene time. And they did notify the hospital, and then you get down to all IV lines will be established en route, and there were no IV's that were established on this patient.
Q: You finished with T-1?
A: We've talked about oxygen, but I think oxygen's more applicable when we get to the actual protocol for treatment of the patient.
Q: Okay. Well let's go onto T-2 and T-3.
A: So T-2 is the trauma transport protocol. This trauma transport protocol defines what your traumatic injuries are that you need to consider with trauma transport guidelines. This patient throughout the transport appeared to remain hemodynamically stable, but we did have a penetrating abdominal injury. So this was a traumatic injury that should be considered for the trauma transport protocol. The patient taken to a level two trauma center. T-3, we get over to T-3, and I think this is

the one we had the biggest problem with is that ---

Q: Well first, why was that applicable?

A: Multiple system trauma or shock, again as we've discussed or has been discussed, the patient had the potential and that is the key in emergency medicine is to do everything you can for the patient without overtreating them, to not allow bad things to happen to them while you're taking care of them. So anything you can do for the patient, what the patient needs or may need is important. Recognizing what might happen is key. We don't take that ability away from them. We say plan for the worst that could happen.

Q: So how was T-3 violated?

A: So T-3, this was or could have potentially been a multiple system trauma. It affected the largest system in the body to start with. It absolutely affected the integumentary system. But then there were several systems beneath where the wound occurred that could have been affected as well. So it would have fallen to the multiple trauma or multiple system trauma, multiple trauma shock protocol. And the

patient obviously at any time had the potential to go into hypovolemic shock.

Q: Okay. Well what did that order? What does T-3 order?

A: T-3 orders the paramedic to initiate airway management, spinal immobilization, or use a rapid extrication technique, which is mostly for somebody who's trapped somewhere, in a vehicle or a building, a piece of machinery. Control the bleeding which was done. Tension pneumothorax for plural decompression protocol. I believe that during Mr. Davenport's depositions and statements, he related that he saw equal rise and fall of the chest. He did not listen to lung sounds, which is the best way to rule out a tension or a pneumothorax is to listen to lung sounds. Any signs that you might see indicating a tension pneumothorax are very late signs that you're going to see, so it's important to listen to lungs early and get a baseline lung sound baseline vital signs. They did load and go the patient, all be it I believe improperly. And then a cardiac monitor was not initiated. There were not fractures to splint. And then, of course, as we get to the

bottom, the main contention is that this patient needed at least one intravenous lifeline started.

Q: Okay. So of the various orders you read. Which ones did he violate?

A: I believe the oxygen that the patient could have gotten would be in the airway management -- it starts at the worst and goes down. If the patient doesn't have an airway you need to establish an airway. And then if they do have an airway but require oxygen or may need oxygen, you can place it. We did not, I believe, include the spinal immobilization as a violation, but we did include the cardiac monitor because that is a tool that you absolutely should have if there's not blood all over the patient preventing you from attaching the cardiac monitor, that's just another tool you have in the toolbox. Maybe you're typing on your keyboard and that's what you're listening to. You can hear that beep and you can immediately look up and see if there's anything going on with the patient's rhythm as well as finally the IV lifelines.

Q: Okay. You mentioned the airway management

protocol. Turn back to page 6.

A: Yes, sir.

Q: Excuse me, page 5. Would this protocol, GP-1 be applicable and if so, could you explain why?

A: So the adult airway protocol tells us at the top the respiratory rate -- I'm sorry. It starts with the pulse oximetry and mild distress and moderate distress definitions. Works down to whether there's an airway obstruction, you would eliminate whatever the obstruction was first, and then use forceps and get an airway if you need one. Or if you can't recover the airway by removing the object and then it goes into oxygen administration. Sorry.

Q: Okay. And would oxygen administration be applicable this particular call?

A: In this particular call, per the protocol, per the standing order it is. It is. Despite the arguments of the pulse oximetry, which I understand, and the conversation back and forth whether oxygen can relieve pain, there are pain relieving qualities to oxygen. Ask any person who has ever had a heart attack. And so in this case this was a severe trauma based on the

penetrating abdominal wound, and the patient should have been placed under a non-rebreather mask.

Q: Okay. Mr. Wronski, turn back to the table contents. Any other protocols, orders that would be applicable? If not we can move on.

A: Yeah, I'm trying not to take too much time. I'm going to go ahead and say no at this time.

Q: Okay. Next misconduct that was alleged after initiating care of a patient at the scene of an accident or illness, EMT discontinued such care or abandoned the patient without the patient's consent. Not providing for administration of care by the equal or higher medical authority. Mr. Wronski, can you explain the distinction between a discontinuation of care, and abandonment?

A: Sure, there are distinctions there. An abandonment would be coming to a vehicle accident, or someone's home, maybe evaluating them and then either talking them out of being transported to the hospital, which happens occasionally, or just doing a cursory evaluation and then leaving and abandoning the patient without taking them to the hospital and

leaving them in a higher level of care. So that would be abandonment.

Q: What about discontinuation?

A: Discontinuation of care is what we find to be applicable in this case. Applicable in this case, to where Mr. Davenport did initiate care of the patient. He took the patient to the ambulance, and then turned the patient over to an EMT basic, which is a lower level of care, not a higher level of care. And being in the front of the ambulance, we did consider it to be discontinuation of care, because he has no visualization of that patient, he can not access the patient. And able to treat that patient, he would have to find someplace to stop, pull over, get out of the truck safely, get back in the back of the ambulance, and then begin care, and get another initial picture of this patient from the beginning, starting with an assessment to figure out what's going on. And that's a discontinuation of care, because you're starting all over from scratch.

Q: Did Mr. Davenport obtain the patient's consent for the discontinuation?

A: No.

Q: Okay. Next misconduct. By actions, or inactions created the substantial possibility that death or serious physical harm could result. Did the department determine Mr. Davenport's actions and inactions create a substantial possibility of death or serious physical harm?

A: Yes, sir. Both actions and inactions in this case we did, Yes, sir.

Q: Can you explain what the actions and inactions were?

A: The actions, obviously we felt that the standing up of the patient and walking to the ambulance was not only a violation of the standing order, but a violation -- not a violation, but absolutely cause a potential to have that patient injure themselves further. And because of where the wound was, and because the knife was still in there, had the potential to cause death or serious bodily harm, Yes, sir.

Q: Any other actions or inactions part of this call?

A: The secondary one to that is when the patient was placed on the stretcher, not only being in

the position of comfort of sitting up, which another responder on the scene suggested at first, but then the decision was made by Mr. Davenport to then sit the patient down again in the sitting position, and then lay him flat and move him via his belt again. So that is a another potential where the patient was compressed and then extended again, that could have caused the movement of the organs within there to hit the knife.

Q: Just for clarification, what about the oxygen? Is that something that served as a basis for a substantial possibility of serious physical harm or death?

A: No.

Q: IV's?

A: Yes.

Q: Please explain that.

A: The IV's, I mean we call them intravenous lifelines for a reason. We don't have blood transfusion on the field in South Carolina, unless you're with an aeromedical helicopter operation, but some volume can be replaced in patients with an IV, and in order to replace that volume if there is a rupture of the

spleen, or the laceration of the liver, even the aorta in this case has been mentioned, where you can start to get some volume back in that patient to keep volume in the system. And so yes, an IV as a lifeline, without establishing that had the patient decompensated, it could have caused death or serious bodily harm. And if not death, you know without oxygen to the brain could have caused, you know, damage to the kidney, the brain, whatever didn't get oxygen for enough time.

Q: Okay. Anything else regarding that misconduct? Substantial possibility of physical harm or death?

A: No. Other than not being in the back of the transport, but that's more of the discontinuing care.

Q: Okay. Now there's also an allegation about the failure to provide to patients acceptable emergency medical treatment. Can explain the basis for that?

A: Yes, sir. The acceptable medical treatment, and I have gone over and over again what acceptable medical treatment is, and had this patient just

not been placed on oxygen, we probably wouldn't be here, but the acceptable medical treatment for this patient is to start with a known psycho-social history, a known epileptic patient, and a known schizophrenic is to not approach them like Mr. Davenport approached him in the beginning of the encounter with the patient. It's to calm, it's to reassure, and it's to gain that patients trust, because there are some procedures that you may have to do on them, such as start an IV, that could be slightly painful to them, and you need to gain their trust and let them know. This patient has had IV's in the past, so we have to gain that patients trust to be able to start that IV. You cannot begin an encounter the way he did, nor sustain it cursing at the patient. You know, we get slightly upset when people curse in front of a patient, but cursing at a patient is completely unacceptable medical treatment. And of course the walking to ambulance was unacceptable to us. The not placing the patient in a position of comfort was unacceptable, especially when it was suggested. The turning over of the patient to

an EMT who was hesitant to take the call was unacceptable. Telling his partner twice he wasn't going to do anything else for the patient. That's been discussed, but he twice said, I'm not going to do anything else for him, was unacceptable to us. So, the IV was unacceptable, because you have to be prepared for the worst, especially in these situations. This knife was impaled as we've heard people say throughout the trial, it's a rare occasion where you still have a knife stuck in somebody, or an impaled object stuck in somebody that you're taking them to the hospital. Usually it's a stab and run, so it's not that common. So, in an uncommon situation, you need to take more steps to ensure that something's not going to go wrong with the patient.

Q: Is that all you can think of at this point? I know it was a lot.

A: That's it. If I can come up with another one I will.

Q: Okay. Now the regulation has a number of enforcement factors that you must consider, in proceeding with enforcement.

A: Yes, sir.

Q: Let me hand you a reg.

MR. ROTHSTEIN: Your Honor, I believe that enforcement factors that DHEC may have evaluated are irrelevant to this case. The issue is for Your Honor to decide whether there's sufficient grounds for enforcement. If not whether DHEC considered factors.

MR. WICEVIC: And Your Honor I've just explained. Let Mr. Rothstein explain the department's decision to revoke this. If you feel it's unnecessary for him to not discuss that, that's fine by me.

THE COURT: I don't think that's necessary.

MR. WICEVIC: Yes Your Honor.

Q: Mr. Wronski, how does the Department attempt to be objective and even handed in their enforcement?

A: We do -- every single one is treated differently. Whether we have a case of it happened exactly the same way. We treat every single one of them differently and objectively. And we take as many factors into consideration as we possibly can when we make a determination. The intent especially, the remorse if you will, is the patient remorseful.

Maybe there was a bad outcome, or maybe they did the wrong thing and really could have hurt a patient. In many cases the paint is not hurt, but there was a potential that the patient could have seriously been hurt. So, we take into consideration the realization of that fact, and then whether the mechanisms are in place for retraining, to send them to particular courses that might reinforce their either lack of knowledge or their skills. In some cases that we get, patients are injured, and it's because the paramedic or the EMT was just not able to complete the skill. So, if the person can be remediated in some way to reinforce that skill, whether it's time in an Emergency Room, time with their medic control physician, time with another paramedic. Whatever those things are, we consider those as whether they can be remediated or not.

Q: I think that's all the questions I have for you Mr. Wronski. Give me one second.

MR. WICEVIC: Your Honor, before I get Mr. Wronski -- finish my direct, I did want to see if I could admit these affidavits that I submitted up to you as exhibits. Would that be

necessary? I just want them to be part of the records.

THE COURT: What type of affidavit?

MR. WICEVIC: These affidavits. The affidavit for Iva Police Department. I handed it up to you previously when we were discussing the body cam footage.

THE COURT: Okay.

MR. WICEVIC: So, I would like to admit that. I suppose, I think we are on Exhibit 28.

THE COURT: Okay. We can admit that.

(Petitioner's Exhibit Number 28 was admitted into evidence.)

MR. WICEVIC: And then the AnMed Health, which would be Exhibit 29.

THE COURT: That was the medical record?

MR. WICEVIC: Yes, Your Honor.

THE COURT: Okay.

(Petitioner's Exhibit Number 29 was admitted into evidence.)

Q: Mr. Wronski, that's all the questions I have for you. Please answer any questions from Mr. Rothstein.

THE COURT: Okay. We'll admit the affidavits and before Mr. Rothstein gets into his questioning,

what I'm going to do is just adjourn the hearing for ten minutes. We're going to take a ten minute break, so we don't have to interrupt his testimony to do that.

MR. WICEVIC: Thank you, Your Honor.

THE COURT: Thank you all.

(Off the record from 10:27 a.m. until 10:52 a.m.)

THE COURT: The hearing is called back to order. Mr. Rothstein, you may begin with your cross.

MR. ROTHSTEIN: May it please The Court.

MR. WRONSKI - CROSS-EXAMINATION BY MR. ROTHSTEIN:

Q: Mr. Wronski, you've talked a lot about admirable things that you've done with regard to EMS provider wellness. I think we talked about some sort to EMS bike ride and you've got somebody working with grants to provide $15,000.00 a year per patient. Was that ever offered to Mr. Davenport in this matter? The $15,000 grant per year option?

A: I don't think that was in effect when this case started. It's sense been established.

Q: So that's a fairly recent development isn't it? This Code ---

A: The Code Green is not ---

Q: The South Carolina's participation is fairly

recent.
A: It is fairly recent in the last couple of years, Yes, sir.
Q: Now this woman ---
A: And if I could clarify, we don't offer that program. A person has to actually request those funds, because we don't want to know who's asking for the funds or who's asking for the reimbursement. So, we don't offer those coverages to people, we've just tried to inform as many people as often as we can, so they can go through the process to obtain them.
Q: You have one of the Upstate investigators Kristen -- I didn't catch her last name.
A: McConnell
Q: McConnell. How long has she been the Upstate investigator for DHEC?
A: Just about two years.
Q: Okay. And the Upstate includes Anderson County?
A: Yes, sir.
Q: Okay. And you said you think she's a licensed psychologist?
A: Not a license, she's got a masters degree.
Q: A Masters. And explain to me what that Fast F-

A-S-T team is.

A: So the Fast team is, I explained earlier, if there is a critical incident that occurs somewhere around the state, either involving fire, EMS, or police officers, this team will deploy. They're trained in critical incident stress debriefing and there's two to three people on the team, sometimes more depending on how big th incident is. And they will immediately deploy upon a call from either the dispatch center, or the Chief of the department or the agency -- someone in the agency, or even someone in the call personally can request the Fast Team to respond, and they're there within a few hours to help de- -- not distress, but to help with the critical incident.

Q: Okay. And you actually know the high rate of suicide among EMT's and paramedics, right?

A: Yes, sir.

Q: Were you aware that Anderson County lost a paramedic ---

A: I was.

Q: In February of 2016, about a month before this incident happened?

A: Horry County as well, yes, sir.

Q: Were you aware that Mr. Davenport was pretty close friends with that particular paramedic?
A: I was not. I'm sorry.
Q: Now, you also at the start of your testimony, I think Mr. Wicevic was asking about your employment history.
A: Yes, sir.
Q: And you said that you resigned from Mt. Pleasant Fire Department, is that right?
A: Yes, sir. Under not great circumstances.
Q: Okay. You were a Captain in the fire department?
A: Yes, sir.
Q: Okay. You didn't resign from that department, did you?
A: The final determination was a resignation, yes, sir. It was.
Q: You were actually charged with DUI.
MR. WICEVIC: Your Honor, I'm going to object to this. There's no relevance to his truthfulness. I don't know what an arrest for DUI, an arrest at that, it's not a conviction number one. Number two, it's not probative of truthfulness. So I don't think it's allowed to come in under the rules of evidence.

MR. ROTHSTEIN: Your Honor, it is impeachment material. I think I can cross-examine him. He testified that he resigned, and in truth he was terminated from the department under pretty questionable circumstances. The other thing is at the time of the DUI, he was operating a Mt. Pleasant Fire Department QRV. It was the middle of the night on 526, Charleston County. He smashed the car into a disabled motorist on the side of the road. Both people were taken to the hospital. He was charged with DUI, terminated very shortly after that, and ended up pleading guilty to reckless driving of some sort. I wanted to explore that, Your Honor.

THE COURT: I'm going to allow him to question the witness in that matter. But remember now, Mr. Wicevic, we're not a jury.

MR. WICEVIC: Right.

THE COURT: It's just me, and I will determine what consideration, if any, will be given.

MR. WICEVIC: Thank you, Your Honor.

MR. ROTHSTEIN: Can we get the Elmo onscreen please?

Q: Just to make sure your testimony's clear, your testimony today is that you resigned from Mt. Pleasant Fire Department?

A: Your statement that you read from the paper was that I was terminated, and I was. And we negotiated a resignation after that. Yes, sir.
Q: And you understood at some point that you were fired from the department?
A: Yes, sir. I was.
Q: Okay. And in fact in the deposition in the case of Bumgarner versus Robert Wronski, you testified -- the question was, have you ever been fired from a job? Answer, yes ma'am. Right? Ms. Bloodgood was asking you questions, Nancy Bloodgood?
A: Yes, sir.
Q: Okay. Next questions said, from where. And you said, Mt. Pleasant Fire Department. Right?
A: (Nods head.)
Q: And then she says, okay tell me about that. In March 2010 I was charged with DUI and subsequently was released from the Mt. Pleasant Fire Department due to that, right? You recall testifying to that effect in the Bumgarner case?
A: Yes, sir.
Q: Okay. And tell us a little bit about this incident. I understand that you were operating

a Mt. Pleasant Fire Department vehicle, is that right?

A: Yes, sir. I was.

Q: Okay. Was that a, what they call, a quick response vehicle?

A: It was a take home vehicle. Yes, sir.

Q: Did it have lights and sirens on it?

A: It did.

Q: Did it have emergency equipment on it?

A: It did.

Q: Okay. And I understand that the accident occurred on Highway 526 in the North Charleston area.

A: Yes, sir.

Q: Okay. It was about 12:30 in the morning?

A: Yes, sir.

Q: Okay. And you ran the Mt. Pleasant Fire Department vehicle into a Jeep on the side of the road, right?

A: To be accurate, it was in the road. Yes, sir. It was in the middle of the road.

Q: Okay.

A: It was not on the side of the road, it was in the travel lane. Yes, sir. But I did run into it.

Q: And there was an occupant of the Jeep, correct? Waiting for someone to come take ---
A: Yes.
Q: --- the disabled vehicle off the road?
A: Yes, sir.
Q: And you were taken to the hospital, and the gentleman was taken to the hospital?
A: Yes, sir.
Q: Did you suffer any injuries from that crash?
A: Minor injuries. Cuts and scraped.
Q: And the gentleman that you hit suffered any injuries?
A: He was taken to MUCS. I don't know. He was taken to a different hospital.
Q: Did he ever file any kind of legal claim over this crash?
A: Not with me. I'm not sure if he did with Mt. Pleasant or not, sir.
Q: And after you went to the hospital with your minor injuries, you were taken into custody in the police department, the North Charleston Police Department?
A: State Police.
Q: State Police. Did you submit to a breathalyzer?

A: Yes, sir.
Q: Okay. And what was the result of the breathalyzer?
A: Point zero seven.
Q: Had you been drinking that day?
A: Yes, sir.
Q: Okay. And I understand that you eventually pleaded guilty to a lesser charge than DUI, is that right?
A: I did.
Q: And what was the charge that you pleaded guilty to?
A: Reckless.
Q: Reckless driving?
A: Reckless driving. I'm sorry. Yes, sir.
Q: Were you originally charged with felony DUI?
A: No, sir.
Q: Okay. You weren't charged with DUI involving a serious bodily injury?
A: No, sir.
Q: Okay. After your arrest, did you self report to -- I guess you weren't the DHEC Bureau Chief at the time. Did you self report your misconduct to DHEC?
A: I did not. It's not required under the

statutes.

Q: It's not required under the statute?

A: No, sir.

Q: And you believe that you committed misconduct as a paramedic in connection with that crash?

MR. WICEVIC: Your Honor, I'm going to renew my objection. This is going way off the course of the proceeding. Mr. Wronski's conducts not at issue in this matter. I don't see how this gets to credibility. He's not testifying as an expert or anything.

THE COURT: Mr. Rothstein?

MR. ROTHSTEIN: Your Honor, Mr. Wronski repeatedly has said, as EMT's and paramedics we owe the public the duty of trust, and we have to sort of hold ourselves to a standard. He said this repeatedly in the interview we'll play in a little bit. He said that in the IRC Committee meeting. And he's sort of sanctimoniously trying to punish Mr. Davenport for unprofessional and discourteous conduct sufficient to take his license, when Mr. Davenport had three cases, no bad outcomes, and he may have said one or two out of the way comments to a patient. And I think it's

relevant, I think it's germane to the case. Again, Mr. Wronski is trying to sit in judgement of Mr. Davenport but doesn't want the same thing done to him.

MR. WICEVIC: And, Your Honor, I mean, that's his job. He's the Bureau Chief of EMS. He has to make these calls. His action's not in question. It'd be a different matter if DHEC investigated that when it occurred and he was -- even that I don't think would have been relevant. This is making this case a three ring circus. I think we need to focus on the allegations in this matter.

THE COURT: I'm going to allow him to continue his questioning the witness.

MR. WICEVIC: Thank you.

Q: Are you familiar with the definition in the South Carolina EMS statute for misconduct for a certified paramedic or an EMT?

A: I am, but I would rather read it than quote it.

Q: Can you see section 44-61-80 of the South Carolina Code? I'm sorry. It's kind of all over.

A: Yes, sir.

Q: You see that?

A: 44-61-80. That's part of the Code. Yes, sir.
Q: Are you familiar with that section of the Code?
A: That's the licensor section I believe.
Q: Okay. And I think this is important because you keep using the term licensor.
A: I'm sorry. Would you like me to clarify? It's another one of those interchangeable terms. EMT's and paramedics are not licensed. Only LLR licenses. We issue credentials.
Q: Okay.
A: Sorry.
Q: You do issue some licenses, but paramedics and EMT's receive certificates, right?
A: Credential certificates. Yes, sir.
Q: The only licenses you issue would be to somebody like Dr. Kickham, the Medical Control Physician, is that right?
A: No, sir. We only issue licenses to agencies.
Q: Okay.
A: So the agency is licensed.
Q: Okay. I'm sorry. So Dr. Kickham's Anderson County EMS gets the license, right?
A: Yes.
Q: Okay. So when you issue licenses it's to agencies, not to paramedics and EMT's?

A: Correct. Yes, sir.
Q: The other kind of licenses you issue are to paramedic training or educational facilities, is that right?
A: We don't license them. No, sir. We just give them, once they meet the requirements we give them a certificate.
Q: Okay. And they have to have that type of certificate to operate a training facility or training program in South Carlina?
A: Yes, sir. They do.
Q: And that's the same kind of facility that Mr. Dean Douglas, your expert witness, testified about that he currently works for?
A: He's a JHS. Yes, sir. We would license him to teach EMT programs.
Q: He testified yesterday about a ---
A: Certify, I'm sorry.
Q: He testified yesterday about a meeting between you, Phil Head his boss, and himself some time last week around Thursday.
A: Thursday. Yes, sir.
Q: And in that meeting you told Mr. Head, we really need an expert witness for the case coming up next week. The Judge has allowed Mr.

Davenport to have a paramedic expert. We need to have a paramedic expert, right?

A: I don't know if I told Mr. Head or Mr. Douglas. But yes, sir. Mr. Douglas was present.

Q: I got a little side tracked. Let's get back to this ---

A: Sure.

Q: --- statute. So under subsection F of this statute, the Department may take enforcement action, okay, against the holder of a certificate at any time it is determined that the holder no longer meets the prescribed qualifications set forth by the Department or has failed to provide to patient's emergency medical treatment of a quality deems acceptable by the Department or is guilty of misconduct. You see that?

A: Yes, sir.

Q: Okay. So this is the statutory authority for you to take enforcement action against Mr. Davenport, right?

A: Against any paramedic or EMT. Yes, sir.

Q: And it's not disciplinary action, it's enforcement action?

A: It's enforcement. Yes, sir. We don't like to

use that word.
Q: And then there's 17 different subcategories of misconduct. You see that ---
A: Yes, sir.
Q: --- listed in the statute?
A: Yes, sir. There is.
Q: I'm going to ask you to look down to item number ten ---
A: Yes, sir.
Q: --- on this list. I got it highlighted. Item ten says that if a paramedic or EMT can be, I guess have an enforcement action taken for misconduct if they commit and act or omission without mitigating circumstances that contributed to or furthered the injury or illness of a patient under his care, right?
A: Yes, sir.
Q: Okay. Did that section come into play with Mr. Davenport? Did he contribute or further an injury to the stabbing patient?
A: No.
Q: All right. Let's look at number 11. This is really what I was wanting to get at here. 11 provides grounds for misconduct against a paramedic or EMT who is careless, reckless, or

irresponsible in the operation of an emergency vehicle.

A: Yes, sir.

Q: Okay. So when you smashed your Mt. Pleasant Fire Department vehicle into the disabled motorist on Highway 526, you were operating an emergency vehicle, weren't you?

A: I was.

Q: Okay. And you pleaded guilty to reckless driving of that vehicle, right?

A: I did.

Q: Okay. So under the statute, even though you didn't have a DUI or didn't get convicted of DUI, you were guilty of misconduct of the statute, isn't that right?

A: If the Department determined to investigate it. Yes, sir.

Q: Okay. Now when you applied to be the EMS Bureau Chief, what year was that?

A: Three and a half years ago. '13, '14.

Q: On the application for employment, did they ask you for your sort of prior employment history?

A: I believe they did.

Q: Okay. Did they ask you if you've ever been terminated from a job before?

A: I don't remember.
Q: Okay. Do you recall disclosing on that DHEC application that you had been terminated for suspected DUI from Mt. Pleasant Fire Department?
A: I don't remember if I did.
Q: You think that would relevant in assessing whether you'd be qualified to be the Bureau Chief of EMS?
A: If I may? Sir, everyone in the State knew about that accident. There wasn't a single EMT, paramedic or firefighter in this State that did not know I had been arrested for DUI, and there isn't today.
Q: And I appreciate you saying that 'cause there was a big article in the Post and Courier paper about that, right?
A: There's articles on national websites, sir.
Q: I've handed you -- I've not marked this. I don't think I need to put it into evidence since it's a public newspaper article. Do you recognize this article from the Post and Courier on March 21st, 2010?
A: At the risk of sounding like I'm not telling the truth, I was told by my attorney, and I've

taken that advice, never watched a news article on the television, and I've tried never to familiarize myself with these articles. Every once in a while a Google search will come up and I will glance at one, but I'm not familiar with this article. No, sir. I'm familiar with the heading on the article, but I am not familiar with the article, no, sir.

THE COURT: Mr. Rothstein, now I've got to wonder. Where are you headed?

MR. ROTHSTEIN: I've got one more question about this, Your Honor.

THE COURT: Okay.

Q: The public who may have read that, even though you may not have read it, the public read that argument, that certainly holds the paramedic and EMT profession in an unfavorable light, doesn't it?

A: It certainly does.

Q: And Mr. Davenport's interaction with this patient, the stabbing patient that we've seen the video body camera footage, that's not been disclosed to the public, has it?

A: Sir, it has not by my office.

Q: Okay. In fact, under the Iva Police Department

regulations, body camera video footage is not FOIAable, right?

A: I do not now, sir.

Q: How did you get it if you didn't submit a FOIA request?

A: We submitted a request to the Police Chief, and the Police Chief provided it to us.

Q: Okay. So your testimony is the first time you became aware of the body camera footage, and he provided it to DHEC. Is that your testimony?

A: No, sir.

Q: Okay. You got it from Dr. Alier, didn't you?

MR. WRONSKI: May I re-answer?

THE COURT: Yes.

A: The initial recording we got was from Mr. Scott Stoller to Dr. Alier. Once I viewed that, within a day I told the investigator to get an official copy from the Iva Police Department to insure that it wasn't tampered with. That's pretty standard for us when we have video. We don't always have video, but when we do we try to get an official copy rather than one we just get sent to us, sir. So, yes. I apologize. The first copy we got was from Mr. Stoller. What I consider to be our official copy before

we subpoenaed it was from the Police Chief.
Q: You recall whether you subpoenaed it from the Police Chief -- did you say subpoenaed it from the Police Chief or requested it from the Police Chief?
A: We requested it as the Bureau of EMS. And then I believe we've subpoenaed it for purposed of this case since.
Q: I'm going to hand you Respondent's Exhibit 3.
A: Yes, sir.
Q: Do you recognize Respondent's Exhibit 3?
A: These are progress notes that we keep with the investigations.
Q: Okay. That's the log of the investigation that was conducted in Mr. Davenport's case. Isn't that right?
A: Yes, sir. Log notes, however you want to describe them.
Q: All right. And what's the purpose of this document in terms of log notes in the investigation?
A: Just to try to keep track of who's done what and if there's something we meant -- did we do that, we can go back and check and see if we got something we were trying to remember just

to -- it's a tasker if nothing else. And then it just records when have interactions.

Q: Okay. And I'm going to look, the first entry on this document ---

MR. ROTHSTEIN: And, Your Honor, I would go ahead and move this into evidence at this time.

MR. WICEVIC: No objection.

THE COURT: It's admitted.

(Respondent's Exhibit Number 3 was admitted into evidence.)

Q: The first entry on this document is Respondent's Exhibit 3, is dated April the 13th, 2016 at 5:04 p.m. You see that?

A: Yes, sir.

Q: Okay. Is that the, what would be referred to as a complaint?

A: Could be. Yes, sir. We could refer to it as that.

Q: Okay. And it says, secure email and file sent to Dr. Alier from Scott Stoller at Anderson County EMS, right?

A: Yes, sir.

Q: And it says that email file included investigation material they had gathered and performed on an Iva Rescue Squad paramedic.

Investigation initiated by Bureau and file started, right?

A: Yes, sir. It does.

Q: And it looks like the next day there's some sort of investigation folder started and that looks like it's got Mr. Naugler's initials beside it, right?

A: Mr. Naugler's initials. Next to that Mr. Alier's initials next to that first one.

Q: Okay. So the sequence is Dr. Alier -- and Dr. Alier's not a medical doctor, is he?

A: No, sir. He's PHD.

Q: Okay.

A: We call him Doc. I apologize.

Q: That's okay. So Dr. Alier gets this email after business hours on the 13th. 9:00 o'clock the next morning the file is started, correct?

A: Yes, sir.

Q: And who assigned Richard Naugler to be the inspector in this case?

A: It was myself or Dr. Alier. I couldn't testify to which one it was.

Q: Now what region does Mr. Naugler typically cover?

A: This region, the Midlands.

Q: Midlands? Does that include Anderson County?
A: No, sir.
Q: Who was the investigator or inspector for the Upstate?
A: It would have been Kristen at that time.
Q: Any reason you didn't assign Kristen to the case?
A: She had some ties with -- that was where she was employed previous to working as an inspector. So she had ties to the area, and I didn't want to have any conflict with that.
Q: Okay. On that first entry, what's the importance of having a secure email of this file?
A: I don't -- I didn't type that, so I don't know.
Q: You know if the police body camera video contains HIPAA protected information?
A: I'm not a HIPAA law expert, but there's a photograph of the patient's face on there. I don't know if it's ever identified in the video other than by first name. So his address is visible, his name is his first name. So if I were more familiar with HIPAA I would guess probably it does contain that information.
Q: Okay. Do you deal with HIPAA at all at DHEC?

A: No, sir. We do not. We forward those complaints on.
Q: Do you think you have to comply with HIPAA at DHEC?
A: Oh, we do. Yes, sir.
Q: Okay. Now the next entry down there, looks like after the investigation was started, and I think the 14th was a -- let me look at my calendar real quick. I think that was a Friday if I'm not mistaking. Let me just double check. April 14th, that was actually a Thursday. And the 18th was a Monday. Do you agree with that? I mean, do you have any reason to dispute that?
A: I will take your word for it, Mr. Rothstein.
Q: So on Monday the 16th, Mr. Naugler sends -- he calls and sends an email contact with the Iva Police Department ---
A: That'd be Monday the 18th, sir.
Q: Sorry. Monday the 18th. Thank you for correcting me. Sends an email and calls the Iva Police Department, and asks for the incident reports and records pertaining to the call, right?
A: Yes, sir. That's what the log says, yes.

Q: Okay. And the Iva Police Force agree to give you the video, right? Or agree to provide Mr. Naugler perhaps the video?
A: Yes, sir.
Q: Okay. And the next morning at 10:00 o'clock is when you met with Mr. Davenport, right?
A: Yes, sir.
Q: Okay. Had you viewed the video before you met with Mr. Davenport?
A: Yes, sir.
Q: How many times had you viewed it?
A: Before we met with him, just a couple.
Q: Okay. Did you view it the same day, or was it a previous day?
A: To when we brought Mr. Davenport in?
Q: Yes.
A: Previous.
Q: Okay. Not you actually tried for a little while to get in touch with Mr. Davenport to discuss the video with him, didn't you? Do you recall? I think there was maybe a phone number was off in Mr. Davenport's ---
A: Yes, sir.
Q: Okay. So it took a little while to get to Mr. Davenport to agree to come in, right?

A: Yes, it did.
Q: All right. But you had seen that video numerous times prior to Mr. Davenport's interview, right?
A: A couple times. Yes, sir.
Q: Okay. And you had seen the video prior to Mr. Naugler's contact to Iva Police Department for an official copy of the video, right?
A: I had seen the copy that was sent to us. Yes, sir.
Q: Okay. And the copy you showed Mr. Davenport on I think it was -- it sounded like it was on your computer at the time of the interview, was the same folder that Mr. Stoller had sent to Dr. Alier to start this matter, is that right? You didn't have the official copy from Iva yet? You agree with me on that?
A: I can't, sir because I can't remember which folder we used. I can't remember if we had had it at that time. Because we asked for it on the 18th. So I don't know why we wouldn't have had it on the 19th. But I could not tell you which version we used, no, sir.
Q: Okay. Didn't they mail you a copy of a CD with the ---

A: Yes, they did, sir.
Q: Okay.
A: So we probably wouldn't have had it.
Q: Okay. So you probably wouldn't have had it at 10:00 o'clock in the morning the next day after you ---
A: We probably would not. No, sir. Thank you.
Q: Now, the interview you had with Mr. Davenport you said that you met with some people prior to the meeting. Let me see if I can find my notes about the word you used. While I'm looking for that, who to your knowledge has seen the video prior to y'all meeting with Mr. Davenport on April the 19th?
A: Just going through my head to make sure. The video was not shown in the office. It was Mr. Naugler, myself, Mr. Alier, and I do not recall if I showed the video to my direct supervisor before or after Mr. Davenport's interview.
Q: Okay. And I found my notes. You testified on direct that going into the interview, you came up with some sort of strategy. So that was the word I wanted to focus on was strategy. Do you remember that?
A: Yes, sir.

Q: Okay. Who was in this strategy meeting?
A: Would have been just myself and Mr. Naugler probably.
Q: Okay. Was Mr. Alier involved in that?
A: No. I don't think he was there.
Q: Okay. Was Mr. Wiznuski involved in the strategy meeting?
A: I don't know if he was involved in the strategy meeting, but I told him why I wanted him to come in, that it involved a trauma call and it was relatively serious and I wanted him in the room.
Q: Okay. Was DHEC's legal counsel involved in that meeting?
A: No.
Q: Okay. Was that -- I think you mentioned there was some compliance person that you ---
A: Bently White.
Q: Bently White? Was she involved in the strategy meeting?
A: No.
Q: Was Bently White a lawyer?
A: She is.
Q: Okay.
A: She's not counsel though.

Q: Is she hired by DHEC in an attorney capacity?
A: No, sir.
Q: Okay. And you said you had, quote ultimate objective going into that meeting. You remember testifying to that phrase, ultimate objective?
A: Yes, sir.
Q: Okay. And wasn't your ultimate objective to intimidate Mr. Davenport into taking a consent order?
A: No, sir. We didn't offer a consent order for several days after that.
Q: Okay. Did your strategy going into that interview include misleading Mr. Davenport about the investigation that was conducted into this matter? Were those part of your strategies?
A: I don't know that we mislead him. We didn't tell him specifically why he was there or what we were looking for. No, sir.
Q: You didn't tell him that you had some QA follow up to this report you had about these three cases from Anderson County?
A: I don't think that's misleading.
Q: Did you actually invite Mr. Davenport down to