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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.

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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

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and Environmental Control,.....Appellant/Respondent,

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

RECORD ON APPEAL
VOLUME 3 OF 4

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this meeting or was that Mr. Naugler?
A: Oh gosh, sir. I couldn't tell you.
Q: You don't remember?
A: I don't remember.
Q: Okay. Did your strategies include entrapment?
A: No.
Q: Okay. Did your strategies include manipulating Mr. Davenport?
A: I don't think manipulating is a good word. No.
Q: Okay. Did your strategies include pressuring Mr. Davenport into accepting some sort of enforcement action?
A: We did not propose enforcement action at those conferences.
Q: Okay. Did your strategies include intimidating Mr. Davenport in any way?
A: No, sir.
Q: Okay. Now Mr. Wicevic played the very beginning of the video just sort of to establish -- that video's like almost two hours long, isn't it?
A: It is. Yes, sir.
Q: And when was the last time you listened to that video?
A: The audio in it's entirety?

Q: I'm sorry. I said video. I meant audio. Thank you.
A: In its entirely it's been a while.
Q: Okay. And you said at some point during the meeting, the attitudes changed. Do you recall that?
A: My attitude changed. Yes, sir. I don't know if I used attitude, but the temperature of the room changed drastically. Yes, sir.
Q: And who changed the temperature of the room?
A: Who changed it?
Q: Who changed it?
A: Myself and Mr. Davenport.
Q: Okay. And I think you described this as -- in your testimony a few minutes ago you said it was slightly more adversarial at some point in the meeting. Is that right?
A: When Mr. Davenport saw the video, yeah he bristled at it.
Q: I'm not talking about Mr. Davenport's response. I'm talking about you and Mr. Wiznuski and Mr. Naugler. Y'all became more than just slightly adversarial toward Mr. Davenport, didn't you?
A: Poor Mr. Davenport did just fine in that interview, sir.

Q: Okay. But your voices got raised. Do you agree with that?
A: I believe mine did once when he laughed. Yes, sir.
Q: Okay. And would you say your blood pressure increased a little bit?
A: I'll say, yes.
Q: Okay. You certainly conveyed anger toward Mr. Davenport. Do you agree?
A: I conveyed anger to Mr. Davenport's attitude.
Q: Okay.
A: And I don't think it was anger. I think it was just disbelief more than anything.
Q: Okay. And at some point during this escalation, you actually had to tell, I think it may have been Mr. Naugler, don't get angry, calm down. You had to calm him down. Do you recall that?
A: I wanted to keep it civil as much as possible. Yes, sir.
MR. ROTHSTEIN: Your Honor, I'd like to play a little bit of the video. I mean the audio. I keep saying video. But I'm going to need the thing switched to my computer. See if I can get this to work. The volume may be a little

off here, so please bare with me.

(Audio Played)

Q: Okay. I don't want to get into all the three calls. But you recall -- does that refresh your memory of what happened at the beginning of the meeting?

A: It does. Yes, sir.

Q: Okay. And you start out that meeting on a sort of a first name basis with Mr. Davenport. Would you agree?

A: I asked him what he wanted to be called. I said, Jim, James, Mr. Davenport, and he said James was fine. Yes, sir.

Q: All right. And you said that Mr. Stoller had sent this one down from Anderson, right?

A: After I corrected his name. Yes, sir.

Q: Okay. And you said that the purpose of your meeting with Mr. Davenport was to do some sort of QA review, is that right? Do you recall that?

A: Yes.

Q: Okay. You said you were looking at protocol violations. You recall saying that?

A: Uh-huh.

Q: Okay. And you also said that the action that

Anderson County took looked appropriate.
A: For what information they had I believe is what I said.
Q: Okay. And you said ---
A: Words to that effect.
Q: You said we called you down here because we have a few things to follow up. We have no statement from you. We have a statement from your partner on one of the calls. We wanted to get a statement from you, do a quick review of these calls. Do you recall?
A: Yes, sir.
Q: Okay. And I think you used the term root cause analysis, right?
A: Yes, sir.
Q: Okay. So you lead Mr. Davenport to believe that this was a QA matter, you're trying to get to a root cause analysis, you already had an investigation done, you want to get his side of the story to make sure was complete, right?
A: The investigation wasn't done. It was still in process. Yes, sir. And I also said to make sure that whatever happened didn't happen again. It was on the tape.
Q: Okay. But you're talking about the QA matters,

right? That there was something that needed to be ---

A: If there was something that needed to be corrected that it wouldn't happen again. Yes, sir.

Q: But at this point you haven't sort of revealed the fact that you guys have the body camera video, right?

A: No, sir. We did not.

Q: Okay. In fact you talked about you got the files down from Mr. Stoller and the actions look appropriate, right?

A: For what information they had.

Q: Okay. And those files would have included the patient run reports? Is that correct? You need to answer.

A: Yes, sir. I'm sorry. Yes.

Q: Okay. And that's a sufficient information to have to do a QA analysis, right? The run report and the protocols?

A: To do quality assurance? Yes, sir.

Q: Okay. And that's what you told Mr. Davenport y'all were doing, was just sort of -- I don't know what the best word is. Sort of a second set of eyes on what Anderson County had done

with their QA right?
A: I didn't use those words. No, sir. But ...
Q: Okay. And you said you wanted to chitchat about these. Do you recall that you used that phrase chitchat?
A: I did.
Q: Okay. Then the next 50 something minutes of the tape, and I'm going to skip over it. I think I'm going to skip over most of it, was talking about three incidents, right?
A: Yes, sir.
Q: Okay. You started with the elderly gentleman and you said, Mr. Davenport it looks like there's some sort of pattern of ALS versus BLS calls in connection with these three cases, right?
A: Yes, sir.
Q: Okay.
A: I will take your word for it that there was. I recall that that's probably part of the conversation we had, that it was ALS versus BLS on the calls. Yes, sir.
Q: And what was the demeanor like discussing those three calls with Mr. Davenport over the next 50 minutes?

A: I believe it was relatively friendly and inquisitive and we asked questions regarding his care of those patients and why he hadn't done certain things and why he had made those calls, BLS versus ALS, some of his actions, why he specifically -- I don't remember a lot about the first two calls 'cause we didn't charge any misconduct on those first two calls. I remember most of the details about the third call where he admitted to not starting an IV and to where I believe he even said he didn't even know if there was a stair chair on it when we asked him why he didn't move by stair chair, he's like, I don't even know if there was one on the truck that day.

Q: Okay. But you started with the two sort of innocuous calls, is that fair?

A: Yes, sir. We did.

Q: Okay. And that was part of your strategy was to bring Mr. Davenport in, sort of relax him by going through these two calls, and then leave the one you were really concerned about till the end, right?

A: It also helped us establish what his pattern of thinking is regarding ALS versus BLS.

Q: Okay. And you're also trying to put Mr. Davenport at ease and establish a little bit of a rapport with him. Is that fair?
A: That's fair.
Q: Okay. Still hadn't told Mr. Davenport you'd seen the body cam video, right?
A: No, sir. We did not.
Q: And then we get to this -- we go through the two calls and then we get to the third call. And again, it'll be in evidence. The Judge can listen to the entire thing. You get to the stabbing trauma patient, right? And the first thing you do is you say, Mr. Davenport will you just run through the call from start to finish? Do you recall something -- I may not have the words quite right.
A: That's mostly how we practice. We ask them to run through the call.
Q: Do you recall when you got to the part about Mr. Davenport standing the patient up with a knife impaled in his chest and walking out to the thing. I think you made a comment, Rich is breaking out in cold sweats right not. Do you recall saying something like that?
A: I might have. Yes, sir.

Q: Okay. And do you recall some discussion with Mr. -- Rich refers to Mr. Wiznuski ---
A: Mr. Wiznuski. Yes, sir.
Q: And he's the trauma ---
A: Director. He's the Director of the division of trauma.
Q: And he reports directly to you, right?
A: Yes, sir.
Q: And there was a discussion about whether this patient required a level one -- to be seen by a level one trauma center, or whether this was a level one trauma?
A: Whether it was a level one trauma patient. Yes, sir.
Q: Okay.
A: A level one trauma patient can go to a two or a one. They can go to a three if that's all that's available, but we prefer twos or ones.
Q: And then there was some question about Mr. Stoller's recommendation of the PEPL class. Do you remember a discussion about the PEPL class?
A: I don't specifically recall it, but I do remember that we talked about the PEPL class. If you want my specific recollection, one of the things that stuck out was that Mr.

Davenport said he wasn't going to go to that class.

Q: That sticks out in your mind?

A: Kind of does.

Q: Okay. I'm going to try and give this a little context. Let's see.

(Audio Played)

A: I won't be coming to that class.

Q: Did he say I will be coming to that class or I won't be coming to that class?

A: I won't be coming to that class.

Q: All right. Let me play a little bit more here.

(Audio Played)

Q: Okay. So was that your voice at the end there?

A: At the end, that was mine. The beginning was Mr. Naugler. Yes, sir.

Q: And you said something about your general patient protocol says all patients get an IV.

A: I said I believe.

Q: Okay. Now when you were in this meeting with Mr. Davenport, did you have that full set of Anderson County protocols?

A: No. We didn't have a full set.

Q: Okay. Did you ever obtain a full set of the Anderson County protocols as part of your

investigation? Let me say prior to the IRC meeting?

A: We have them on file. The agency's required to send us protocols every time they update them or when they relicense.

Q: Okay.

A: We had a full set on file, but we didn't have a full set in front of us at the interview.

Q: Okay. Did you review a full set of protocols when you were doing this, what you represented to Mr. Davenport was a QA review of ---

A: No. I hadn't done a full review.

Q: Okay. What you were doing was looking at what Mr. Stoller provided to Dr. Alier, right?

A: I think we pulled a couple extra protocols. I cannot recall if we just used the ones he sent us, or if we also pulled some extra ones.

Q: Okay. You recall some discussion with Mr. Davenport of that call about the fact that the EMT basic rode the call in the back of the truck?

A: I'm sure that was part of the conversation.

Q: Let's move ahead to one more section here.

(Audio Played)

Q: And you recall that discussion ---

A: Sure.
Q: --- where Mr. Davenport says, I don't care if this is a stubbed toe, if my partner's not comfortable riding the call in, I'm not going to make her ride it, I'm going to ride in the back of the truck, right?
A: He did say that. I don't think he demonstrated it, but he said it.
Q: You recall telling Mr. Davenport several times during this interview that we've got to take care of people who can't take care of themselves?
A: I was saying that for specific reasons. Yes, sir. I wanted to see his reaction.
Q: Okay.
A: Because that patient -- I'm sorry. Go head.
Q: Okay. And there was a -- I went back after the hearing yesterday and listened to the whole thing. I mean I was up till about 2:00 o'clock last night.
A: Yes, sir.
Q: I counted four separate times when you told Mr. Davenport, we've got to take care of people who can't take care of themselves.
A: And that was for specific reactions, and wanted

to see how he would address that. Yes, sir.

Q: That was part of the strategy?

A: That was part of my strategy. Yes, sir. It was.

(Audio Played)

Q: Okay. So that part of the conversation was pretty jovial. There's a lot of joking around. Mr. Davenport is trying to explain himself what he's done and said, you now I my experience this was not a critical trauma, right? That's a summary of what that ---

A: In his experience.

Q: Okay. How many penetrating abdominal traumas have you been involved in where the knife was still in the person's body when you arrived as a paramedic?

A: I had to think about his 'cause I heard the question over a couple days. Only one where it was still in the body, and that was a traumatic arrest. So with a live patient, never still in the body buy many stab wounds.

Q: Okay. When was the one that you're referring to that you saw the knife still in the body?

A: Late '90's. And it wasn't the same patient. It wasn't nearly the same patient.

Q: Over 20 year prior to your interview with Mr. Davenport?
A: Yes.

(Audio Played)

Q: So at that point in the video, it sounds like things are wrapping up. You went around the table. Anybody else have any questions. That kind of thing. Was that part of your strategy with Mr. Davenport as well?
A: Well any more questions regarding that call, or did he have anything else he wanted to add about the call. Because we wanted him to tell us everything he remembered to see if it matched up with what was in the video.
Q: Okay.

(Audio Played)

Q: Okay. So, was part of your strategy going into this meeting to ask Mr. Davenport a bunch of questions y'all already knew the answer to after you watched the video?
A: Not all the questions we knew the answers to.
Q: Some of the questions ---
A: But some of the questions we thought we knew the answers to. Yes.
Q: Okay. And this meeting was on I think the

April the 19th. We established that. The incident that the video is from was from March the 19th, right?

A: Yes.

Q: So one month to the day after Mr. Davenport ran that call your showing him the officer camera video for the first time, right?

A: We were. Yes.

Q: Okay. And I heard before you showed him the video you asked him to give his recollection of the call, right?

A: Yes, sir.

Q: Okay. Did he have any notes in front of him or anything that might have refreshed his memory about the call?

A: I think just the patient care report.

Q: Did y'all ask him when you invited him down to Columbia for the meeting to bring anything with him?

A: No, sir.

Q: Did you tell him that he might be subject to some type of enforcement action from DHEC when you invited him down?

A: At that point, no. We don't know.

Q: Did you tell him he had the right to have an

attorney present if he wanted to have an attorney present for that meeting?

A: I will not say specifically that he knew that. But we try to tell everyone that because we like to have one of our office of general counsel's attorneys available as well. So if someone says they're bringing an attorney, we want to make sure one of our attorneys is there as well, so we try to convey that. So whether -- I cannot accurately tell you, I have nothing in writing that tells me that we did. But I would venture to say yeah.

Q: Okay. But part of your strategy was to get Mr. Davenport to voluntarily come in and talk to y'all, right?

A: Yes, sir.

Q: Okay. And at the time you asked him to come down, you knew about the video?

A: We did.

Q: Okay. And you thought there was something pretty serious about the video, right?

A: We did.

Q: Okay. And so you asked Mr. Davenport a bunch of questions in the first half of this meeting after you kind of established some rapport with

him ---
A: Uh-huh.
Q: --- about things like did he do an assessment in the house, right?
A: Uh-huh.
Q: And Mr. Davenport said he remembered bending down and doing a pedal pulse and that kind of thing. And I think there was a question about breath sounds or lung sounds, right? And at some point they said, well how do you check for lung sounds? And somebody mentioned a stethoscope, right?
A: Yes, sir.
Q: Okay. So at the time all that occurred, Mr. Davenport did not know that y'all had already seen the video, right?
A: No.
Q: Okay. But you already knew the answer to that question because you can't see a stethoscope around Mr. Davenport's neck ---
A: Yes, sir.
Q: --- right?
A: Uh-huh.
Q: Okay. So you kind of trapped him into laying the foundation that he did breath sounds and

then you were going to confront him with the fact that he didn't have a stethoscope around his neck after you showed him the video, right?

A: That's not a trap.

Q: It's not a trap.

A: No, sir.

Q: Okay.

A: Like I said, sometimes we'll ask questions that we know the answer to to see how the person answers, so we can -- the ones we don't have the answers to, we can then try to establish whether that's going to be a truthful answer or not.

Q: Okay.

A: That's not a trap.

Q: Okay. Were you sort of cross-examining Mr. Davenport?

A: I'm not an attorney.

Q: Okay. This morning one thing I did with you is get you to commit to the position at the very beginning of your deposition that you resigned from the department, right?

A: Yes, sir.

Q: And then I confronted you with the fact that you were actually fired from the department,

right? Is that the same thing you were doing with Mr. Davenport in this meeting? Getting him to commit to a position and then taking his knees out from under him, or knee out from under him?

A: No, sir. It's to try to see if what they're telling us is going to be truthful or not if we had the evidence. Sometimes we don't have a video tape of that and we just have to go by other statements and by patient care reports. But in this case we had a pretty goof video.

Q: Okay. And as Mr. Davenport was watching the video -- well, I think when it first started he says something like, oh this is where I call the guy and idiot, or something like that. Do you remember that/

A: Yes, sir. And he chuckled.

Q: Okay. And then when the video portion -- we got to that portion you could hear Mr. Davenport laughing ---

A: Yes, sir. I did. He chuckled a couple times, but I held my teeth.

Q: Okay. And you sort of jumped on Mr. Davenport and said, you see anybody else laughing in this room?

A: I did not jump on him. I calmly said, do you see anyone else laughing. Please watch the video.
Q: Okay.
A: If you're asking me was I a little uptight at that point, yes, sir I was.
Q: Okay this is just about when the temperature of the room's starting to change a little bit?
A: Oh it changed at that point. Yes, sir. It did.
Q: All right, so I'm going to skip through the rest of the body cam video.

(Audio Played)

Q: That last comment. Who is that making that comment?
A: That was me.
Q: Okay. You said, would it surprise you if he, meaning the stabbing patient ---
A: Uh-huh.
Q: --- said that you treat him like this regularly?
A: Yes, sir.
Q: Okay. And have you ever met the patient in this stabbing call?
A: Never.

Q: Okay. Have any of the investigators in here met this stabbing patient?
A: Not officially.
Q: Okay.
A: Not that know of.
Q: All right. So you're kind of telling Mr. Davenport that you all have spoken to the patient, and he said that Mr. Davenport regularly treats him like this, right?
A: I said, would you be surprised if the patient said that?
Q: Okay. Was that loaded question you asked Mr. Davenport a part of your strategy?
A: That was not an original strategy. That came into effect when -- that came into my head then. I didn't write that down as a strategy. No, sir. But sometimes we'll ask someone if we have some sort of proof to see if they will, you know, say, well maybe I've talked to him like that before. And he did say he's run him five times previously too, and he has not run him five times before.
Q: Now, have you taken some sort of investigator or interrogation training?
A: I have not.

Q: Okay.
A: My inspectors do, but I don't.
Q: Okay. Is this part of your watching too much TV, like you said with the Grand Jury thing.
A: No. It's worked before.
Q: Okay. So when you told Mr. Davenport, would it surprise you if he, meaning the patient, said that you treat him like this all the time, that's ---
A: I didn't indicate that I spoke to the patient.
Q: But you certainly lead Mr. Davenport to believe that you had spoken to the patient.
A: And he said he did not.
Q: That's a bit of a loaded question, right? It's like saying ---
A: He said he didn't.
Q: That's like the classic, when did you stop beating your wife question, right?
A: Classic. Yes, sir.
Q: Okay.

(Audio Played)

Q: Okay. So at that time you told Mr. Davenport a copy of this tape or this video has not left the building, right?
A: Yes, sir.

Q: Okay. But in fact the copy of the video you got from Mr. Stoller was outside the building, right? I mean he didn't -- I mean you can physically have a copy of the tape or the body camera footage in the building at that time, and official copy, right?

A: I'll say yes to that question, but I don't know where you're going with the copy hasn't left the building 'cause it's still there as far as I know. Nobody that shouldn't have seen this video has seen the video.

Q: Okay. But the video came from Mr. Stoller ---

A: Right.

Q: --- from the Iva Police Department.

A: Right. But a copy has not left the building. A copy arrived at the building, but a copy had not left the building.

Q: And you also said that Dr. Deschamps has seen it. Is that a truthful statement?

A: I will say, yes.

Q: Okay. So that'll clear up Dr. Deschamps's ---

A: When he saw it. Yes, sir.

Q: --- testimony about when he saw the video first?

A: Yes, sir.

Q: So Dr. Deschamps saw the video before Mr. Davenport was even aware you had the video, right?

A: Yes, sir. I'm sorry. Yes, sir.

(Audio Played)

Q: What did you mean by, you had half a dozen or so that you liked? What did that mean?

A: Just a phrase. Half a dozen that looked like they were applicable.

Q: When you went through the list of things that you thought were applicable, and you said ---

A: Going through the entire list and stopped on the ones. That's pretty common too. We like people to hear what the actual statute, because a lot of people aren't familiar with the statutes of misconduct.

Q: Okay. And so you were kind of intimidate Mr. Davenport into -- it's like almost coercing a confession out of him. Would that be a fair characterization?

A: It's not coercing a confession. We already had him tell us what happened and we had the video tape. We like to let them see the gravity of the situation as we see it. And lots of times that's when the remorse kicks in. And it

didn't.

Q: So you were hoping he would break down and say, okay you got me. Go easy on me. Is that kind of what you were hoping he would do?

A: They rarely say go easy on me. They usually tell us -- when I asked -- if I might? When I asked him where do we go from here, we ask most everybody that. And they'll say, you gotta take my license for a little while. Or I've had somebody thank me for taking their license because they needed some time away from patients. So we always ask that to see what they say, because many times they say, I need to go to this class or I need to do that, or I need some time off. And we say, perfect. Let's write that up and see where we go. And that's where we get a lot of our consent orders.

Q: Okay. So your strategy going into the meeting was to try and convince Mr. Davenport he needed to sign some sort of a consent order?

A: Not that day. We never do consent orders. It takes several weeks, a couple weeks, easy.

Q: So going into the meeting ---

A: And we tell them that. I don't know if it's in

this tape. But I believe we always say, nothing happens today, you still have a license. That's pretty standard end of investigation or end of interview statements.

Q: Okay. So before you even got Mr. Davenport's side of the story as of this call, you already had in your mind misconduct -- or you were thinking about what kind of consent order you could write up for Mr. Davenport, is that right?

A: We weren't thinking what kind. We were hoping to get one. We didn't know what kind.

Q: Well I mean, why were you hoping to get one?

A: I wasn't hoping to get one. We hope to get consent orders over administrative orders always. Because that way we both reached an agreement that something happened.

(Audio Played)

Q: Who was that speaking?

A: That was Mr. Naugler.

Q: Okay. What is a revoktion?

A: I don't know. Probably a revokation is what he meant.

Q: So when you were telling Mr. Davenport about this consent order, you said it's likely going

to involve having your paramedic certificate revoked?

A: I did not say that.

Q: I'm sorry. Mr. Naugler. You didn't correct Mr. Naugler on that did you?

A: I would have to listen to it, but if you say I didn't I didn't.

Q: Okay.

MR. ROTHSTEIN: Your honor. I'm finished with the video. I appreciate your patients. I'm sure it's time for a lunch break.

THE COURT: Okay.

MR. ROTHSTEIN: I've still got a little bit of time left with him.

THE COURT: Oh, you haven't finished your cross?

MR. ROTHSTEIN: Right.

THE COURT: Okay.

MR. ROTHSTEIN: This is a good time to break since the video is finished.

THE COURT: Okay. That's fine with me. We can reconvene at 1:30.

(Off the record from 12:27 p.m. until 1:38 p.m.)

THE COURT: If everyone is ready, I'm going to call the hearing back to order.

Q: Good afternoon ---

A: Afternoon.
Q: --- Mr. Wronski. Do you have that Exhibit 3 that we were looking before the -- the log of the ...
A: I think I gave it back.
Q: You gave it back to me? And we established that that was the log of the of investigation with -- regarding Mr. Davenport's case.
A: Yes, sir.
Q: And do some of the injuries in here have your initials on them?
A: Yes, sir. They do.
Q: Primarily it's Mr. Naugler that filled that out?
A: Yes, sir. According to his initials, yes, sir.
Q: Okay. And then in your paramedic training, I think we've had several people that testified that there's a saying that says if it's not written down, it didn't happen?
A: On a patient care report. Yes, sir.
Q: Well do -- you think these investigation notes are important, the document and what was done on the investigation?
A: Yes, sir.
Q: Okay. Do you think that this Exhibit 3 is a

fair and accurate representation of what happened in the investigation into Mr. Davenport?

A: Fair and accurate in what way? I -- they're accurate. I ...

Q: Okay. That's fine.

A: Okay.

Q: And do you recall that after the meeting on the 19th, where the stuff we went over before lunch, April 19th, that you called Mr. Davenport up on the 27th of April and made an offer of a consent order. Do you recall that?

A: Yes, sir. I was told I couldn't talk about that but yes, sir.

Q: And the offer you made to Mr. Davenport was, we'll give you a consent order if you agree to a two year suspension of your paramedics certificate, right?

A: Yes, sir.

Q: And I didn't see any additional investigative entries between the time you talked to Mr. Davenport on the 19th and the time you offered him the two consent order. Was there any other additional investigation done after you broke up the interview meeting on the 19th?

A: Not that I can recall, truly.
Q: All right. And then on the 27th, they're saying -- later on the 27th, about an hour and a half after you first offered Mr. Davenport the two year consent order, you told him that he could come by and pick up copies of the investigative file?
A: 'Cause he asked for it. Yes, sir. He requested them.
Q: Okay. And you told him we'll make it available to you here in Columbia but we're gonna have to have to redact all of patient care reports because of HIPAA concerns, right?
A: Yes, sir.
Q: Okay. And then later on the 28th, the whole investigator file that you had for that date was copied and placed in a confidential envelope and Mr. Davenport picked it up the next day, right?
A: According to the log, yes, sir.
Q: And one of the -- one of the things you gave Mr. Davenport when you came and picked -- or the Department gave Mr. Davenport when he picked up the packet was a copy of the -- the log of what y'all had done in the

investigation of that date, right?
A: I don't know what was all in the packet, sir.

Q: If you look down at the entry on the 29th of April ---
A: Okay.
Q: It says, Mr. Davenport picks up investigative packet and signed receipt, placed in filed a copy given to him, right?
A: Yes, sir.
Q: Okay. So that entry wouldn't be on the copy of the log that Mr. Davenport picked up right, 'cause that entry happened after Mr. Davenport picked up the packet. You agree with that?
A: I guess I would have to.
Q: Okay. So everything -- and this was a chronological listing of it.
A: Correct.
Q: So my point is that everything after that entry was not on the log that was given to Mr. Davenport as here's a copy of the investigation, right?
A: I don't know. If he was given it, it shouldn't have had any entries that were predated, no.
Q: Okay. And did you do any investigation

between the time you offered Mr. Davenport the consent order and time of the IRC meeting?

A: I think we got in some more documentation but I don't know all of it.

Q: Okay. Is that reflected anywhere in the log?

A: It says, additional -- this could be an additional email requests documentations and -- that we probably received an email from Mr. Davenport or you requesting documents and informing the Department of other actions initiated by J.D., and that would be Mr. Davenport, against Director Stoller. That happened in May.

Q: Okay.

A: So that's the only entry that I see off the top of my head for actual adding items to the investigation.

Q: All right. So after you sent the -- or did you actually give Mr. Davenport a proposed consent order or did you sort of tell him what the ---

A: No.

Q: --- terms would be?

A: No. I -- we don't write one up ahead of time.

Q: Okay.

A: He may come back and told me a year and I would've had to think about it and we go back and forth until we come to what the actual consent should say before we write it. It may take awhile.
Q: Okay. And on May 2nd, I sent you a letter of representation saying I'm representing Mr. Davenport and he's turning down the two year proposed consent order, right?
A: Yes, sir.
Q: All right. And the next thing you did was scheduled this IRC meeting, correct?
A: Yes, sir because at that point, I still felt that some sort of suspension was in order and I have to have the Investigative Review Committee look at that, so ...
Q: Okay. And that notice of the IRC was sent out -- looks like on May the 6th, 2016? You see the entry on the second page?
A: Yes, sir.
Q: And the date of the IRC meeting was originally listed as May 25th. Do you recall that?
A: Yes, sir, I do.
Q: Okay. And I had a -- I had court protection.

I think I was having -- I think I was recovering from surgery or something at that time and Mr. Davenport had a pain appointment scheduled with his V.A. doctor for that same day, right?

A: Yes, sir.

Q: And so, you agreed to move that IRC meeting from May the 25th to June the 23rd, right?

A: Yes, sir.

Q: Okay. Was there any investigation done -- were any additional investigations done in preparation for the IRC meeting?

A: I think we requested some documents and I don't know which ones we got in before the IRC and which ones we got in after the IRC.

Q: Okay. On that second page of Exhibit 3, you have two entries on the 21st of June. That would've been two days before the IRC, right?

A: Uh-huh.

Q: The second one from the bottom says, contacted Rich W. and inquired as any ED actions or alerts done for patient transported to AnMed from this call, right?

A: Yes, sir.

Q: Had Mr. Wiznuski got in the actual Emergency

Department medicals records at that time?
A: I -- Mr. Rothstein, I would like to say that we had them, but I do not recall at the top of my head when they arrived. We have a very thick package of information.
Q: It doesn't appear to be an investigative log, does it?
A: No.
Q: Okay. I'll represent to you that the packet that you gave to Mr. Davenport doesn't have any ED notes from AnMed. Would you have a copy of that?
A: We didn't have them at that time, No, sir.
Q: Okay. Then the IRC meeting was held on June the 23rd.
A: Yeah.
Q: Looks like it lasted about a total of maybe three or three and a half hours, something like that?
A: Yes, sir.
Q: Okay. And this is the first IRC meeting you ever been involved or were ever involved in as the EMS ---
A: Second.
Q: This was the second?

A: Yes, sir.
Q: Okay. 'Cause I thought you told me at the beginning of the IRC that no one here had done one before.
A: Before I got there.
Q: Yeah. Before Mr. Davenport's?
A: No, sir.
Q: Okay. When was the first IRC meeting that you were involved in after you became Bureau Chief?
A: Eighteen months. Eighteen months ago give or take.
Q: And so, I think you testified earlier that you learned a lot from the first IRC meeting ---
A: Yes, sir.
Q: --- about how to handle Mr. Davenport's IRC meeting. Is that right?
A: Just some pearls, yes, sir.
Q: Okay. So you had already had sort of a learning experience with the IRC before you met with Mr. Davenport, right?
A: It was a learning experience, yes, sir.
Q: And what does it mean in your mind -- I think you used the term recuse. You said sometimes that one of your investigators or somebody has a personal connection or a direct connection

with the subject or the compliant, they recuse themself.

A: Uh-huh.

Q: What does that mean in your mind?

A: It means we tried to keep them out as much as we possibly can. At a small staff, so occasionally we will have people that may run and get documents or may assist but we try to keep them out as mush as possible.

Q: Is it your understanding that Dr. Alier recused himself with regard to Mr. Davenport's investigation?

A: In the strict sense of the word he was not recused, but we kept him out of it as much as we possibly could because of his relationship Mr. Stoller that was, you know, touchy. But he is the EMS Director so I needed him for some things.

Q: Okay. Have you heard that term recuse since, maybe, say, you know, January -- whenever the inauguration was in here?

A: Yes, sir.

Q: Okay. And specifically in the connection with the current Attorney General of the United States, had to recuse himself or decided to

recuse himself from the Russia investigation, right?
A: Yes, sir.
Q: Okay. And that means he's not supposed to have anything to do with the invest- -- the Russia investigation, okay?
A: Okay.
Q: Okay. And I think you talked earlier, I think ---
A: I don't think I used the work, recuse with regards to Dr. Alier. I just said sometimes we do do that.
Q: Okay. I'm going to hand you this document. Have you ever seen the document before, Mr. Wronski?
A: Yes, sir.
Q: Okay. This is the interrogatory responses DHEC submitted to me in this case. Do you understand that?
A: Yes, sir.
Q: And do you understand that interrogatory responses are signed or provided under oath or under penalty of perjury?
A: Yes, sir.
Q: Okay. One of the things I asked for was to

list all the witnesses in the case and what they would -- well they're two things. One, list witnesses. Item number two, the people you identified, summarize what they know and what they might testify about, right?

A: Yes, sir.

Q: Okay. And you do you see page 2, I'm sorry, page 3 of those interrogatory responses states, Arnold Alier as a certified South Carolina paramedic and the Director of DHEC's division of EMS?

A: Yes, sir.

Q: Dr. Alier oversees the operations of EMS division which administers the EMS regulatory program. Dr. Alier received the compliant, which alleged regulatory violations against Mr. Davenport and initiated the investigation. I read that right?

A: Yes, sir.

Q: And that last sentenced there says, Dr. Alier recused himself from the investigation into Mr. Davenport.

A: Yes, sir.

Q: And you believed that Dr. Alier recused himself from the investigation into Mr. Davenport?

A: If the definition is that he should've not been involved with the investigation at all if he was not recused.
Q: He was not recused?
A: If that's the definition of recuse. We kept him out of it, absolutely as much as possible.
Q: Okay. And tell me again why you felt it necessary to keep Dr. Alier out of things as much as possible.
A: Because his -- he knew Mr. Stoller.
Q: Okay.
A: He -- he had a relationship with Mr. Stoller. They teach classes together.
Q: Were you aware they were former partners together with thee Greenville County EMS?
A: Not until we got into this, no, sir.
Q: Okay. Did Dr. Alier disclose to you that Scott Stoller, the Anderson County EMS director, was his former partner with Greenville County EMS?
A: Not until we got into this, no, sir.
Q: Now Mr. Wicevic asked you some questions about whether you teach paramedics and EMT's. And I think you said because you're over the paramedic teaching programs in South Carolina, the only place you can teach is outside of

South Carolina?
A: Yes, sir.
Q: And that's because of the conflict of interest?
A: That and the department won't let me. Yes, sir.
Q: Now, let's talk about the IRC meeting again. I think you described it at one point as a grand jury proceeding and I think you said that may have been too much TV, right?
A: Yes, sir.
Q: Okay. There's a white notebook up there. No I think it maybe ...
MR. WICEVIC: 8?
MR. ROTHSTEIN: Exhibit 8? Is that what you said?
A: The transcript is right here.
MR. WICEVIC: Correct.
Q: You see the Exhibit 8 in the DHEC notebook?
A: Yes, sir. I'm here.
Q: After the IRC meeting, did you have a chance to -- have you HAD a chance to review the transcript?
A: Yes, sir.
Q: Okay. To your knowledge or to the best of your ability or best of your recollection, when you

reviewed the transcript, did it appeared to be an accurate reflection of what happened in the IRC meeting?

A: Yes, sir.

Q: And during the IRC meeting, Dr. Alier participated in the IRC meeting. Isn't that right?

A: He was there, yes, sir, I believe. Yes, he was there.

Q: Okay. He was there for the initial part and then when Mr. Davenport and I were excused after we made our presentation, you all went in to executive session, right?

A: I don't think we were in the executive session but I will have to check. I -- we weren't in any deliberations whatsoever that the IRC had.

Q: Are you sure about that?

A: If they called us in to ask a question, we went back in and came back out.

Q: Okay. Do you know if Mr. Stoller was called during the executive session?

A: They told us they had called him and then I saw that in the transcript, yes, sir.

Q: Why didn't he get called in the main part of the case instead calling you in executive

session?
A: I do not know why the IRC did not do that, sir.
Q: Okay. Executive session is kind of a secret meeting, isn't it?
A: I don't think there's a true executive session on this committee but it's not secretive. It's in the transcript.
Q: Okay. And for a lack of better term, I mean, would you consider the executive session for the like the deliberations of the -- of the panel.
A: Yes, sir. I do.
Q: And I'll you to turn to page -- there's four pages on a page. Executive page 30 of the document, but it's page 119 of the transcript.
A: Yes, sir.
Q: Okay. This -- is that part of the executive session portion of the IRC?
A: I would have to go back through the whole thing sir, and ... Can I read it real quick and tell you how ---
Q: I don't think you need to go back through the whole thing. Let me direct you to page ...
A: It says on page 116 that we re-entered the room at that point. So right before page 119.

Q: Okay. So that's during the executive session. You went out to the lobby, came back in. Is that right?
A: We were out for quite a while. Yes, sir.
Q: Okay. And at this particular, on page 119, y'all are talking about the appropriate grounds for taking some type of enforcement action against Mr. Davenport's certification, right?
A: Yes, sir.
Q: Okay. And there's a Dr. Clanton. He's starts on page -- on line 5. And he says, I having a hard time really fitting this behavior into any of these 17 things here, right?
MR. WICEVIC: Your Honor, I'm gonna object to that. He moved to have that offered as truth of the matter is served. Dr. Clanton is not here. It's hearsay.
MR. ROTHSTEIN: I'm asking Mr. Wronski if he recalls that -- that happening.
THE COURT: The objection is overruled.
Q: Do you recall that happening?
A: I recall this conversation, yes, sir.
Q: And then he says, there are some things you can make a case for but I mean, it's hard to really

come down on any of them, definite. Hey, this is where he fell down. And then he says, under F though or has failed to provide patient's emergency treatment of a quality deem acceptable by the Department, question mark, right?

A: Yes, sir.

Q: So he's saying there's really hard to make a case under either under the discipline part of the statute or fail to provide emergency care deem acceptable, right?

A: Yes, sir.

Q: Okay. And then at that -- you say yes, sir and then Mr. Clanton makes another comment. And -- and you say ---

A: Uh-huh.

Q: --- as deemed appropriate by the Department, right. We've never used that specific one, right?

A: Yes, sir.

Q: So, as far as your knowledge, DHEC never used that ground as a basis for taking enforcement action against the paramedic. Is that right?

A: Yes, sir.

Q: Okay.

A: To my knowledge.
Q: Now if you look at page 120, you continued. Line 5 you say, we never, to date, in two and a half years used F as an example because judgments can be judgements, right?
A: Okay.
Q: And you agree with that statement that judgements can judgements?
A: Based on as many facts as you can gather, yes, sir.
Q: And then at the bottom of page 120, Dr. Clanton says -- says, you know, and this starting line 21, you know in the trauma parameters or protocols, I really don't see anything about penetrating trauma as a criteria specifically spelled out. So it's hard to say that he violated protocol, right? You agree with that?
A: I agree that's what you read, yes, sir.
Q: Okay. And you were present when that discussion was happening, correct?
A: Yes, sir.
Q: Okay. And what protocols were you looking at in the IRC meeting to see if Mr. Davenport comply with or violated the protocols?
A: It's hard to recall exactly which ones but

probably the trauma ones that are minimum as was the general patient accounts.

Q: So you're -- did you look at all the ones that Mr. Wicevic went through on your direct testimony?

A: I can't say for certain if we did or not, sir.

Q: Okay. I think you mentioned may six Anderson County protocols that -- and you remember he walked you through those before lunch ---

A: Yes, sir.

Q: --- correct? Were there any other -- other than a Anderson County protocols, did you all discuss any statewide protocols in the IRC meetings?

A: I don't think so sir, but if we did, you can point them out to me.

Q: All right. Now, it you look down on page 124. Is it again, Dr. Clanton, line 14 ---

A: We had left at that point, sir.

Q: Oh, you had left at that point?

A: Yes, sir, we had.

Q: Okay.

A: They brought us in to ask some questions and we left back out.

Q: After the -- after the IRC meeting you -- I got a recommendation and I think you described earlier from the IRC about what the appropriate enforcement action against Mr. Davenport's certificate is, right?
A: Sure, that sounds correct.
Q: After the IRC meeting, you received their recommendation from the IRC about what the appropriate or what they believe would be appropriate enforcement action against Mr. Davenport certificate.
A: I receive two, yes.
Q: Okay. And after that point you had -- or you meaning DHEC, prepared another proposed consent order for Mr. Davenport. Is that right?
A: That would've been the first one we prepared.
Q: Okay.
A: Not another one.
Q: Did you review that document before it was sent out?
A: Yes, sir.
Q: Okay. I thought I had a hard paper copy of it but I don't. So I'm going to show it to you on the screen here if I can make this work. I'm just gonna scroll through. Do you recognize

the heading of the document as the format that you typically see ---

A: It's a typical format, yes, sir.

Q: Okay. I'm scrolling down. This gonna be page 2 of the document.

A: Okay.

Q: It's paragraph two at the very top. You see it? It says on April 13th, 2016, the Department received a complaint alleging Mr. Davenport was verbally abusive, provided sub-standard care, discontinued care and further injuries to a severely injured trauma patient.

A: Yes, sir.

Q: You see that?

A: Yes, sir.

Q: So that was kind of the lead end of this proposed consent order was describing the complaint to against Mr. Davenport, right?

A: Yes, sir.

Q: And when -- when it says, the Department received the complaint, what does that mean?

A: It's just pretty standard language that we received a complaint on that day. That's the day we opened investigation.

Q: Okay. It didn't say the made or filed a

complaint, right?
A: We don't file complaints. No, sir.
Q: I thought you said you can take action if you received information from somebody. It's not in a formal complaint. And then you can convert that into a complaint?
A: Right.
Q: Okay. Which happened here? Did you receive a complaint or did you receive information and turned it into a complaint?
A: We received information that was concerning to someone. So it could go either way. We call it a complaint. We don't file complaints. We either get a complaint or we don't get a complaint.
Q: Okay. That's fair it enough. And Mr. Davenport rejected this consent order, right?
A: Yes, sir. He did.
Q: And this consent order, if he had signed it he would've sort of giving up his certificate for a least a year, right?
A: Not at least, one year, sir.
Q: Okay. And he would've -- well, he -- couple with that, giving it up for a year, he would have to go to a psychiatric evaluation. Is

that right?
A: I would have to read just to be sure, sir.
Q: Okay. So in this proposed consent order, you're asking Mr. Davenport, number one, to admit that he committed a misconduct, right?
A: That's the first part. Yes, sir.
Q: Subsection B also admits misconduct, right?
A: Yes, sir, it does. C as well.
Q: C admit misconduct. Okay. Here's the agreement, right?
A: Yes, sir.
Q: Mr. Davenport agrees to suspension of his EMT paramedic certificate for a period of one year, right?
A: Yes, sir.
Q: And suspension means that his paramedic certificate is temporally voided, right?
A: Yes, sir.
Q: Okay. Suspension of his EMT paramedic certificate includes all levels of EMT certification, right?
A: Yes, sir.
Q: Okay. So you can't even work as a basic or intermediate?
A: Not under this suspension. No, sir.

Q: Item two. Mr. Davenport agrees to submit to a comprehensive psychiatric evaluation within 45 days of execution of this consent order, right?
A: Yes, sir.
Q: And was he required to pay for that?
A: In the consent order I would guess, yes, sir, that he'd pay.
Q: Did you tell them there was a $15,000 grant per paramedic per year?
A: I don't think there was at time. It was right after this that we signed the paperwork.
Q: Okay. And you specifically said that the evaluation needed to include an assessment for anger management, right?
A: Yes, sir.
Q: Okay. And then it said, proof of the evaluation should be provided to the Department prior to reinstatement of Mr. Davenport as a paramedic, right?
A: Yes, sir
Q: So, for some reason in that 45 day period, he didn't get the evaluation done, his suspension would continue indefinitely. Is that right?
A: Yes, sir. But if I may, we do negotiate days all the time. If somebody says they couldn't

get it for whatever reason, we give them another 45 days or however long it would take. We're not animals.

Q: Okay. And paragraph three says that -- that he has to comply with whatever recommendation the psychiatrist makes with regard to the psychiatric evaluation, correct?

A: Yes, sir.

Q: Even if it continued beyond the period of the suspension?

A: Right. But we still would've given his certificate back. Yes, sir.

Q: Okay. Item four, you gotta do the -- that we talked -- talked about PEPL class, right? Is that right?

A: Yes, sir. PEPL class.

Q: Okay. And then number five, he had to agree to a civilian trauma life support course?

A: Yes, sir. Within the 12 months.

Q: And it had some boilerplate about failure to comply with the order can -- can lead to further enforcement actions, right?

A: Yes, sir.

Q: And then there's, I suppose, some signature pages. Okay.

A: Yes, sir.
Q: So Mr. Davenport rejected that consent order, right?
A: Yes, he did.
Q: Okay. And that lead to the entry of the administrative order that caused us to appeal to this Court, right?
A: Yes, sir.
Q: When was the last time you actually rode an emergency call as paramedic on an ambulance?
A: I think it was Charleston County.
Q: Okay.
A: Unless I rode in when I was in Mt. Pleasant we had an ALS entry program. So a lot of the times our paramedics would jump on the Charleston County ambulance. I may done that a few times.
Q: What year are we talking about?
A: Before 2010.
Q: So it's more of seven or eight years ago. Does that sound about right?
A: As a paramedic, yes, sir.
Q: You used an interesting phrase, I wrote this one down too, IV lifeline. What is a IV lifeline?

A: Intravenous lifeline is line that's placed so that we can do medication and can give normal saline if we need to. It's a lifeline that you count on. You get it and you hold it if you can.

Q: Okay. Is that like a silver bullet? Like you -- I mean, it that -- is that a term you came up with, IV lifeline or is that something ---

A: I think you can find it in other places.

Q: Okay. Is that different than a -- than a saline lock or hepwell? An IV lifeline?

A: No. Many medications we give, we cannot give unless we have an IV. We stop giving them down in ET tubes and other ways. Any medications that's fluid we can give them.

Q: Okay. And I think one of the other grounds that you've mentioned for proposed disciplining -- sorry, enforcement action against Mr. Davenport's paramedic certificate is patient abandonment. Is that right?

A: The abandonment, no. We used the other term that's in misconduct. Discontinuation of care I believe. Abandonment order or discontinuation of care. And I think that's what was in the order as well.

MR. ROTHSTEIN: Would be possible to get the Elmo back up, please?

Q: Let me show you the title of this section. You see section 1100 of regulation of 61-7?

A: Yes, sir.

Q: Okay. And you recognize 67-7 as the DHEC regulations for emergency medical services, right?

A: Yes, sir. Is this the most one? We just updated this.

Q: Current through -- as of the 2016 version.

A: Yes, sir.

Q: Okay.

MR. WICEVIC: Your Honor?

THE COURT: Yes.

MR. WICEVIC: This is probably a minor detail. Before -- at the time of this incident, there was another version of regulation in Affect. It has basically the same version and language, per misconduct. I have a copy of the -- the version of the reg that was in my packet.

THE COURT: That's in affect, okay.

MR. ROTHSTEIN: Your right, you reminded me. I apologize. I think you're right, Mr. Wicevic. Thanks for refreshing my memory.

Q: This is the one in book, section 1100, right?
A: Yes, sir.
Q: And I think we're talking about subsection eight.
A: Yes, sir. I see it.
Q: Okay. The holder of the certificate has after initiating care of patient at the scene of an accident where illness discontinued such care or abandon the patient without the patient's consent or without providing for the appropriate administration of care by equal or higher medical authority. You see that?
A: Yes, sir.
Q: Okay. So that's the -- that's one of the bases alleging this comment against ---
A: Yes, sir. Not the abandonment but the discontinuing of care.
Q: Okay. Does the statute or regs define the term abandonment or discontinuation, excuse me, discontinuation of care?
A: I'll have to look at the definition, sir.
Q: Well, when you made ---
A: It have to be a original one denied.
Q: But when you made the determination that Mr. Davenport discontinued care of his patient, did

you consult the Anderson County protocols?
A: No. I don't think we did for discontinuation.
Q: Look in the book.
A: Yes, sir.
Q: Exhibit 1, page 89. Authority of a patient management policy.
A: Which page is this, I'm sorry.
Q: 89.
A: 89.
Q: And it's actually the bigger pages so you ---
A: Okay.
Q: Yeah.
A: Yes, sir.
Q: Under procedure, I'm gonna go down to the fourth paragraph.
A: Okay.
Q: The most appropriately trained and knowledgeable provider at scene is ultimately responsible for all patient care activities while he or she is present. You see that?
A: Yes, sir.
Q: Was Mr. Davenport present throughout the entire encounter from the -- when he goes into the trailer until patient's dropped off at the emergency department?

A: He was.
Q: Okay. And it says, he or she may delegate all or part of the patient management and transportation to others who are qualified to meet the patients immediate needs or reasonable perceive needs.
A: Yes, sir.
Q: Okay. Semicolon, however, he or she must intervene and take control anytime if management of a patient becomes unacceptable. You see that?
A: Yes, sir.
Q: Okay. So this part of the policy appears to align Mr. Davenport if that patient was stable and the EMT basic handled the immediate needs are reasonably perceive needs to let the EMT ride in the back of the truck and Mr. Davenport drive the truck, right?
A: Yes, sir.
Q: Okay. And if that patient, for some reason, starts have an -- what are the first to shock that you were gonna -- if a patient goes into shock, what are the first signs that you're see with regard to that patient?
A: The first signs of shock you're gonna see is

some anxieties, some anxious. And then maybe some pulse rate increase. Maybe some skin color change. We get into layer of the moisture and the temperature going down, are signs and symptoms of shock. But typically anxiousness is the first one we see.

Q: Are EMT basics trained to recognize the symptoms of shock?

A: Yes, sir.

Q: Okay. So if the paramedics driving -- if Mr. Davenport's driving the truck, EMT's in the back ---

A: Uh-huh.

Q: --- she can alert Mr. Davenport if that patient starts to get restless or anxious before the pulse starts to increase, right?

A: If she had something on the monitor as pulse. Yes, sir

Q: Okay. And you've seen their vital signs taken ---

A: There were.

Q: Okay. So she did have something to monitor the pulse, right?

A: Somehow. Yes, sir.

Q: And again, when you were first trained as a

paramedic, did they have the Life Pack 15?
A: No.
Q: Well, how did you do a pulse back then?
A: With a Life Pack 5 or 10
Q: Okay.
A: Or by manual ---
Q: That's what I was gonna -- you can take a manual pulse, can't you?
A: Yes, sir. You can.
Q: Okay. And EMT basis can be do manual pulses, right?
A: They're trained to. Yes, sir.
Q: So if that -- Ms. Aiken started to see that patient exhibit signs of, you know, increase pulse rate ---
A: Uh-huh.
Q: --- she can James, the patient's pulse is changing, right?
A: She could, yes.
Q: Okay. In fact, she had duty to do that. If there's a change in the vital signs, the basic needs to tell the paramedic?
A: I would hope she would, yes, sir.
Q: And if that were the case, then Mr. Davenport to pull the truck over in a safe position and

switch places with Ms. Aiken. Isn't that right?
A: Not best practice but he could. Yes, sir.
Q: Okay. But that's what the policy in Anderson County says he could do.
A: I don't ever think I said he violated this policy. I said my in order that he discontinued care of the patient on the scene and did not provide for a high level of care.
Q: Okay. But the patient didn't need a higher level of care.
A: It -- that's why we're -- that's why we're here. I -- I believe that that patient did.
Q: All right.
A: I absolutely believe that, sir.
Q: And I wanna ask you to turn to page 125 of the Anderson County policy.
A: Yes, sir.
Q: And Mr. Davenport reminded me, these policies are submitted to DHEC, aren't they?
A: They are.
Q: Any they are approved by DHEC, right?
A: We don't approve them. We just check to make sure they don't exceed what the State allows.
Q: All right. This is the non-paramedic transport

of the patient's policy. Anderson County Policy 26. Do you see that?

A: In this particular, it could have 256 versions for everyone of your services.

Q: Okay. And when you made determination that Mr. Davenport discontinued care of the patient, did you consult this policy?

A: I don't believe so.

Q: Okay. If you look at item -- the bullets under policy, there's fourth one down. Says that, provider with the highest level of certification on scene shall conduct a detail physical assessment and subjective interview with a patient, determine their Chief complaint and level distress. You see that?

A: Yes, sir.

Q: And no dispute that Mr. Davenport was the highest level of certification on the stabbing scene, right?

A: No dispute.

Q: Okay. And then it says, if the technician determines that the patient is stable, then all patients care needs can be manage by the 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: That's what happened in this case, isn't it?

A: You talking about paragraph four, being ...

Q: Bullet four. Mr. Davenport ---

A: Yes, sir.

Q: Is the technician on the scene.

A: Uh-huh.

Q: He determined that the patient was stable, right?

A: Yes, sir.

Q: And he determined that all the patient needs could be manage by an EMT basic, Ms. Aiken?

A: If we're gonna do this word by, sir, he did not conduct a detail physical assessment or a subjective interview of the patient, which is the first two lines that you skipped over. We did not complete that task.

Q: Well, I didn't skip over, did I? I mean, I just read into the record, right?

A: The ones you just read.

Q: But Mr. ---

A: You didn't complete the entire bullet part is what I'm saying.

Q: What is a subjective interview?
A: It's when you can obtain subjective, objective to -- there's a -- they're medical terms in which you obtain a subjective interview. Takes a subjective interview of the patient by subjective ---
Q: What's the difference between subjective and objective?
A: You mean?
Q: What is the different -- do you understand the difference between something that's subjective versus something that's objective?
A: Yes. It's what see and feel. What you -- what you can determine without getting too deep into what's going on.
Q: Okay. Subjective is from the point of you, the paramedic on the scene assessing that patient, right?
A: Yes, sir.
Q: Okay. And Mr. Davenport, you saw him in the video talk to the patient for, I don't know, two or three, four minutes before they stood up and walk out the bank to the ambulance?
A: I would not call that a subjective evaluation of a patient, sir. No.

Q: All right. In you're viewing of the video, do you recall the patient responding back to Mr. Davenport and talked about why he did this to himself and do I really have to go to the hospital, have this knife taking out. All of those interactions occurred after Mr. Davenport said, did anybody ever tell you you're an idiot? You're being told that now. Do you remember that?

A: If I can recall the video. It was a regular conversation going on between the patient and the Police Officer. And as soon as Mr. Davenport made that statement, the patient shut up and he barely mumbled the word, nerves, when he asked him why he did it. He said, my nerves. He barely mumbled that word. So I noticed a very distinct change on the patient's affect after Mr. Davenport address him as he did. And throughout the rest of the encounter when he spoke to Mr. Davenport.

Q: So your testimony is, according to your recollection, after Mr. Davenport said, idiot, the patient didn't say another word to Mr. Davenport?

A: I didn't say he didn't say another word. I

said his demeanor changed and he barely mumble a one word answer when he asked him why he did it.

Q: How many times did you review the video?

A: Five or six.

Q: When was the last time you saw the video?

A: Today. I listened to it today.

Q: You listened to it. When was the last time you actually saw it?

A: A couple days ago.

Q: Okay. Did you noticed the reflection of Mr. Davenport in the mirror right before he said, has anybody ever told you -- called you an idiot?

A: Yes, sir.

Q: And could you see that he was kind of grinning when he said that?

A: One of the reasons I watched the video was to see that because I heard it in court and no I did not. Saw him smiling when he got out the ambulance but I didn't see him smile when he talked to the patient. No, sir. I'm sorry, but I -- that's -- no, I didn't see him smiling.

Q: Were you looking at the video on a normal size

screen or were you looking at it on a ---
A: I didn't -- never watched it on a phone size screen. Its been a computer screen or the tv's in this room.
Q: Wasn't there some interaction in the video about Mr. Davenport -- some interaction about whether Mr. Davenport -- whether the patient had to go to the hospital to have the knife removed?
A: Yes.
Q: And that occurred after the idiot comment, right?
A: Yes.
Q: Okay. And remember the patient was hesitate to go to the Operating Room, right? He said, you mean I gotta go to the OR to get this taken out? You can't take it out for me?
A: Right.
Q: And Mr. Davenport said, oh, I can take it out but I'd lose my job, right?
A: Yes, sir.
Q: Okay. If Mr. Davenport took that knife out of that patient and sutured him up like he could've done if the patient were in Afghanistan, that would be a clear violation of

his paramedic scope of practice ---
A: Yes, sir.
Q: --- as a civilian, right?
A: Uh-huh.
Q: He didn't do that?
A: He did not.
Q: Okay. He carefully pick the knife in place and stabilized the knife. You agree that this was an appropriate thing to do?
A: It was an appropriate treatment for that. Yes, sir.
Q: Okay. And he spent some time conversing with the patient. I know you don't agree with the demeanor or the tone of his conversation or the words that were used. But he talked to the patient for several minutes.
A: He cursed at the patient. Yes, sir. But again, I would agree he talked to the patient but not in a manner that you should ever speak to a patient, ever.
Q: And where is that writ- -- is that the protocol that says, professionalism and courtesy?
A: In every textbook that you read when you learn how to talk to patients. Yes, sir.
Q: Isn't that more of a aspiration thing in terms

of paramedic service?
A: Not to me.
Q: Okay. Have you ever heard paramedics in your experience in a firehouse of ER's use what you would consider unprofessional or discourteous language?
A: In a firehouse? Yes, sir. Not to a patient or at a patient. As I stated previously, when we hear somebody curse in front of a patient, not even at the patient, we look down upon that.
Q: Okay. Well, did you see at the end of the video when Ms. Aiken was in the -- in the side of the truck, the door -- well, side door of the ambulance was open. And she uttered the word shit.
A: Yes, sir. She did.
Q: And that door was open in front of the patient, right?
A: Uh-huh.
Q: Have you taken any disciplinary action against, I'm sorry, enforcement action against Ms. Aiken's paramedic -- EMT basic certificate?
A: No, we have not.
Q: Okay. But under your definition, she was unprofessional when she used the word, shit, in

the presence of the patience, right?
A: I said we frown upon that when you say it in the presence of a patient.
Q: But I thought you said that that was a standing order because it said, demonstrate, professionalism and courtesy.
A: Okay. Yes.
Q: That's not a standing order. That's a protocol, isn't it?
A: I'll have to look at the page to verify that, sir. I'm not sure which one it would fall under at this point. But she was not in front of the patient. She was outside the patient.
A: But the door was open, right?
Q: I believe it was at that point. When she was standing outside, there were two Police Officers inside, I believe, at that point or one at least and her outside.
Q: Okay. Do you remember in the video where Mr. Davenport had just put the patient to the back of the compartment. And the door was open. There's some discussion about who was gonna ride in the call.
A: Yes, sir. There was.
Q: Okay. And I think somebody came in and Ms.

Aiken said, please somebody check on the on wife, she's the one that has the medical problems. The patient has psychiatric problems. You remember hearing that?

A: I respect that. She said that. Yes, sir.

Q: And did you hear the Police Officer say, he just crazy. I think it was the 10 like on page six or 1060. What's the 10 code for crazy?

A: We don't use ten code anymore, sir.

Q: But did you see it on the ---

A: Police might. But we don't.

Q: Okay. Have you ever heard of 1068 or 1086 or something for ... Which one is it?

MR. DAVENPORT: 1086.

Q: 1086 ---

A: No, sir. I've heard it.

Q: Okay. And did you hear him say, oh wee, he 1086 crazy?

A: I don't have any jurisdiction over the Police Officer, sir.

Q: You think that was unprofessional with Police Officer to make that comment?

A: In front of the patient? Yeah.

Q: The door was open when he made that comment, right?

A: I don't know if the patient heard it. I know the patient heard what Mr. Davenport said to him.
Q: Okay. Well if I remember correctly, at the interview we listened to, somebody made the comment that the Police Officer gave better care or was more compassionate with a patient then Mr. Davenport.
A: Towards the patient. Yes, sir.
Q: Okay.
A: I believe that comment was made.
Q: You believe that's just the meaning to say, oh wee. Somebody -- that guy's crazy. 1086 crazy?
A: I don't have any jurisdiction over that Police Officer.
Q: Well, why would you compare Mr. Davenport's language in assessing this patient to the cop's language?
A: Because he was the primary patient care giver at that point. Not the Police Officer. But the Police Officer was much more compassionate to that patient than Mr. Davenport was.
Q: Well, the Police Officer coddled him. Would you agree with that?

A: I don't think you can coddle psychiatric patient. I think he a rapport on the psychiatric patient. That Police Officer at that point was alone and he was trying not have to pull his gun but they kept pulling the knife out of him.

Q: Okay. You remember ---

A: He was trying -- he was trying to establish the rapport. And he -- the patient told him, I have warrants, and that Officer said, I don't care about your warrants, I wanna get you help for what's going on.

Q: And I know initially he was alone. But later after Mr. Davenport came in and Mr. Davenport was taping up the guy's belly, putting the knife stable, right?

A: Yes, sir.

Q: The Police Officer said, keep your hand away from him. I'm going to have to put you in handcuffs if don't stop messing with it. You remember that?

A: Yes, I do.

Q: And he said something like -- I think the patient said, well you seem like a nice guy.

A: Yes, sir.

Q: And the cop said, I am a nice guy.
A: Uh-huh.
Q: And he said, don't make me be bad guy.
A: Right.
Q: Okay. That's like talking to a -- to a six year old child, isn't it?
MR. WICEVIC: Your Honor, I'm going to object. This is going off the subject, what the Police Officer did.
MR. ROTHSTEIN: Well Your Honor, he just said that the Police Officer showed more compassionate and care to the patient that Mr. Davenport did. And -- I mean, I think talking somebody to like they are a six year child is not compassionate and caring.
A: The Police Officer at that point could've immediately handcuff that patient, but he did not. So he just let him know he did not want to be the bad guy. I'm speculating, but he could've immediately handcuff that patient he wanted to and he did not. So yes, he was more compassionate. By talking him out of it first. That's my belief not a fact.
MR. ROTHSTEIN: Beg The Court's indulgence for one minute. I may be about finish.

Q: Let me ask you this question. After Mr. Davenport's matter came out of the IRC ---

A: Yes, sir.

Q: --- did you investigate a complaint about Mr. Stoller's management of the Anderson County EMS Department?

MR. WICEVIC: Your Honor, I'm going to object to -- to relevance. I think the focus is on the allegations that the Department against Mr. Davenport.

THE COURT: What's the purpose of that question, Mr. ---

MR. ROTHSTEIN: Well, I was gonna contrast how Mr. Wronski handled that investigation versus how he handled the allegation against Mr. Davenport. For example, if they call Mr. Davenport in for -- for this initial interview, and told them it was a QA meeting and the first hour of the meeting, sort of this friendly discussion of the calls and then they, you know, sort of lower the hammer on him. I was just gonna ask Mr. Wronski how they handle the investigation of Mr. Stoller.

THE COURT: If there was an investigation.

Q: You recall handling an investigation about

allegations made about Mr. Stoller's mismanagement of the Anderson County EMS Department?

A: We did not. There were several allegations that was given to us and don't have the authority to investigate the mismanagement of the agency that was alleged, but we did look through it. It was a ten page complaint, I believe received. And we did look through it and found three that may possibly have had DHEC impact and we investigated those three.

Q: Okay. And did you notify Mr. Stoller that he was being investigated for some impropriety or misconduct?

A: Yes, sir. We did.

Q: Okay. And did you ask Mr. Stoller for a written response to the allegations that were made against him?

A: We asked for a written response because I believe his mother or father had passed. I can't remember who ask for an immediate written response. And we collected inventory records. And we did multiple other things regarding DHEC related items that may have been under our purview.

Q: And did you convene an Investigative Review Committee?
A: We did not.
Q: Okay. Did you offer Mr. Stoller a consent order?
A: We did not.
Q: How long did your investigation of Mr. Stoller take?
A: A month or so.
Q: No further questions.
A: May I? We did asked Mr. Davenport to come and give a statement. He did not.

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

THE COURT: Okay. Thank you.

MR. WRONSKI - RE-DIRECT EXAMINATION BY MR. WICEVIC:

Q: Okay, Mr. Wronski. Just a few follow up questions for you.
A: Yes, sir.
Q: Can you explain to The Court, your strategy going into an interview.
A: Every interview is different. We have different strategies that we go in with.
Q: What's your ultimate goal?
A: The ultimate goal is to ---

MR. ROTHSTEIN: Your Honor, this is asked and answer. He asked that on direct. I was just emphasizing what the ultimate goal was.

Q: Why was Mr. Wiznuski present at this interview?

A: He's my Director of Trauma. He's very familiar with trauma regulation, with the trauma triage protocols. And I wanted also has an opinion the treatment that was render.

Q: What's his role at the Department.

A: He's division Director for the division of trauma and time sensitive emergencies.

Q: Okay. Why was Mr. Naugler present?

A: He was the lead investigator.

Q: Why was Ms. White present?

A: She sits in on several of our interviews when she had time. She's the -- I don't know her official title but she works directly for my boss as a communications and policy advisor.

Q: Can you explain to The Court your -- the general process for drafting consent orders?

A: We -- over the alleged allegation or violations, with the paramedic or the EMT, we always tell them that they don't look pretty. We say, this is what we alleging you did, on paper it's gonna look a lot worse. We discuss

that with them. We tell them what we are alleging and why. We then draft those up into a draft order, then we send them to the Office of General Counsel to make sure we're on the right side.

Q: And then what do you do if they look good.

A: If they look good there's a signature process we go through. The Office of General Counsel signs them, I sign them and the person committing signs them. We always tell them up to the point of signature you do not have to sign this piece of paper.

Q: That's what I was going to get at.

A: Yes, sir. They have to sign if they don't want to. We tell them that multiple times.

Q: When they have not consult counsel?

A: Absolutely.

Q: You mentioned the first IRC was a learning experience for you?

A: Yes, sir.

Q: Can you explain that?

A: The IRC does not convene very often. We try to make every effort to object consent orders with people that, you know, violations or alleged violations. And so, when the IRC is convene,

it's very rare I find no records of -- I found a previous IRC that occurred but it was just some notes and so we tried to go the best we could. And develop the process from there -- and it evolves each time we do it.

Q: Are you still working on that process?

A: We had a pretty solid process now, I think. Probably polished up a little bit more after this week. Yes, sir.

Q: Okay. There was mention of the compliant against Mr. Stoller. Did that allege patient care issues?

A: No patient care issues, no.

Q: Would there be reason to convene the IRC were that the case?

A: Well, if had found something that was a violation that, you know, we felt we need to take his license for, but we're very careful when someone comes in for alleged violation. I'll give you a quick example. If a training officer comes in because they maybe mishandled some training records, generally, we don't takes someone's paramedic license. We may tell them can't be a training officer anymore. So, it doesn't have to be directly with your

patient care, we usually don't take your paramedic license are reduce your EMT license. I can't remember every single order we've written but we try to be very specific and I put the Office of General Counsels thoughts into it now that we've written a bunch of them. The DHEC board how they would perceive what we did. I of course now the court.

Q: How would you characterize Mr. -- excuse me, Dr. Alier's involvement?

A: Minimum, very minimum.

Q: There was some discussion with misconduct regarding discontinuation of care?

A: Yes, sir.

Q: What's the -- what's your interpretation of discontinuation?

A: Discontinuation ---

MR. ROTHSTEIN: Your Honor, again, this is asked and answered. He asked exact question on direct exam. And I even asked ---

THE COURT: And you -- yeah. You touched on it as well.

Q: Well let's turn to the policies.

A: Sure.

Q: Let's turn to page 89 please, Exhibit 1.

THE COURT: I'm sorry. What page was that?

MR. WICEVIC: 89.

THE COURT: 89.

Q: Mr. Wronski, this is the authority of the patient management policy.

A: Yes, sir.

Q: The fourth paragraph under procedure. I think Mr. Rothstein record this.

A: Yes, sir.

Q: Second sentence, paragraph four.

He or she may delegate all the part of the patient management in transportation to others who are qualified being patient's immediate needs or reasonably perceived needs. What's your take on that as it applies to this case?

A: As far as the patient's reasonable perceived needs, I don't believe that she was qualified to do that.

Q: The she you're referring to ---

A: I'm sorry, Ms. Aiken wasn't qualified to do that in case the patient had start to crash.

Q: And then moving to page 125 of Exhibit 1. Mr. Wronski, this is a non-paramedic transport patient's policy -- policy 26.

A: Yes, sir.

Q: List a number of patient who cannot be transfer to a low level certification?

A: Yes.

Q: And particular patient's applicable for this matter?

MR. ROTHSTEIN: Your Honor, he testified that he didn't consider this policy when they made the decision. Now Mr. Wicevic is directing him to part of the policy he never considered. I mean, that's completely improper for this witness. Ms. Wicevic wants to raise on closing argument or something, he's fine to do that but he's just leading this witness right to the point. That's not -- that's an improper examination.

MR. WICEVIC: Well, Your Honor, he walked him through the same policy. I don't why Mr. Rothstein would be allow ask the applicability of this particular policy but I can't.

THE COURT: What was your question, please.

MR. WICEVIC: I asked Mr. Wronski whether any of the patients listed as not being able to -- to transfer to a lower level certification were applicable to this matter?

THE COURT: Okay. You can ask the question.

Q: Mr. Wronski.
A: One more time please. I'm sorry, sir.
Q: Under policy 26, it says the following patients cannot be transferred to the lower level certification.
A: Yes, sir.
Q: Are any of those listed patients applicable to the is matter?
A: There's -- there's definite and one probable. The one definite is, one, two, three, four, five, six, seven -- seven down. That's applicable here because the crew member did express discomfort when assuming care of the patient. She asked if it should have been an ALS patient and he said, you're fine.
Q: Have you read through all of them?
A: Oh, yeah. The line above it. The patient has received ALS intervention. The patient should have received ALS intervention, but they did not.
Q: Any others?
A: One more time. The one above it, slightly. I mean there -- there applicability too even the last one. Paramedic test to rule out pathology, so when checking the skin color temperature,

moisture and pulse oximetry, that's a test to rule out the bleeding but that patient still could've -- could've had a bleed or obtained one during transport so he should've back of the ambulance.

Q: Okay.

A: Yes, sir.

Q: I think that is all I have here, Mr. Wronski. Hang one second. That's all I have. Thank you.

THE COURT: Mr. Wronski, I've got, let me ask you. In your proposed consent order -- well, let's just say under your statute or regulation, it provides for revokation. But it revocation is not a permanent ---

MR. WRONSKI: It is not. No, ma'am.

THE COURT: If it is not permanent, they can reapply ---

MR. WRONSKI: Yeah. If the EMS ---

THE COURT: --- or they can petition is what it says. They can petition for ---

MR. WRONSKI: They can petition for ---

THE COURT: --- to receive the license.

MR. WRONSKI: --- to receive license, yes.

THE COURT: Credentials.

MR. WRONSKI: After that period. Yes, ma'am.

THE COURT: Yeah. But if they petition, to me that indicates that the Department had some discretion on whether that person will be recertified?

MR. WRONSKI: Yes, ma'am. It implies that, it does. We have to approve everyone that comes through. Whether it was this person or another person, but yes. We never had that occurred though.

THE COURT: Okay. But there is a possibility that you would either issue them a lower credential or deny there petition for ---

MR. WRONSKI: There's -- there's potential. We -- we don't -- if they applied for a paramedic certificate, we can't tell them we'll give them an EMT certificate. We would just deny that one then they would reapply for a basic certificate if that's -- if that's want they wanted but -- what we would -- we never turned one down that's complete an order. If that -- if that make sense. If someone's completed there time on their consent we'll give them their license back or the requirements of the consent, we'll give them there license back. So, we've never turned anyone down that's

completed that.

THE COURT: Okay. Now you also indicated that the -- your IRC has process has had gone through some changes ---

MR. WRONSKI: Yes, ma'am.

THE COURT: --- since Mr. Davenport's meeting. Can you kind of elaborate some and tell me what -- what changing have you made in the IRC process?

MR. WRONSKI: That meeting, we have not made any changes, but from the first one to the second ---

THE COURT: Okay.

MR. WRONSKI: --- obviously, the court reporter and now like I said, we're going to tweak it some more after this hearing. Just make sure you get the right people in the room at the right times and don't use the words grand jury and things like that. So we're -- we're trying to make a very unbiased process, Your Honor.

THE COURT: Okay. And when you consider a complaint or information has been brought to your attention ---

MR. WRONSKI: Yes, ma'am.

THE COURT: -- that there may be some violation. When you consider the possibility of there

being violations, do you look at the protocol from the agency involved. The county level agency to ensure that their protocols don't exceed the state protocol.

MR. WRONSKI: Yes, ma'am. And if that did, it -- it would be our plan. I would have to take that hit but we do. When -- when they come in -- well, first when they send us the new protocols or they relicense, we check through them and make sure they don't exceed the scope of what the state allows.

THE COURT: Okay.

MR. WRONSKI: And when we -- one of the first things we do with the patient care issue comes up, is pull that county's protocol that are applicable to -- to what might be alleged to make sure.

THE COURT: Okay.

MR. WRONSKI: Not to necessarily make sure that there are different because if they were different, then I would have to take that hit. I would be on me because we looked at those protocols and -- you know, that low protocol went through the system. So if somebody did something like that, that would be on me.

THE COURT: Okay. Okay. Thank you.

MR. WRONSKI: Thank you.

THE COURT: And we're gonna take a -- that's your last witness. Right, Mr. Wicevic?

MR. WICEVIC: Yes, Your Honor.

THE COURT: We're gonna take a ten minute break at this point.

(Off the record from 2:45 p.m. until 3:06 p.m.)

THE COURT: Okay Mr. Rothstein.

MR. ROTHSTEIN: There's one thing I want to clear up before I make a motion.

THE COURT: Uh-huh.

MR. ROTHSTEIN: And I think this is sometimes the trouble sometimes you get when you ask that a fact witness a legal question. The statute actually defines what revocation suspension is. And I just -- I've got it up on the screen and it's section 44-61-30. This is the definition section and it's subparagraph 28 is revocation. And you can see that on the screen, Your Honor. It's the permanent voiding of a license or certificate.. And Your Honor, certificate holders are paramedics and EMT'S. And so, the certificate is voided for a period of four years, okay. And then at the end of that period, it says, the holder may petition for

reinstatement. So that's -- that's what a revocation is. And then a suspension is I think what is what Mr. Wronski is referring to. That's temporary voiding of a -- in this case, certificate. I just wanna make sure there was not misinformation conveyed to the court. And, Your Honor, is DHEC resting its case at this point?

MR. WICEVIC: Yeah, the only other thing I wanted add, and this might be better to hold until the end of the case. The confidentially issues with this. The video footage that has a patient's face and I think there was patient name mentioned.

THE COURT: Yes. I noticed that. And I was gonna ask you about that. Did you all not kind of edit out the patient's name?

MR. WICEVIC: You know what, Your Honor, we can go -- I've done this in the past where we've had our IT department like bleep out a name ---

THE COURT: Uh-huh, yeah.

MR. WICEVIC: I can do that and we can replace with DHEC interview 'cause I did hear that one name.

THE COURT: Yes.

MR. WICEVIC: I can do that. The video footage, I

don't if we're gonna have to put that under seal. I -- I can ask our IT folks that sensor off like faces. I was just concern for the confidentially of this individual.

THE COURT: Yeah. I -- yeah.

MR. ROTHSTEIN: There's lot of trouble on the stuff. There's the address of the residence on the police call. That's why these aren't subject to FOIA. I think that's -- I think that's a problem. So, I agree that something needs to be done to protect this patient's privacy.

THE COURT: Right. I mean the problem is is that our files are -- they're opened to the public.

MR. WICEVIC: Right.

THE COURT: So I do believe that the audio ---

MR. WICEVIC: Right.

THE COURT: --- yeah. Needs to be -- have that name bleeped out. I only heard it once but then I didn't listened to the entire two hours.

MR. ROTHSTEIN: Right.

THE COURT: I don't know if there ---

THE WICEVIC: My mistake for not catching that. And I'll go back and we'll make sure we get that. I just wasn't even -- I'm not sure if we'd ever get the abilities to the sensor the guy's face.

THE COURT: Okay. Will you check and see if you do.

MR. WICEVIC: Yeah, I will.

THE COURT: Or, if not, we're gonna have to figure out something to place that under seal.

THE WICEVIC: Yes, Your Honor.

MR. ROTHSTEIN: And Your Honor, at this time, on behalf of Mr. Davenport. I move under rule 50 of the South Carolina Rules of Civil Procedure for -- for directed verdict in favor of the Mr. Davenport, respondent in this case. As Your Honors knows, this is a de novo bench trial. I think Mr. Wicevic has a different understanding of the term de novo than I do. My understanding is that de novo means that you look at the -- the case fresh without any deference to DHEC. I don't think it means that DHEC gets to reopen its -- you know, doesn't get a second shot at the apple. I mean, I -- I think if they didn't adequate investigation that lead to the administrative order, I think it's too late for them to now try and push all that stuff in -- in front of Your Honor. So, as I mention in the beginning, that this is a case that DHEC bares the burden of proof on. And I remember -- yeah, the burden of proof is

always a -- a tough thing to get across in -- in trial to obviously not to Your Honor, but I've seen various demonstrative devices for how they illustrate the burden of proof to a jury. And the best one I've ever seen is -- is the football field analogy. Like a plaintiff part of the burden of proof here and petitioner has the burden of proving their case by preponderance of the evidence. So they have to take the ball. They're on offense. And they have to get the ball pass the 50 yard line. Just ever so slightly to win the case. Just like a football game with three different periods. So maybe it's like a hockey game, but that it -- so the plaintiff puts on their -- petitioner puts on their case in Chief to try to get the ball at the 50 yard line. If at the end of this time, first period, they haven't gotten the ball pass the 50 yard line, the case is over. Okay. If they've gotten the ball pass the 50 yard line, then we put our case in Chief and we have the opportunity to try and push them back behind the 50 yard line and then they have their rebuttal case. Okay. At the very end of the case, there's another directive

diverted motion if they hadn't gotten the ball past the 50, your case over and we win. Here, there's no need for us -- and I appreciate Your Honor's patience sitting here all day. I really thought case would take three -- three days to present the entire case. We're here on day four, and we just finished DHEC case in Chief. I think I can get my entire defense case on in less than a day and a half. But I don't think it's necessary for us to do anything because at the end of this first period, they haven't gotten the ball near the 50 yard line. And, Your Honor, in typical, I do a lot of jury trials. Well, not a lot of -- no jury trials are tried very much anymore. But then a trial standard for a directed verdict is, you have the Judge kind of like the referee in the middle of a field. And if it's a close call about whether the -- the plaintiff was carrying the burden of proof, you can call out the jury. What's the -- the chain referees that have that ten yard chain to see if they go a first down. And if that ball is ever so slighted to even touching that chain, you gotta deny your motion -- the motion for directed

verdict because you take the facts in the light most favorable to the non-moving party on -- on a motion for directed verdict in a jury trial. This is much different here because there is no jury. You serve as the referee, the finder of fact, if DHEC finished it's case and they haven't gotten the ball to the 50 line, it's over. Your Honor, I'll give them the 20 yard line, maybe because if there's a kick off and it goes into the end zone and you just down your knee, that ball comes out to the 20 yard. I suggest, Your Honor, they haven't moved the ball at all in this case pass the 20 yard line. Not even close to the 50 yard line. I think that the issue is not whether somebody's upset with how Mr. Davenport interacted with his patient. You have actually look at this statute. And the statue gives you two basic tracks for disciplining a -- not disciplining, enforcing an action against a certificate holder -- or revoking certificate of a paramedic. One, you can say that the paramedic has failed to provide patience emergency medical treatment for the quality deem acceptable by the Department. Okay. Mr.

Wronski testified that they never used that standard before. He said, judgments can be judgements. That's a very difficult standard of proof. So I don't think they meant that standard. The other issue -- and we can get to that in a minute. The other issue is whether the paramedic is guilty of some type of misconduct. And Your Honor, misconduct is a statutory defined term. And it included seventeen different forms of misconduct. This is -- actually, there's two places where the -- the term misconduct if defined. The first one is in the statute itself. Let me get to the sanitation on that one. The grounds are the same but there -- but there -- it's 44-61-80, subparagraph F. And -- and remember, Mr. Wronski said, we've never F before. You know, that's just too mismatch. Judgements can judgements. And you saw their own expert witness say, I can't -- I lost count of how many times he said, well this is a judgment call. You know, that the flow charts and the protocols have innumerable judgments calls that paramedics make. If you look through protocols, they say, assess for need. They

don't say administer an IV. They say assess for need. They don't say, administer a cardiac monitor or administer oxygen. They say, assess for need. So, in that protocol, there's decision tree. If you have an experienced paramedic say, this patient doesn't need oxygen or this patient need an IV, doesn't need a cardiac monitor, that's your decision. And you complied to the protocol because you got to that decision tree and went no doesn't need it. That's all -- all you need to worry about. As long as that is a objectively reasonable decision that's your discretion. If you say yes, I'm gonna apply this particular type intervention or drug or treatment, that's when you get down in standing orders. And that's why I think this little chart is important. And their own expert witness -- Your Honor, you remember, I went to the chart with that. And then he said, now that's a fair representation of what the relationship between protocols and order is. And you see that little overlap right there. And remember the red is the order. And I did it in red on purpose because that's what you can't do. Okay. You can't go

outside of the order box. If it's a standing order which mean you make a decision to do something and you got to give, you know, are you going give saline to the this patient, that is how much you give. Or if you're going give to morphine to pain patient, this is how I should give. It says, he doctor says you can do this under my medical control without having to call me or to call the ER and order it. So, it's like. That's what a standing order is. A standing order is not be courteous and professional. I mean that's a directive but it's not a standing order. And no matter how it's written, if it's written in, you shall do this. If it has nothing to do with the patient care that you otherwise would have to call the doctor in for, it's not a standing order, it's a protocol. Somewhere up in the green area. And that way up green area is the best practice circle you'll remember. How many times on the stand that we hear people say well, it's not really the protocol, but its best practice. It's a -- we're gonna err on the side of caution. And that's what they're saying Mr. Davenport should've done is erred it on the

side of caution. I submit to you, Your Honor, that erring on the side of caution is a paramedic that doesn't know what their doing or doesn't have the experience or hadn't seen this kind of patient before. And their like, oh my God, I don't know what to do. So they started oxygen. They put the patient on a IV. They saw that patient on the monitor. You heard the mantra 30 years ago that -- their expert witness said, I learned the O2 IV monitor when I went to paramedic school. He graduated the same year that I went to -- graduated from high school. And I had a lot of hair back -- back then in high school, Your Honor. I mean, that's a long time ago. And you also heard that same witness say, O2 IV monitor, but that's been out a long time. Okay. We're on cutting edge medicine now. We look at needs base medicine. We look at -- we look at -- what's the -- evidence base medicine and -- and he said that's passe. Well, I said were do these advances come from? Well, they generally come from the military. And that's where Mr. Davenport came from. He came from a military. So he -- and this isn't an arrogance issue or

-- or Dr. Davenport knows better then Dr. Kickham. I mean, he is one of the most highly trained medical personnel in the world, other than a licensed physician. Okay. He can perform surgeries. He's trained on how to do these things. And -- and the fact that he can recognize a patient whose got a knife in his belly, is a stable patient. I mean, he seen these kind of injuries much worse type of injuries in the field. And the -- the key is not, oh my God, I've never seen that kind of thing before. We better fall back on the erring on the side of caution. I think it's better not to err at all. Just treat the patient for what the patient presents with. And that's exactly what happened in the stabbing case, Your Honor. He treated the patient appropriately. The patient from the time the patient got in the back of the ambulance until they got to the hospital. The patient has the same vital signs when they got to the hospital. Five minutes after the patient arrives at the hospital, vital signs are taken, patient stable. The only thing that change was the pain levels went from a four to

a nine. That's not an indication that the patient is decompensating or going into shock. That's a sign that -- when they got to the hospital, the ambulance crew brings the stretcher in. They gotta move that patient from the stretcher, the ambulance stretcher to the Gurney at the ER, right? So, you saw, Your Honor, when they move the patient how he actually sat him down on the stretcher at the scene, how they kind of winched in pain. Two minutes later, he's sitting on there the -- officer Burns comes in, takes photos. Those photos are in evidence. That patient is laying back. It's like he's almost about to go to sleep. His face is relaxed. He got a good color. I submit, Your Honor, that is not a patient in pain. Does not need medication. He told the -- Ms. Aiken, the EMT basic that he had a pain scale on one to ten, he was about four. I've got migraines that are worse than a four. This guy had a knife in his stomach and says yeah, I'm about four on a scale of one to ten. There's no medication needed. So when he gets to the hospital, when we don't know what happened to him from the time the

ambulance door or the am- -- the ED door closes, Mr. Davenport and Ms. Aiken go clean up the rig and -- we don't know what happened in that ER between the time they dropped him off and he reported that his pain was a nine. There's a lot of dressing and tape on that knife. If the -- it the ER doctor starts looking up the knife to see how bad the wound is and rips off that tape and pull hair with it, I mean, that's gonna hurt. Maybe that will explain what -- why there was a nine. There was -- but there's -- there's no doubt that this patient was stabled. And that's a judgment that Mr. Davenport can make on the scene. The fact that some of these other guys that haven't ridden an ambulance in 20 or 30 years, may have treated this patient differently or put him on oxygen, 02 IV monitor, has nothing to do with whether Mr. Davenport provided appropriate care of this patient. So, they can't win on the issue of appropriate treatment. This patient -- all three of the patients that we talked about had good outcomes. Okay. Nobody had a worsen condition from the treatment they received from

James Davenport. We don't even what standard to apply in this case 'cause DHEC said, we don't apply the 200 different protocol sets that we get from the agency around the state. We apply the -- the DHEC statewide protocols. And Your Honor, we put them up on the screen. There were no protocols that they identify that they believe were violated in Mr. Davenport's care here. So that first branch is out. The lose -- they can't get past the 50 yard line on whether or not Mr. Davenport provided emergency medical treatment for the quality, deemed acceptable by the Department period. Fact that -- that it might have been troubling to -- Dr. Deschamps is not the issue. Dr. Deschamps is not the trauma physician. He's not an Emergency Room physician. He's not board certified in any of that. He is an internal medicine doctor. He had three year residency in -- in medicine. He fought me on whether that was consider a generalist or not, but when Mr. Wicevic asked him, well what is internal medicine? He said that means the of the treatment of the adult body or something like that. I can't imagine a more general practice

are than internal medicine. And I -- I didn't mean to offend him if calling him a generalist is offensive to him, I'm sorry. But the fact that he doesn't recognize that Mr. Davenport's care was perfectly acceptable does not mean that Mr. Davenport loses his certificate. We had a renowned trauma surgeon come in from Philadelphia, Your Honor -- Mr. -- Dr. DeAngelo. He is a full bird colonel in the United States Army. He is the surgic -- he's the Medical Control Officer for the Special Forces teams or the group unit, group that Mr. Davenport operated under. He knows Mr. Davenport skill. But more importantly for this case, he knows what trauma patients look like. He works in Atlantic City. I can't imagine, you know, that's not -- he said he worked for a level two trauma center. I imagine they have a lot a -- it's like they gun and knife club I would imagine. Even -- even after Mr. Trump, you know, left Atlantic City. So, he sees stabbing patients. He seen stabbing patients with the knife impaled. He testified that that patient was stable. He also testified that whether or not to give an IV to that patient is

a judgement call. An IV, I'm sure Your Honor's had IV before, involves poking a needle into the vein. It can be a painful procedure. Especially if you have someone who has a knife in their belly. And -- and, I mean, you don't stick a patient with an IV just to have it ready in case. And we haven't gotten to our case yet, but Mr. Deason is here. If we get that far, he'll explain why that's old medicine. That is the old school O2 IV monitor. So Mr. Davenport treated the patient appropriately. I don't think there's any dispute about that. So that gets us down to whether Mr. Davenport committed misconduct as defined in the statute. And there are three issue in misconduct. I know you saw during the interview that Mr. Wronski says well, I like that one. And like that one. I think I can get you on six or seven of these but all I need is one, right? Well they were like three that that are alleged at this point in the case, Your Honor. Three out of the 17. Let's look at the first one. Disregarded and -- think I'll put this on there. On the Elmo. Subparagraph six is the first one at issue

here. Disregarded an appropriate order by a physician concerning emergency treatment or transportation. Okay. It says order. Down here in the red. That's the order. Everything that Mr. Wicevic did in the case was go through the protocols. Okay. He didn't raise a single standing order that Mr. Davenport violated. Not a single one. These are all judgment calls that experience paramedics make. Protocols are made to be broken. Okay. That's what it says. It says, you can deviate from a protocol, in fact, we don't want blind inherence to protocols. That's what in the introduction -- introduction even to Dr. Kickham's, he said protocols. He says the goal of training experience is that you should be able -- if you need deviate from a protocol, you should be able to do that. You just have to document it some where. It doesn't say where. It doesn't say in the patient care report. It doesn't say that you have to put an addendum to the patient report. It just says you have to document it and explain it. Well he certainly explained it to Dr. Kickham. He tried to do a written explanation of it. But when the email he sent

asking for -- show me what I did wrong on March the 30th, he never got a response. So they never gave him an opportunity to document what he did in this case. The first meeting they had in -- in Anderson County was on Friday, the 25th of March, 2016 when Mr. Davenport. You recall the -- for some testimony that Mr. Stoller, Dr. Kickham, met with James Davenport, in morning, actually it was after. They met with Kim Aiken first. And they hadn't told Mr. Davenport why he was suspended -- I mean specifically why he was suspended except -- the letter just says, we gotten some concerns. You're hereby suspended until further notice pending an investigation. Two days later, bring Mr. Davenport to get his side of the story. That's the first time Mr. Davenport was given an opportunity to even to know what three case they're talking about. They have the elderly gentlemen from the nursing home that had a low systolic reading -- systolic reading of his blood pressure. They had the pediatric seizure patient and then the had the stabbing patient. Well, the significance of the two -- well they -- I think Mr. Wronski said -- were

sort of two, not that important cases. Those were in February. Those were over a month, prior to the stabbing incident. There had been a QA meeting in March. You remember there was some testimony that said that the QA meeting occur every other month. So you had a QA meeting in February. I mean, in January. You had a QA meeting in March. I think they said it's the second Thursday of every month. So if Mr. Davenport did something wrong in February, that should've been brought to the attention -- through the QA process in the March meeting. Mr. Davenport, that never happened. So what happened when they got the standing call, is they went looking for dirt on Mr. Davenport. And they called up the QA officer and said look, you know, we got these concerns about Mr. Davenport. Do you have any other cases that we could use sort of as ammunition against Mr. Davenport. And the only two that they could come up with were the nursing home patient and the -- and the pediatric seizure patient. Again, I think those are out in terms of discipline but I think it's important to see the contact in which Mr. Davenport has brought

here before you today. So that brings us to the -- to the stabbing patient. And again, Your Honor, there's no physician order Mr. -- Dr. Kickham said, James never disregarded an online physician order. And their trying to fit the whole protocol book into the little standing orders part of the -- of the Venn diagram. It just don't make no sense, Your Honor. I mean, just because the protocol said something like, treat patients professionally and courteously. And that's not something, you know, standing order, that's -- that's aspirational creed. You don't have to call online medical control to say we'll drive. You know, should I be professional with this patient or should I be courteous with this patient. That's aspirational. The order piece is the doctor telling you to do something. And if you disregard what the doctor is telling you to do, in the form of an order, you're guilty of -- it's almost like insubordination or -- oh, I know better than the doctor. I'm just gonna do my own thing. That's not what happened here, Your Honor. So, I believe number six is out. There's no disregard of an

order. At best, there's some judgment calls about some protocols. The subsection, Your Honor, is eight. This is the patient abandonment section. Paramedic is subject to enforce action against a certificate if -- after initiating care or patient at the scene of the an accident or illness, the paramedic discontinued care or abandonment the patient without the patient's consent or without providing for further administration care by equal or higher medical authority. I think you have to have a little bit of common sense here. I think Wronski even -- even could see that there's no abandonment here. This isn't a, you know, a paramedic that comes to a scene, sees a patient and says oh, I'm just gonna leave this patient in there home. I'm not gonna get a consent form and then the patient has a bad outcome because the paramedic should not have left that patient alone. Or this could be a situation where Emergency Room or an ambulance comes in the Emergency Room, they just leave the patient on the door step of the Emergency Room and take off. Okay. When they leave, they hey, Mr. Custodian of the -- of the

Emergency Room, can you bring this patient to the doctor inside. I've got another call I gotta get to. That's patient abandonment. Okay. 'Cause the care of that -- I meant the -- the paramedics is just leaving the patients, sort of, to his own devices. So we're down to discontinue care. Did Mr. Davenport ever discontinued of the stabbing patient? And again, Your Honor, this is -- Mr. Davenport provide a tremendous amount of care of this patient. He -- he assess the patient. Determined the patient was stable. Conversed with the patient. I know there's some dispute about, you know, whether he should, you know, use different wording or whatever. But the patient never complain and didn't bothered to see if the patient was offended by -- by if the patient was offended by -- by what was said by Mr. Davenport. Dr. Davenport provide the patient care. Stabilized the knife. Stood him up, walk him out. And Mr. Davenport rode in the ambulance. He -- I mean, he drove the ambulance. He never discontinued care. He was always there. And I think it's important to look at the Anderson County protocols for

this because this is exactly what Mr. Davenport did on this case. So there's two provisions here, Your Honor. There some paramedic transport -- no, I'm sorry. Non-paramedic transport of patients policy 26. And there's the authority for the patient management policy. And they both say that if a paramedic starts care, he can delegate that to a lower level provider as long as that provider is qualified to meet the patient's immediate needs or reasonably perceive needs. And that says, however, he, mean paramedic or she must intervene and take control anytime the management of a patient becomes unacceptable. That's exactly what happened here. Mr. Davenport said -- and this is interesting too, Your Honor. But yeah -- and this is -- if you'll remember, Ms. Aiken was on the stand, the first witness. He had this discussion about -- I just kind paraphrase -- phrasing, the collection, the video.

And I said, you recall in the video where Mr. Davenport says, are you comfortable writing this thing. And he said something like it's your call. That was my -- those are my words.

Just paraphrasing what Davenport said. And Ms. Aiken said, well I understand that when Mr. Davenport said, it's your call, was referring to I'm going to order you to ride this call on this particular patient rather than it's your choice. The actual wording of that is important, Your Honor, 'cause Mr. Davenport didn't say, it's your call. What he actually said ... He said, you comfortable or you want me to ride -- ride it in. That's what Mr. Davenport said. And then Ms. -- Ms. Aiken express a little bit of, I think she was not quite as self confident as maybe she could've been. And then Mr. -- what Mr. Davenport says is, it's up to you. Now that's the quote that Mr. Davenport said to Ms. Aiken. I paraphrase it and said, didn't Mr. Davenport it's your call. And what he actually said was, it's up to you. Meaning, it's up to Ms. Aiken to make that decision. And -- and Mr. Davenport give her the thing before lunch. He said, even if -- a partner of his, a basic, had stubbed toe patient and the partner said, I'm uncomfortable riding this patient in. Mr. Davenport said he'd ride that call in. I mean, he's not

looking to short responsibility for this patient. He's in the ambulance the whole time. I mean, if they wanted to have a policy that says, anytime the ambulance goes out, the paramedic has to ride on the back of the truck. They can put that in the policy of they want. But I -- would submit that that's, number one, bad medicine. And number two, it's potentially some type of medicare or medicaid or insurance fraud because ALS calls are much more involved and have higher reimbursement than BLS calls, but, you know, that's really not the issue here. But -- again, the policies give Mr. Davenport expression to delegate that task to EMT basic as long as that basic can do what Mr. Davenport's asking for them to do. The only thing she did in the back of that truck or than -- excuse me. Other than comfort the patient and kind of calm the patient down, which I think that's a pretty good call on Mr. Davenport's part because this -- you heard the video, Ms. Aiken goes into the house and she says, what did you do now, Johnny? I mean, they have a much closer relationship. And so, putting that -- Ms. Aiken in the back of that

truck is a soothing mechanism for Mr. -- Mr. Doe. The patient -- I mean, Ms. Dav- -- Ms. Aiken's perfectly capable of managing the care of that patient at the level that patient needed. You know, you have a stable person sitting in the back of the truck. He does have a knife in his belly but their not gonna do anything until they get the Emergency Room Again, Mr. Davenport -- if this were Afghanistan, could take that knife out and fix it, but he didn't do that. He left the knife in, stabilized it. And this is something that Ms. Aiken is perfectly confident to manage the care of. Even Mr. Wronski said yes, you know, watching for changes in vital signs like a pulse is something that basics are trained to do if -- and they know that if there's a change in that vital sign, they need to tell the paramedic hey James, his pulse just went up. You know, five beats per minutes or whatever the -- the appropriate thing is. And Mr. Davenport will say, okay, I better get in the back now and take real good care of that patient. That's what this policy 07 provides for. It also is provided for policy number 26,

Your Honor. And again, this is at page 125 of Bates label. Fourth point down it says, if the technician determines that the patient is stable, the patient care needs can manage by the load -- lower level provider. Patient care can be transferred to technician of lower certification for care while en route to the hospital. That's exactly what happened here. And then at the bottom of that policy it says, the paramedic must accompany a patient to the hospital. Mr. Davenport did accompany the patient to the hospital, right? He was in -- in the front seat of the -- of the ambulance. I'm sorry. Says, he must accompany the patient to the hospital if the BLS crew member expresses discomfort with assuming the care of the patient. The fact that Ms. Aiken initially questioned her own experience and abilities to care for this patient, doesn't mean she said no, I don't feel good about riding this patient here. She may have had two or three discussion with Mr. Davenport about it and Mr. Davenport says, you got this. You know, the patient's stable. Your fine. This is a BLS call. The policy puts the burden on the crew member of

the BLS crews member. It is the obligation of the BLS crew state that they're not comfortable with managing the patient. Ms. -- Ms. Aiken didn't do that. In fact, she had gotten in trouble before for not raising that objection. So this is not discontinuing of care. You and Mr. Davenport's there. The patient under the policies, he's allowed to do that or under the protocols. Subparagraph 14, by his actions or inactions created a substantial possibility that death or serious harm could result. Okay. I think this is where -- I think this is the crux of the case here, Your Honor. And that phrase in -- in the regulation of the statute, it doesn't say -- it doesn't say -- they're trying to read out the words, substantial in there. There's -- that, I guess that's a adverb, substantial possibility or adjective, I guess. I'm sorry. Substantial possibility. It doesn't say created hypothetical, you know, what if. It says, substantial possibility that death or serious physical harm could result. Did Mr. Davenport do anything to this patient that -- that was substantial possibility that death or serious physical harm could result.

And what did they focus here on? They focused on Mr. Davenport's decision to walk this patient out of the house. They say that -- that James -- and I didn't understand, this ... You know, I give him credit for trying but -- but Mr. Douglas, he's only been in the case since, I mean, I guess, you know, less than a week at point. He tried to say that Mr. Davenport should've consider using the -- the kitchen chair or improvised some type of carrying device with a sheet or some sort of cushion to prop up the patient's back. I mean, I thought it was a little silly. But Your Honor saw when I was sitting in the chair like I was -- like how are you gonna move me out of the -- you know. Well, you should've used the stair chair. How do you get from the couch to the stair chair. He said, I would get behind it, we pulled the stair chair up and then I would kind of scooch around. Somebody else would get on my side. I mean, you talking about moving the patient and that would create a substantial possibility or I would say, likelihood of death or -- I mean, can you imagine if you try to improvise something or

use the kitchen chair to try and make sure he's in a seated position as he's going out of the house? I can't imagine what angers a situation. So, Mr. Davenport excised his skills and experience and lifted that patient up off of the couch. You gotta get the patient out of the house. And you got to do it fairly quickly. Now could there -- could they have use the stair chair, possibility. We saw Ms. Aiken say, well, that stair chair has straps that go across the chest. You gotta crank it down pretty good or you have the possibility of the patient falling out of the stair chair going down the steps. Well those straps are right where that knife is gonna be, Your Honor. You'll remember, I'm sure Ms. Aiken's testimony to that effect. And then -- to crank down on that stair chair strap, you have to get it pretty tight. I mean I think it's -- we're not talking about, you know, airplane seat belt. I mean, I'm sure there's -- that's probably a similar type of mechanism. But if you do that across your chest, your pushing in on that chest. I mean that -- that may compress your chest a little bit. That may move the knife.

And that is a recipe for disaster 'cause if that knife moves and it hits the aorta, I mean, that patient is gonna be dead before they even get down to the bottom of the steps. I mean that is a disaster if that happens. So Davenport again, using his skills and experience, gently lifts the patient up with two people on each side of him. Mr. Davenport's looking at the knife the whole time and much sure the knife doesn't move. They gingerly walk the patient to the steps and they get the patient down the steps. Ms. Davenport blow the patient, keeping the eye on the knife. If the patent stumbles or something, Mr. Davenport is gonna go for -- I mean he's gonna stabilize that knife. That's the -- the ??? way to get that person out of the house. Well, they trying to say -- well, the policy of a protocol say, you should've ambulate the patient to the ambulance. You shouldn't walk a patient to the ambulance. Well what if that house was on fire? What if -- there are times when the -- you have to use your own common sense. That is not a standing order. That's a suggestion. That's a protocol. That gives

the paramedic discretion on how to get that patient safely out of the house. And if the paramedic uses his judgement and experience in executing that, maneuver, and it's different than somebody else would've done it, that's within that decision box. That's not violation of a physician order.

THE COURT: Ms. Rothstein, you know, I'm -- I will listen to -- I'll sit here all afternoon and listen to your argument for directed verdict. But I will tell you right now, I'm not granting it.

MR. ROTHSTEIN: Okay.

THE COURT: Because I think the state has carried it's burden at least to the point where we're now shifted to you presenting your case.

MR. ROTHSTEIN: The only other point they -- they made, Your Honor was that -- laying the patient flat on the back led to a substantial possibility that this patient would suffer death or serious injury. You Honor, this patient was laid flat on his back in the -- in the hospital room or in the ER. This patient wasn't laid on his back when the surgery was perform. I -- I mean, putting the patient in

a prone position is -- is not a -- it's not a violation of -- of a standing order. And it's not a violation of any type of standard care. It's a decision that Mr. Davenport made. Patient had no bad outcome from that decision. And, you know, I think this is not grounds for taking a paramedics certificate here, Your Honor. Thank you.

THE COURT: Thank you. Mr. Wicevic, I don't know if you want to say anything in response because I've already said that I'm the -- I'm denying the motion for directed verdict.

MR. WICEVIC: Yes, Your Honor. I think it's time to move on with ---

THE COURT: Okay.

MR. WICEVIC: --- the respondent's case.

THE COURT: Okay. Mr. Rothstein?

MR. ROTHSTEIN: Call Leo Deason to the stand, Your Honor.

THE COURT: Mr. Deason if you will face the court reporter. Raise your right hand, he'll swear you.

LEO DEASON, having been duly sworn, testifies as follows:

MR. DEASON - DIRECT EXAMINATION BY MR. ROTHSTEIN:

Q: Good morning, Mr. Deason.
A: Good afternoon.
Q: Can you state your name for the record, please.
A: Leo Jack Deason.
Q: Okay. Where are you from, Mr. Deason?
A: Birmingham, Alabama.
Q: What do you do for a living?
A: I have two different living, no three. One I make firefighter paramedic. I'm with -- coming up on 25 years. I'm also a EMS program chair for a EMS program in Birmingham. Recently credited, non-profit private university. And I'm also in the military.
Q: I want to had you -- we marked as Exhibit 22.
A: Yeah.
Q: You recognize that document?
A: Yes, sir. I do.
Q: And is that a copy of your current curriculum vitae?
A: Yes, sir.
MR. ROTHSTEIN: Your Honor, move Exhibit 22 in evidence.
MR. WICEVIC: No objection, Your Honor.
THE COURT: Okay. It's entered.
(Respondent's Exhibit Number 22 was admitted into

evidence.)

Q: Mr. Deason, are you a nationally register paramedic?

A: Yes, I am.

Q: Okay. And I think you said you been a paramedic for 21 years. Is that right?

A: I been a paramedic since '96, I believe. Yeah, '96. Been an EMT since '94.

Q: And have you held your certificate in good standing with your nationally registered paramedic and your certificate with Alabama since ---

A: Yes, sir.

Q: --- through that time.

A: Yes, sir.

Q: Did you have any type of disciplinary action or enforcement action taken against your ---

A: No, sir.

Q: And I think you also mentioned that you work at -- at school in -- is it Homewood, Alabama?

A: Yes, sir. Homewood is more like Birmingham. And it's also where I worked for the City of Homewood Fire department.

Q: Okay. Can you describe what the significance of the City of Birmingham is to the practice of

paramedicine?
A: Yeah, we have -- we have a lot of trauma in Birmingham, in the Homewood area. We have a lot, you know, kind of penetrating traumas, stabbing, that type of stuff. We have a lot of crime in our area. A lot -- lot of overdoses, also. A lot of heroin usage right now.
Q: Okay. Kind of describe the school you worked with or for in Birmingham?
A: Yes, sir. I worked for Herzing University. There are 11 campuses across country. We originally accredited with North Central Association out of Wisconsin in that are. It' liked Michigan, Wisconsin and all that. The reason is that's where the home office is. I started the paramedic program seven years ago. We started out with five students. And I have the largest in Alabama.
Q: What is your school's philosophy about treating or training paramedics and EMT?
A: Our philosophy, we train to the national standard.
Q: Okay. You been here for a couple of days and do you still teach 02 IV monitor?
A: No, sir.

Q: And how has that been obsolete for awhile?
A: At least seven years. At least since 2010 since I got into the education program.
MR. ROTHSTEIN: Okay. Your Honor, I tendered to offer Mr. Deason as a expert in emergency medical education the standards of care of -- a certified national register and certified paramedic.
MR. WICEVIC: May I voir dire?
THE COURT: Yes.
MR. DEASON - VOIR DIRE BY MR. WICEVIC:
Q: Good afternoon, Mr. Deason My name is Vito Wicevic.
A: How are you?
Q: Doing well. It's kind of late in the afternoon. I'm a little tired. I might tongue tied.
A: I gotcha.
Q: If I say something you don't understand just let me know.
A: I will.
Q: So you have a significant experience in the miliary. First of all, thank you for your service.
A: You're welcome.

Q: Let's focus on your care EMS experience?
A: Okay.
Q: So, you have your CV in front of you?
A: Yes, sir. I do.
Q: Okay. Perfect. Well, it looks like you received your bachelors of the science degree.
A: Under education? Yes, sir.
Q: You got it? I'm going to -- so, it looks like you received your bachelor of science and your criminal justice and psychology. No relationship of ---
A: None.
Q: --- EMS? Associates degree in applied of science. Fire Science?
A: Fire science. Yes, sir.
Q: That doesn't relate to pre-hospital care, does it?
A: First responders falls under fire science.
MR ROTHSTEIN: Your Honor ---
A: So yes, it would.
MR. ROTHSTEIN: --- I mean, this is gonna take -- he put his case on four days. I've got a day and a half to my case my done. If he wants to go back to this gentleman's undergraduate, we're just wasting time. I mean, if he wants to voir

dire the witness about his credentials that are relevant to whether he's an expert, I think he needs to move on and do that. Or we're not gonna get our case done.

MR. WICEVIC: Your Honor, I mean, expert witness talking about education. I think this is wholly within the bounds of the voir dire to question his -- his education experience.

THE COURT: Okay. You can go on.

MR. WICEVIC: Okay.

THE COURT: But let's just kind of move it along so that we can get to this testimony.

Q: Well, let's say this. Okay. So the only ed-- formal education that you have concerning pre-hospital care, was your -- it says your associates degree in applied science emergency medical services, '96 to '98?

A: Yes, sir.

Q: Two years, okay. You said you obtain your EMT and PRMT credential in '94?

A: Yes, sir.

Q: Did you -- I guess that's the year you obtain also your Alabama certificate?

A: Yes, sir.

Q: '96 you obtain your paramedic and PRMT?

A: That's right. I was in intermediate also.
Q: Okay.
A: Yeah.
Q: You're currently in the Army, correct?
A: Yes, sir.
Q: When did you join the Army?
A: '87.
Q: How often during this time period, I guess, from '94 to present were off on obligations?
MR. ROTHSTEIN: Your Honor, this has nothing to do with his qualifications. Whether he's in the Army or was deployed somewhere had nothing to do with whatever he's ...
THE COURT: Mr. Wicevic, how does that relates to his qualification?
MR. WICEVIC: Well, if he's -- he's off on military duty, he's not practicing civil paramedicine. He's not doing civil pre-hospital care. I think it's -- I mean, if he' not practicing, that goes his experience which is relevant to making your determination as to his qualification as a witness.
THE COURT: Okay. You can answer his question.
A: The total, 48 months, since 1994.
Q: 1994? That's nothing.

A: And it's been 11 years since I deployed
Q: Okay. So, four years. Subtract that off of that -- of your experience as paramedic.
A: Yes, sir. Can I qualify a little bit more. I got 13 months of it. I was brought on active duty by first Army to teach TCCC. Combat Life Saving.
Q: Okay.
A: For all the deploying soldiers in Alabama. So I did 13 months of education with the Army.
Q: Sure. Okay where did you attend your certification for DOS instructor?
A: Oh, I couldn't really tell you. It's been years, 15, 20 years.
Q: Okay. Don't know that. Do you know that ACLS instructor?
A: ACLS, probably 15, 20 years.
Q: ITLS?
A: ITLS, has been quite ten years.
Q: Okay. And then your TME instructor certification.
A: Tactical medicine. I did that six years ago.
Q: Okay. Now does that relate to civilian pre-hospital care or is that for the military?
A: No, no. That's for civilians. That's for

tactical medics on squad teams.
Q: Okay.
A: It's for civilian paramedics. Yes, sir.
Q: So your 24 years of fire rescue, correct?
A: Yes, sir. Coming up on 25 years.
Q: Now substantial part of that does not have to deal with patient care. Is that correct?
A: No. I ride an ALS fire truck, sir.
Q: Okay. But -- okay. Firearm truck, correct?
A: Yes, sir.
Q: Your duties at Homewood. They maybe focused firefighting?
A: No. It's mainly -- 80 percent of our calls are EMS.
Q: Okay.
A: That's a statistic. A known statistic.
Q: Well, it does look like you had supervisor position?
A: Yes, sir.
Q: How often you get out in the field?
A: I'm in the field every -- every third day.
Q: Every third ---
A: I ride only in fire truck. Yeah. And the way Alabama works, me being a senior medic with those license. I am with a medic on every

call.
Q: Okay.
A: So I run five to ten calls a day, every third day.
Q: Every third day?
A: Yes, sir.
Q: Okay. Are Homewood Fire and Rescue Service and also the McCalla Fire District, are they licensed services?
A: Yes, sir. Yes, sir.
Q: Now it's my understanding they're not transporting services.
A: Right. We don't transport.
Q: So you don't transport patients?
A: But we're ride in with them. We -- we continue care of them.
Q: So would you be aboard another license ambulance service?
A: Yes.
Q: And would you be a subject to the -- those Medical Control Physicians ---
A: No.
Q: --- protocols?
A: If we maintain the patient contact, then it, -- it stays as our care under our physicians.

Q: Okay.
A: Yes. That's Alabama state law. The way -- way it works, the City of Homewood owns a jurisdiction for EMS. The transport company is a private transport that we only use to transport patients.
Q: Yeah.
A: But if we have an ALS call, then we have to continue care.
Q: Okay.
A: A medic -- one of our medics or myself would ride in.
Q: I understand. Okay. I see that you're also part of Alabama EMS Association?
A: Yes, sir.
Q: Is that just pay a fee and you're a part of it?
A: Pretty much. But we have a voice in protocol for the state of Alabama. I'm actually the vice chair of the EMS education division. So we help -- we help develop protocol in the state of Alabama. We have a voice.
Q: Now have you ever been sued for malpractice?
A: No, sir.
Q: You said you never subject to disciplinary action but an -- an employer?

A: No, sir.
Q: Okay. Now you're not certified as a South Carolina EMT. Is that correct?
A: No, sir.
Q: Okay. You're not familiar with the standard practice here in South Carolina. Is that correct?
A: No. All I know is they follow the national registry.
Q: That's correct. You are familiar with practice in Alabama, correct?
A: No. I'm national standard. I'm a national registry EMT representative.
Q: Okay. So the national standard and then Alabama?
A: Yes, sir.
Q: Now, EMS practice varies significantly by state, correct?
A: It varies based on legislation.
Q: Right.
A: Yes, sir.
Q: I mean, Alabama standards are completely different than South Carolina's. Is that correct?
A: I can't really tell you that. I don't ...

Q: 'Cause you're not familiar with South Carolina, correct?
A: This correct.
Q: Alabama has a set of protocols that are developed by their Alabama Department of Health, their office of EMS, correct?
A: It's advisory boards.
Q: Okay.
A: Yeah.
Q: And are all EMT's in the state -- and when I say EAT's I'm talking ---
A: I know what you're saying.
Q: --- they're all subject to that protocol, right?
A: Yes, sir.
Q: Okay. We are you aware ---
A: Except -- except flight medics. Flight medics are not.
Q: Okay. Do you understand here in South Carolina, EMT's protocols, they are required to comply with, vary by agency?
A: Yes, sir. There are some states that do that. Texas does the same, so does California.
Q: Okay.
A: It's not an uncommon practice.

Q: Right.
A: And it can -- it can go by jurisdiction also.
Q: Okay.
A: Alabama just falls under one umbrella.
Q: And your teaching responsibilities at Herzing. It appears that you're the department chair. Is that correct?
A: That is correct.
MR. ROTHSTEIN: Your Honor, the purpose of voir dire is to challenge the expert's credentials, not to establish the expert's credentials. All Mr. Wicevic is doing is reading his CV. This is gonna take another hour if he wants to go through everything in the CV. I'm trying to move this along and get this finish this week, Your Honor.
MR. WICEVIC: I am too, Your Honor. I'm just trying to understand his qualifications. If he wants to be qualified as an expert in education, I think I have a reason to explore his actual instruction within the university that he works. My understanding is department chairs don't do a whole lot of instruction, so I think I'm well within my bounds to inquire ---
THE COURT: Yeah. But you need to move it along.

MR. WICEVIC: Okay. Yes, Your Honor.

Q: The periods that you served as department chair.

A: Yes, sir.

Q: What are your teaching responsibilities?

A: I teach at least 15 hours a week.

Q: 15 hours a week?

A: Yes, sir.

Q: And you've been doing that for the past five years?

A: Seven.

Q: Seven years. Your actual teaching experience. Do you do any teaching prior to that?

A: Yes. I taught fire science at Wallace State.

Q: Okay.

A: Several years ago.

Q: But apply to pre-hospital care, correct?

A: I been a ACLS instructor, BLS instructor, did the training for State Homewood and McCalla Fire.

Q: And that's ---

A: And I'm an Army basic instructor. I've been an instructor in the Army.

Q: Let me ask the question.

A: Oh, okay.

Q: So medical training within the services, that's in-service training, correct?
A: It's certification courses.
Q: Is it in-serviced training for your agency?
A: No. They don't require that. ACLS and BLS are not required of the agency.
Q: Okay. So they're kind of continuing education.
A: Continuing education.
Q: Okay.
A: For national registry. If you deem you want teach those right.
Q: When was the actual associates degree in the EMS program establish that Herzing?
A: When I started.
Q: Okay. And you said you had five students ---
A: We started with five EMT students. Yes, sir.
Q: Okay.
A: And I got 125 paramedics.
Q: So it's EMT's and paramedics.
A: And paramedics. Yes, sir.
Q: What about the other ...
A: We did advanced EMT for awhile. Kind of like Mr. Douglas said, we really didn't find a need for it in our area. It's an optional instructional base ---

Q: Yeah.
A: You know it helps in rural areas maybe, volunteer services. They can do a little extra. But it -- we don't -- we go for EMT and paramedics. And it's five total semesters. One for EMT and then four for paramedic.
Q: Okay.
A: With 600 hours of rotations.
Q: Now have you provided patient care to patient with impaled abdominal injury?
A: Yes, sir.
Q: Okay. About how many times?
A: I can't tell you really how many times. We have a -- I've had people shoot themselves in the stomach with nail guns. I'm had rebar. I've had pencils. I've had knifes. So, a few over the 25 years.
Q: Okay. When was the last time?
A: The last time has probably been about eight years ago.
Q: Eight years. Okay. Now you've never been qualified as an expert in the pre-hospital care education field, have you?
A: No, sir. Not in a courtroom, no.
Q: What's that mean? Have you been retained to

provide expert testimony and just never resulted in you ---

A: No. I have not. No. I have not, sorry.

Q: All right, Your Honor. The Department would ask that Mr. Deason not be qualified as an expert. He has limited years of education in the EMS field. He has limited experience as far as teaching instruction. His program, brand new. Compared to our expert, I think it's very minimal experience requirements, educational requirements, so forth. So the Department respectfully request that he not get qualified.

THE COURT: That may be the case Mr. Wicevic but still it's my determination what weight I give his testimony. And I do find him qualified ---

MR. WICEVIC: Thank you.

THE COURT: --- to testify as an expert in this case.

MR. WICEVIC: Thank you, Your Honor.

MR. DEASON - DIRECT EXAMINATION BY MR. ROTHSTEIN (CONT.):

Q: Mr. Deason, is oxygen a type of a drug?

A: Yes. It's considered medication. Yes, sir.

Q: Can oxygen be dangerous?

A: Yes, it can.
Q: Have you ever heard of oxygen being used as a pain relief therapy in pre-hospital patients?
A: I have not
Q: You heard Mr. Wronski -- were you here -- you were here for Mr. Wronski's testimony.
Q: Yes, sir.
A: When he said -- I asked him that question, he said, just ask a patient with a heart attack if oxygen is a pain reliever. Something along this lines. You recall that testimony?
A: I did. I heard.
Q: Okay. Do that catch your attention in anyway?
A: It did.
MR. WICEVIC: Your Honor, I'm going to object to pitting witness about something that's not even related, heart attacks. Is that correct?
THE COURT: The objection is overruled.
Q: And why did that catch your attention, Mr. Deason when Mr. Wronski said something about using oxygen with heart attack patients?
A: American Heart Association has -- and let me qualify. The primary heart Association is what the national registry standard goes by. They're influence. So, we -- we've ben giving

oxygen in 2010 to chest pain patients unless they're in respiratory depression or distress. A normal chest pain patient, what happens is, anytime you give oxygen, everything vasoconstricts. For stroke and cardiac, you don't give it because normally a chest pain patient coronary arteries can help clot it causing the pain. If you vasoconstrict that coronary artery, what they find out through evidence based, we're actually killing patients. We were actually causing them harm. Same way with a stroke. 80 -- I think it's 86 percent. Somewhere around there. Most folks are call it ischemic stroke or clots in the brain. So, the idea is not to tighten up on a clot were vessels being included. That is to keep it open.

Q: Okay.

A: So the evidence was proving it was very dangerous to patients. Acute coronary syndrome and stroke.

Q: Now, tell me what you did to prepare for your testimony here today. What you reviewed or what you studied up on or -- first let me ask. How -- how much time would you say you spent in

connection with reviewing the medicals records and the varies factual documents here?

A: Just a few hours really.

Q: Okay. How much time have you prepared in sort of studying up on -- I mean, did you spend 54 on this case learning the new techniques?

A: No, sir. I feel I know the modern ---

Q: Okay.

A: --- medical also.

Q: Did you have to do any research in terms of finding out whether IV's -- when IV are required or what critical trauma is or any of that kind of stuff in preparing for your testimony today?

A: No, sir. The only thing I did, I talked to my Medical Director, Dr. Michael Chandler. He taught my -- my Medical Director at Herzing is actually one of the physicians that taught one of the first paramedics schools in Alabama and the country. Birmingham, Alabama was the one the first out of five paramedic schools that started back in the 70's, he was one of the first instructors ever. He was a physician. And I conversed with him and asked him about the use of IV's before I came, just to confirm

what I already knew.
Q: Okay.
A: And he concurs.
Q: All right. Let's focus on this particular case. Have you seen the video -- the body camera video in this case?
A: Yes, sir. I have.
Q: Okay. How many times did you watched the video?
A: Only two times.
Q: Okay. When you watched the video, were they -- was it the same. I mean, did you do anything different from one viewing?
A: First time I watched it, I watched without sound.
Q: Without sound?
A: Yes, sir. Without sound.
Q: Why did you watched the video without sound first?
A: I wanted to watch it objectively without the emotion of being involved in it.
Q: Okay. And when you saw it the first time without sound, did you see anything that caused you any concerns?
A: No, sir.

Q: Okay. Have you had any experience with abdominal -- I think Mr. Wicevic actually saved me this question. I think we answered that, yes. And what's the most important thing as -- form a paramedic standpoint when you are called to a penetrating abdominal trauma call?

A: Well, if the only injury is the actual impalement with no signs of shock, don't move the object. You wanna stabilize the object and get the patient to the hospital or surgery.

Q: Are abdominal traumas historically -- I mean, do they lead to a lot of deaths?

A: If it's -- if it's gunfire, not stabbings. Stabbings don't have a high mortality rate. The time it's gonna have a high mortality rate is when it hits the liver. The live is like number one.

Q: Are you familiar with the internal anatomy of the abdominal area?

A: Yes, sir. I am. Actually, I teach anatomy physiology class.

Q: Okay. Were you here when Mr. Douglas was talking about the internal organs were just floating in the air, there not suspended or not attached in anyway in the body?

A: I didn't hear him.
Q: Have you ever heard that in a anatomy or physiology course?
A: No. They're attached by ligaments.
Q: Are you familiar with a different organs that are in the left upper quadrant of the abdomen?
A: Yes, I am.
Q: Okay. Are there more then the three that Mr. Douglas mentioned?
A: You got the pancreas, you got the spline. You got your colon -- small intestine. Part of the liver goes up toward the left. It's mainly underneath the rib cage. The liver is pretty well protected by the ribs.
Q: Are you familiar with this? I'm going to hand you international trauma life support for ---
A: Yes, sir.
Q: --- emergency care. Are you familiar at all with that publication?
A: Yes, sir. Actually, Dr. Campbell who wrote this was our State Medical Director.
Q: For Alabama?
A: Yes, sir.
Q: Is that book used, to your knowledge in national registered paramedic EMS for paramedic

training courses?
A: It is an optional tool, it's optional. It's not required in -- we teach it in Herzing, yes.
Q: Okay. Do you -- have you use that book before in your ---
A: Yes, sir.
Q: Okay. Is it a generally accepted learned treatise in the area of pre-hospital training and care?
A: Yes, sir. It's one of them.
Q: Do you recognize that diagram?
A: Oh, yes.
Q: What is the retro peritoneal abdomen?
A: That's -- that's the area right here that we're talking about. Right to the stomach. Inside of it.
Q: Inside the stomach?
A: Stomach. Back toward the spine area.
Q: What causes most death in a abdomen trauma in your experience?
A: Depends on what it hits. If it hits the liver, it's got a be hemorrhage.
Q: And let's say it doesn't hit a vital organ.
A: It's gonna be an infection.
Q: Okay. What type of infection are typically

caused by abdominal traumas?
A: The bowels dumping into it.
Q: Okay. Is there anything a paramedic can do from the time he arrives on the scene until the patient is transported to the Emergency Department in an abdominal trauma to cure an infection?
A: No. No, sir.
Q: How are infect -- or potential infections treated with abdomen trauma patients?
A: Antibiotics is all I know.
Q: Okay. And do you know -- are those antibiotics typically started in the field or they typically started at the hospital?
A: No. They would be at the hospital.
Q: Okay.
A: Under physician's care.
Q: All right. Tell me about the second time you viewed the video of this care of this particular patient.
A: Yes. The second time I viewed it with the sound bite sound audio.
Q: Okay. Did anything about Mr. Davenport's interactions with the patient caused you any concerns about Mr. Davenport's care for that

patient?
A: Not for the care of the patient, no.
Q: You reviewed the patient care report or the run report that was prepared in this case?
A: I did. I did.
Q: Okay. Could you tell by looking at the patient's vital signs of whether or not the patient in your expert opinion was stable at the time that Mr. Davenport arrived on the scene?
A: Yes, sir. He was stable.
Q: Okay. In your professional opinion was Mr. Davenport, I mean, was the patient stable at the time they place the patient to the back of ambulance?
A: Yes, sir.
Q: Okay. And based on your review of the records, do you have an opinion to a reasonable degree of medical certainty about whether the patient was stable throughout the trip to the hospital?
A: Apparently, it seemed so.
Q: Okay. Do you treat -- I mean, I'm sorry. Do you teach your students in Alabama how to move patients?
A: It taught at EMT level.

Q: Okay. All right. Is moving patients in any textbooks for ITLS?
A: I don't think so.
Q: Okay. And what are the typical ways that you can -- they have available to move a patient from the site of a trauma to a place were you can transport them like the ambulance?
A: Oh, there's many ways. You got -- it depends if they're stable, unstable or if they ambulatory or not ambulatory. All that plays into the factors.
Q: Okay. If a patient is ambulatory -- what does ambulatory means?
A: They can walk.
Q: Okay.
A: They can walk with no risk to them or harm.
Q: Okay. You've seen the video again of the knife being impaled and left in place. Have you ever responded to a call like that where there's a knife still stuck in the abdomen?
A: I have.
Q: Okay. And what's the most important thing to do with regard to -- the position of that knife position of that knife?
A: You gotta stabilize that knife.

Q: Okay.
A: The main thing is, don't allow the knife itself it to move.
Q: Okay. You believe the use of any type of improvised carrying device would be appropriate with a patient with a knife impaled in his stomach?
A: I wouldn't take a change on it.
Q: Okay. You think a kitchen chair -- just grab a kitchen from the house would be appropriate to move this patient?
A: That is not appropriate.
Q: Okay. Does this patient need to be moved in a seated -- like a fowler's position or ---
A: Oh, semi fowler's position?
Q: Semi fowler's position?
A: You move the patient which is best for the scene in a situation, sir.
Q: And you're ---
A: You know, I move patients different ways all the time. It depends on the patient and the injury.
Q: So, in your professional opinion and to a reasonable degree of medical certainty, did the manner in which Mr. Davenport remove this

patient from the couch into the back of that ambulance meet the expected standard of care?

A: Yes, sir. There's no harm for it.

Q: Okay. You agree with me, that's a risky proposition to move any patient with an impaled object in his belly?

A: Absolutely.

Q: Okay. If this were your call, would you use a stair chair?

A: Negative.

Q: Okay. Why not?

A: There's too many factors. It takes three people to move -- use a stair chair for one. Plus, it depends on the strapping situation. They're many, many types of stair chair. And to use a stair chair, the key to moving any -- anytime we move a patient, the key to moving that patient is proper security of that patient to that object. If those straps can't go across his abdomen or it comes in -- or it's gonna move that object, that impaled object in their abdomen, I'm gonna create harm by doing that. That's not a good choice.

Q: Okay.

A: Walking the patient out is not a bad choice

because they're under their own movement. They know when they're hurting and they know what's gonna harm them.

Q: Okay.

A: So we let them do that. Like in mass casualty incident, the first thing we do is remove the walking wounded from a scene because they can move under their on care because -- it's like this. If I had a knife in my stomach, I would not want you to move me. I would wanna move myself cause I know what hurts.

Q: Okay.

A: And pain's a great indicator for when we're moving somebody. We want them to have some pain so we don't harm them. So, not using anesthetics like morphine and stuff, I don't wanna kill this guy's pain because now I can't judge it from hurting him or not. Whatever I'm doing to him. And the key is, don't move the knife inside the abdomen itself, so ...

MR. ROTHSTEIN: And can we bring up this side input.

Q: Do you recognize the device that's pictured in this photograph that's on the screen?

A: Yes. I have one in my school.

Q: Okay. What is that device?

A: That's a -- that's a stair chair.
Q: Okay. And you can explain to The Court how you go about using the stair chair properly?
A: You get a patient sitting there, who's not ambulatory. You go to sit in it and strap the top strap. You strap that across the legs and you strap lower ankles on that stair chair. That right there is what we call low bed stair chair.
Q: Okay. Is that a fairly common stair chair?
A: It is. It's correct.
Q: I noticed that one didn't have the -- sort of the railing or something. I think somebody testified earlier that there are some stair chairs that have a rail.
A: They got tracks. If you buy one that's called the stryker. The stryker come two ways. It comes with tracks or without tracks. It's -- without the tracks, it's $1,500, and to put the tracks on, it's $1,500 additional. So it goes to $3,000 just for the tracks. I've seen a lot of agencies use things 'cause they can't afford the $3,000 stair chair.
Q: Okay. Do you see this upper strap on this particular stair chair? Where would that strap

hit a patient if they were sitting in that stair chair?

A: It's going to hit about midway right here.

Q: Is that about where that knife, I believe it was in the video you saw?

A: It's close to it. Yeah.

Q: If you had the patient strapped by the knife and walked them down the stairs, is there's a possibility that that knife could kind of hit up against the strap and move?

A: Sure.

Q: You see this third bullet down here under -- I'm sorry, second bullet, under disadvantages, unstable to use with trauma patients?

A: Correct.

Q: Have you ever -- in training and experience, seen device given to paramedics or trainees that using a stair chair can be unstable to trauma patients?

A: Absolutely.

Q: Okay.

A: Yeah. Stair chair is -- anytime we move a patient, it's unstable. It's not a -- the choice is, if a patient can move out of their own will, it's a lot safer than us to move

them. There's too many factors that come into play when we start moving patients. That's why you need three people to move the stair chair. You gotta have two. One on the top and one on the bottom. Then you gotta have a spotter behind them, making sure there's no trips. Because one person is walking backwards. Anytime you move somebody on the back board also, there are people moving backwards. We -- we try to avoid people walking backwards moving the patients. And Alabama has -- can I say this? I had a student, they actually dropped the patient off a stretcher because, stretchers aren't designed to go up any stairs at all. And that is a standard. They're not -- because it exceeds weight limits. And they did that, and when they came down, couple -- and it was just like one step. They dump the stretcher and it killed the patient.

Q: I was gonna ask you about that. Did you review any of the Anderson County protocols and standards in preparing for your testimony today?

A: Not really.

Q: Okay.

A: Just what I've heard in here.
Q: Okay. Have you ever seen a standing order where a Medical Control Physician has ordered his people under his medical control not to ambulate a patient?
A: No, sir. I've never seen that.
Q: Okay. When using the normal stretcher on the back of the ambulance be an acceptable way to move the patient -- the stabbing patient that you saw in video? The stretcher from the ambulance up the stairs.
A: No. You, no? You don't move the stretcher up and down the stairs? That's -- it's in the textbooks. That's everywhere. That's under safety and most liability for ambulance companies and all that. There -- they won't allow them to move them up and down stairs anyway. Too dangerous. And it exceeds weight. What we're dealing with, we're dealing with weight.
Q: Do you know how heave an empty stretcher -- a typical empty stretcher in an ambulance is?
A: About 100 pounds, probably.
Q: Okay.
A: It depends on the brand.

Q: Okay.
A: Yeah. Some are lighter than others, but yeah.
Q: Is it a -- like a range is what you say of weights for ambulance stretchers that you've encounter?
A: Yeah. Yes, sir. And some of them have battery operated where they lift them up and down because -- of course, biggest injury to all medics and EMS personnel are back injuries.
Q: Okay.
A: So now you have these battery operated, and they're hitting. Oh they're weighing 175 pounds probably just the stretcher. And the standard is anything over 250 pounds, it takes more than two people to move it.
Q: Okay.
A: If you're gonna do any lifting.
Q: What happens if the more people you add to moving situation, what happens to the risk factor involved in moving that patient?
A: Trippage.
Q: Okay.
A: Yeah. You got fall hazards. Too many moving pieces.
Q: What about a back board. Would you given your

professional experience and education -- would you have used a long spine board to get the patient -- this stabbing patient out of the house that you saw in the video?

A: No. He was ambulatory. I would not.

Q: Okay. Are you aware of any standard that says, ambulating a patient with an impaled knife wound that's stabilized in place, is in violation any type of the standard of care?

A: No, sir. The only standard of care I know is, do not move the impaled object itself.

Q: Now, there is a lot of talk on the DHEC's case about a condition known as shock. I'm sure you're familiar with shock, right?

A: Yes, sir.

Q: Okay. And there was a discussion about keeping an eye on the blood pressure for a shock patient. You recall one of the witness experts talks about ---

A: Yes, sir.

Q: Is blood pressure a good indicator for when a patient is going into shock?

A: No. It's one of the last sign we're going to see. Basically they are gonna be pushing in the irreversible shock, the blood pressure

drops.
Q: Okay.
A: We're probably not gonna get them back.
Q: What happens first when a patient first starting heading shock in your experience?
A: The first thing gonna happen, their heart rate is gonna go up and their breathing is gonna up.
Q: Okay.
A: I could use medical terms but I mean, Yeah. Heart rate goes up, breathing goes up. You have anxiety. And when they start going in to decompensated shock, the first thing that's gonna go is altered mental.
Q: Altered mental?
A: Their -- yeah because they're not getting enough blood going to the brain. So when they become -- when they become -- say like this guy with the knife in him. If he had got to the point where he didn't know he had a knife in him and what was going on, I would start thinking he's moving altered mental. But this guy, he had mental function the whole time.
Q: Okay. Do you teach EMT basics, how to interact with patients to detect whether there's an alteration of their status?

A: Yes, sir.
Q: Okay. Do you teach EMT basics how to monitor blood pressure. I'm sorry, pulse and respiration rate?
A: Yes, sir.
Q: Okay. Do you teach EMT basics to alert a higher certified pre-hospital provider like a paramedic if there's a change in any of these vital signs?
A: Yes. There's -- there's always that step. Anytime we need additional resources, we call for them. And that would be an EMT basic when -- if they realize the can't handle what they have in they call for additional resources which means a higher level of care. Or it could mean hazmat. It could mean fire service. It could be extrication. Anything they can't handle, the first thing they need to do is, I need additional help.
Q: Okay. If a paramedic has difficulty starting an IV on a patient who needs fluids or needs treatment for -- to head off the effects of shock and they can't get an IV start on, are there mechanisms to provide some fluid to that patient?

A: Yes, sir.
Q: What is the -- the standard for rapidly infusing fluid in the patient where you can't start an IV?
A: We can do a interosseous.
Q: Okay. What is interosseous?
A: Interosseous, there's methods you can use or different devices. They're really not methods. Basically we put the catheter into one of your bone, and we're able to infuse fluid or medication through your bone. We can do the tib-fib. We can do femurs in small children. You can do the humerus up here. And basic -- there's three different devices right now that I know we use and that we teach. Well, we can't use them all right now, but we teach them. The EZ-IO drill. It look like a Dewalt drill and I can punch this into your shoulder and I can drill and put a catheter into your humerus. It's a very quick method. It takes about -- I can do it like 10 to 15 seconds, initiate an IV. If I can't get an IV catheter started in a vein. The other one is Fast. Fast goes in your manubrium right here. The military really use the Fast one. The Fast one

is probably the best device out there. Most people don't buy them because they cost around $275 each. There are expensive. But they interfere with nothing and they are the closest to all your vital organs, it's got the shortest route to get into your systems. The other is called a bone injection gun. Bone injection guns, I've used them where it acts as a spring loaded -- it's almost like a ram set. You know what a ram set is. But long story short, you put it against your shin bone and we can shoot it in and it'll put a catheter inside your bone marrow. And then we can infuse you.

Q: Are those skills that you teach nationally certified paramedics?

A: Yes, sir. They are required.

Q: Okay. Is that an ALS skill?

A: Yes, sir.

Q: Do you have an opinion to a reasonable degree of medical certainty based on your training and experience about whether an IV needed to be started on this particular patient after you reviewed the records and saw the video?

A: There were no indications of shock. So I -- no, there was no IV needed.

Q: Okay. In your studies and in your teaching at the school in Alabama, do you -- have you come across any literature that says anything about the mortality of patients who have IV's started in the field as oppose to starting at the hospital?

A: Depends on the condition. Consider, I mean -- it -- the thing about this particular patient's condition, it wouldn't have helped him at all. There's no treatment plan for it. Talking about pain scales, IV's and IO's. IV's and IO's, when look pain scale of IV's and IO's, people rate them as a four. So, when we're talking about pain scales, I remember this guy saying his pain scale was a four. That's to say it's equivalent to an IV or an IO being inserted. An IO sound pretty brutal, but you can watch live videos of them, they really don't complain much about the IO going into bone 'cause there's really no nerves on the -- in the density of a bone. It's hurts more when you start the infusion.

Q: Okay. If paramedic started a IV on this particular just for the risk of starting an IV or a hepwell or just a just in case -- I think

Mr. Wronski referred it as a -- have you ever heard the term, IV lifeline before?

A: I have not.

Q: Okay. What risk -- are there any risks that would be involved in starting an IV on this particular patient with the knife in his stomach?

A: There's risk every time you start an IV.

Q: Okay. Is an IV sometimes a painful thing to get? I know -- I think said ---

A: Yeah. The average is around a pain scale four. Most people say four.

Q: And you recall that being the same pain scale level as the patient reported for the knife being stuck in his belly?

A: What I remember him saying. Yeah.

Q: Based on what you reviewed, do you have an opinion to a reasonable degree of the medical certainty about whether Mr. Davenport in this case rendered appropriate care to this stabbing patient that you saw in the video?

A: I do. There was no harm.

Q: You believe based on your education and experience that Mr. Davenport provided good care to this patient?

A: Yes, sir.
Q: Okay. Do you know Mr. Davenport personally?
A: Me and Mr. Davenport have business transactions.
Q: Okay. And by business transactions, can you explain to The Court what you mean?
A: Yeah. I heard of Mr. Davenport through a mutual friend. Another Colonel in the Army. I needed an 18-Delta to come teach a tactical medical course, the one that I teach and I know 18-Deltas are the most highly trained tactical medics there are.
Q: How many course would say that Mr. Davenport has taught at your school?
A: I think we've done four.
Q: Are you familiar with Mr. -- or have you observe Mr. Davenport's knowledge base and experience in treating critical trauma patients?
A: Just through instruction.
Q: Did Mr. -- I assume if Mr. Davenport was not doing a good job you wouldn't have hired him four times. Were you pretty pleased with the level of ---
A: Very, very pleased. He's very demanding right

now, to come teach a courses.

Q: Have you sat in on any of the courses that Mr. Davenport's taught?

A: Yes, sir.

Q: Okay. Now, I see your military services is at the back of your CV. Does that appear to be a complete listing of your military awards, education, and certifications?

A: It's changed since then.

Q: Have you ever been deployed with Mr. Davenport's Special Forces team?

A: No, sir.

Q: Now you mentioned the term, 18-Delta. Can you explain to The Court your understanding of what type of or how an 18-Delta is regarded in the military trauma?

A: Yeah. They are at this highest regard. An 18-Delta's a Special Forces Medic. They can do field surgeries. They can do sutures. They can do infection treatments. they have a large scope of practice because when they're -- where they operate there's no physician that they fall under the orders of. So they have to be able to survive. You know, I'm been 29 years going on 30. I'm a, I was an NCO. I am a

officer, now. And the Special Forces Medics. They attached them to seal teams. They attach them to Marine Recon. They use 18 -Deltas across the military in different branches because they're so highly trained.

Q: Thank you. I don't have any further questions. Mr. Wicevic may have some.

MR. DEASON - CROSS-EXAMINATION BY MR. WICEVIC:

Q: Don't think I have all too much. It's getting near the end of the today. All right. So, Mr. Deason, are you being compensated for this ---

A: No, sir.

Q: --- testimony?

A: No, sir.

Q: It's just your friendship with Mr. Davenport?

A: I was on military duty and he asked me to be a subject matter expert witness. So I came up here. The military let me come up here.

Q: Okay. How were you retained Mr. Davenport? Did he just call you up?

A: I think he did. I tell you what, he was teaching. He came up to teach the last tactical medic class.

Q: This is in Alabama?

A: Yes, sir.

Q: Okay.
A: June 26th.
Q: So it's -- I think you said this is more of a business relationship with Mr. Davenport. Is that correct?
A: Yes, sir.
Q: Am I correct that if DHEC were to revoke his certificate that would affect his NREMT credentials? Is that your understanding?
A: I'm not sure how South Carolina reports.
Q: If they did report it, would the ---
A: Yes. I think would.
Q: Now that would impact his ability to teach your courses. Isn't that correct?
A: No, sir. You don't have to be a -- you don't have to qualified. 18-Delta is qualified to teach this course.
Q: Okay. So NREMT is not a requirement to teach the tactical medical course?
A: No, sir.
Q: Did you ever serve or deploy with Mr. Davenport?
MR. ROTHSTEIN: Your Honor, I asked him that exact question.
THE COURT: You did.

MR. WICEVIC: Okay.
A: No, sir.
Q: I'm sorry. I was talking with my client. The only thing you reviewed in this matter were the patient reports, body camera footage. Anything else?
A: I read some of the deposition.
Q: Which deposition?
A: I think it was the IRC or maybe not. Maybe it was the one where he was in there. I can't remember. This one, I read short piece of it.
Q: Now, is it correct to say that a Special Forces Medic and a civilian paramedic are totally different?
A: Scope of practice, yes.
Q: Scope of practice. Are there any other differences?
A: I can't qualify that.
Q: There's not ---
A: Well, I can't qualify it because I know the Special Forces training is a higher level than civilians, so I really don't know.
Q: Okay.
A: Just specifics. I think. I couldn't lay it out on a piece of paper and say yeah, this one,

this one, this one, so ...
Q: All right. This patient -- the patient in question, he had a significant trauma injury. Is that correct?
A: Well, it didn't look like it.
Q: You wouldn't consider that a traumatic injury?
A: Yes, that's traumatic injury, so is a broke toe.
Q: Okay. But you wouldn't -- you told me, it's not a trauma injury?
A: No, this is trauma. You said a significant.
Q: Okay. So it's not significant, yet it would require surgery. Is that correct?
A: Correct.
Q: Okay. And this patient did have surgery?
A: Correct.
Q: And there was a knife penetrated the peritoneum?
A: Right. If I'm remembering.
Q: So something requiring surgery is not significant?
A: My wife broke her ankle the other day and had to get pins put in with surgery.
Q: So you're ...
A: Surgery doesn't -- surgery does not qualify to

be significant.
Q: Okay.
A: There are a lot of significance traumatic injuries that require no surgery.
Q: So I know you said that this patient was hemodynamically stable throughout the call.
A: From the numbers. Yes, sir.
Q: Okay. Now isn't it correct that. He could've decompensated to the point that he was in shock?
A: Could he? He could had a heart attack also.
Q: Right. Well I mean, this type of injury, wouldn't that present a significant possibility?
A: Well it didn't. Could it? You know we had a guy -- I'll give you a for instance but yeah. The last penetrating trauma call I went on, it was a gunshot wound. The guy got shot I the stomach and he got shot in the back of the knee. The back of the knee shot killed him. It hit his popliteal artery. The abdominal wound was not his death fall, it was the back of his leg.
Q: Right.
A: So, when we -- when we look at things that are

significant, we saw what the outcomes are for whether they're significant or not.

Q: Okay. But I mean, if the organs involved in the left upper quadrant, that presents some significant injuries if punctured, correct?

A: Depends on which one.

Q: Which one would be significant?

A: Upper left. If it got under the rib cage, the liver.

Q: The liver?

A: Yeah. If they got it on the rib cage it could ---

Q: The rest of the organs would not be significant?

A: The pancreas is pretty -- that's a pretty bad one. Spleen, probably wasn't gonna reach his spleen. Wasn't going to reach kidneys. The intestine, you're going to have the large intestine and you gonna have a small intestines. And they are gonna be about -- they are gonna have spillage, so you could get an infection from that.

Q: I'm sorry? We don't know the length of the knife, correct?

A: Correct.

Q: So that's an uncertainty that we're presented with.
A: It is.
Q: Would you err on the side of caution?
A: What do you mean?
Q: When you have uncertainties such as the length of the knife.
A: We don't treat for shock unless shock presents itself.
Q: What about the potential for shock?
A: I can put an IO in ten seconds.
Q: But you're an expert in paramedicine. Can an EMT?
A: An EMT? No. Advanced EMT's can.
Q: Do you straight to an IO before you or do you -- is IO acceptable to an IV?
A: It is acceptable practice. Yes, sir.
Q: It is?
A: Yeah, yeah. Anybody who is a life threat and decompensated fast, you can go straight IO.
Q: Right. But I mean the preferable treatment would the IV prior to the IO, correct?
A: That's gonna be opinion.
Q: Is that something you teach your students to go straight to the IO?

A: For the life threat. Yes, sir. We do.
Q: We'll take life threat out of the equation.
A: Then you just do an IV. But here's what we teach our students. If we're gonna an IV and we can't accomplish that, you gotta be willing to start the IO or they did not need it at all.
Q: Yeah. I don't think that's the ---
A: Yeah. So that's the theory behind IV's now. Talking to trauma docs, Dr. Will Ferguson, Shay Durin, Dr. Chandler. He's a professor at UAB, the thought is, I treat was is there. I don't add to what I have because I can cause harm. Starting that on somebody that doesn't need it is potential harm just as mush as other things, you know, the ways of the world. But to start an IV, I can start an IV, I mean, if you're good medic, you start an IV. Ten or 15 seconds will get it going. And if not, you have a IO backup. And so, you treat significant injuries when they prevail. When they show themselves.
Q: Okay. So, I mean, there's occasions where yeah, I'm not gonna treat for an IV or establish IV access to the point where he decompensates, to the point where I can't do an IV so I move to the IO. So, is that a practice

that you teach?

A: No. We do, I do -- and not -- not really this. We do a lot of trauma. We do a lot of trauma. We have I-65 running through there. So I do significant traumas a lot -- standard care now for trauma. Dr. Jones said it best to me. He said, right hospital, right route, right speed. And he said, and here's the thing, even after registry. If you answer any question on national registry, certain case and test that you starting out there on the scene for trauma or a shock patient, you fail. You do it en route. You only do it en route. I do CPR probably -- we probably do the CPR -- and it's kind of containing but it becomes decompensated. Anybody whose heart stop beating, they're decompensated. We, 95 percent of the time, get IV's. They don't even have a blood pressure at all 'cause we're actually good at what we do. I can use the EZ-IO one time in the last -- I've used an IO on a full rest. And I do at least one to two full rests a month. And I only use an IO, my and my crew, probably twice in my years when starting IV.

Q: So the IV is preferable.

A: Yes, sir.
Q: So you shouldn't wait until you need to use the IO when the -- when you can establish an IV?
A: Say that one more time.
Q: You shouldn't wait to establish an IO when you can establish an IV?
A: Well the standard on that is this. You go for an IV because the hospital -- you go for an IV, but -- and I'm gonna speak from Alabama or any care. If I decide IO is a better route, then it's a better route. You take somebody with amputations. You may not have IV access. You may have to go IO route. So the situation dictates. The bottom line is, you have to get IV access to somebody that is in the need of it. There's only two reasons to even start IV's or IO's. One is for drug medication and continuous infusion of fluids. If I'm not gonna do it continuous infusion fluids, there's really not a need for it.
Q: Okay. So what were those two? Need for fluids or medications?
A: Or medications, correct.
Q: What happens when you suspect somebody would decompensated and you need to establish IV

access? Isn't that one of the reason why ---
A: Well, they'd have to have signs of shock for me to indicate that.
Q: So ---
A: They'd have indicators.
Q: So you wait for the signs of shock to ---
A: Absolutely.
Q: --- begin? Even when it's an injury where you suspect shock might be coming?
A: No if I -- if I suspect shock to be coming, I go ahead and initiate, yes.
Q: Okay.
A: Yes. That is correct.
Q: Now, would you consider this a trauma that would require a trauma alert?
A: In South Carolina, I really can't tell you. Alabama, that would not be.
Q: And why is that?
A: It doesn't meet any of the criteria.
Q: Okay.
A: Yeah. Trouble alerts come with criteria. And those are deemed by your state.
Q: Okay.
A: And I don't -- I don't know your trauma system. I don't know your trauma system in South

Carolina. Ours is pretty specific in what it says. And then it's also discretions, we need to have discretion. We have one level one trauma in the Birmingham area.

Q: Okay.

A: To trauma alerting we can only go to a level one trauma, okay?

Q: All right.

A: If we -- if we choose not to trauma alert and we take them to a level two and they could still remove that knife from that patient because he's stable. It's not required in trauma alert if I level two.

Q: So a traumatic injury is not something that would require a trauma alert?

A: No. Not all of them, no.

Q: Okay. Now, what about oxygen for traumatic abdominal injuries. Is that something that's generally required?

A: No. Not anymore.

Q: Okay. Let me hand you this. I think there's some reference to this. And you said, the international trauma life support text is generally accepted?

A: It is. In any textbook, there are -- any

textbook that is used, there's a difference of opinions in different textbooks. And it's different doctors who write it. Dr. Campbell wrote this one. So this is Dr. Campbell's opinion. And -- and unfortunately, Dr. Campbell right now, he's got meningitis on a cruise about three or four years ago.

Q: Right.

A: And I think he authored this book, but I don't know what the date is it came out but this was written probably way before the publishing date, so.

Q: So you're saying this book is not ...

A: No. I'm saying it's accepted. Yeah.

Q: Well, let's take look at the ---

A: Yeah.

Q: --- 259, please.

A: Okay.

Q: And this is in chapter 13, abdominal trauma. Is that correct?

A: Yes, sir.

Q: Okay. Under stabilization. I'm going to read this to you, you let me know if you agree.

A: Okay.

Q: Intervention should follow priorities

established by the ITLS primary survey. They should proceed in the same order in which the assessment occurred. A, airway; B, breathing; and C, circulation. This sequence changes to CABC if there is obvious severe uncontrolled external hemorrhage for the patient in whom only enter abdominal injury is suspected, give supplemental oxygen by the most appropriate method and be sure breathing is adequate before dealing with circulatory issues or shock or potential shock. Is that correct?

A: That is correct.

Q: So ---

A: I read that.

Q: This ITLS, it says, supplemental oxygen is required for this, is appropriate. Is that better wording?

A: That's what it says.

Q: Okay. Moving on, next paragraph. The patient should be ready for immediate transport, appropriate spinal motion restriction if indicated of no penetrating trauma to the abdominal or chest. No signs of neurologic episode. Does not require immobilization of the spine. Go to the next paragraph. Time to

the definitive care at the trauma center is critical. Unnecessary intervention on scene should be avoided. Once en route to appropriate trauma center established two large bore IV lines of normal saline. If the patient's blood pressure drops below 90mm. hg systolic signs of shock, then IV fluids should be titrated to maintain the systolic blood pressure at 80 to 90 mm Hg.

A: Right.

Q: However, keep in mind that overly aggressive food resuscitation might dislodge protective clots, and or diluted clotting factor both of which could lead to a worsening hemorrhage. So that seems to be contrary to the accepted standards that your just explain.

A: Yes, sir. But this is not an accepted standard on the national registry for EAT'S.

Q: You told me ---

A: It's an accepted standard in the -- as a textbook that can be we used ---

Q: Okay.

A: --- as a reference. We don't do two large bore IV's anymore. And now the standard is one large bore, one large bore IV.

Q: Okay. So you disagree with this? This guidance in this text?
A: Not all of it.
Q: Okay.
A: Yeah. Just that one part ---
Q: What I read to you?
A: Yeah. And this is -- what's the publishing date on it? The eighth edition, 2016. 2012, 2016. There's been a couple modifications. Seventh edition was out for a long time.
Q: Okay.
A: And then they came out with this a couple of years ago. And, you know.
Q: So you're telling me the standards have changed since 2016?
A: This isn't, yeah. This isn't the absolute standard.
Q: Okay. All right. So there's significant differences between the pre-hospital trauma life support and this international ---
A: I'm not really familiar with pre-hospital. Like I said, not that manual. Not that textbook.
Q: Well aren't you certified to teach both of these, ITLS?

A: No. No, ITLS not PHDLS.
Q: Well, ITLS is what I just read to you.
A: Yes. I'm certified in it, correct. Not the PHDLS.
Q: Is that an acceptable standard?
A: It is.
Q: Okay. So you're not certified in acceptable standards?
MR. ROTHSTEIN: Your Honor, Mr. Wicevic is throwing around this term, acceptable standard. I mean that -- as far as I know that's not a relevant term to anything. I mean, if this were a malpractice case, it would be the standard of care expected of pre-hospital provider. If -- I think what Mr. Wicevic would have to share is whether DHEC viewed Mr. Davenport's actions as below DHEC's acceptable standard. Whether it's contrary to what's in a book is completely irrelevant.
MR. WICEVIC: Well then I -- I mean, he's just testifying to his subjective professional judgement. I don't know the relevancy of that to this determination regarding our allegation for acceptable medical treatment. Our position, that goes to national standards of

care. From I believe Mr. Douglas' testimony, ITLS, PHDLS, explain the basic national standard for care. I'm going to move on, Your Honor.

THE COURT: The objection is overruled.

Q: Okay. All right. So we talked about the knife. There's no way to know with reasonable care of certainty, the length of that knife?

A: No, sir.

Q: There's no way to know if it punctured -- with reasonable certainty if it punctures another organ, correct?

A: Correct.

Q: Okay.

A: Not in the field.

Q: Now, in those cases of uncertainty, you must perceive with a bonus of caution of correct?

A: Yes.

Q: I think we talked about this. I mean you -- I believe it's your position. If the patient decompensated to the point where IV access was no longer feasible, you would just do an IO?

A: Correct.

Q: Okay. Intraosseous?

A: Correct.

Q: Now, for traumatic injuries, time of the essence. Is that correct?
A: Yes.
Q: And you've heard of the golden hour rule?
A: That's out. The golden period is what they all it now.
Q: Okay. So there's no set hours?
A: No. It's no set hours.
Q: And that refers to the time, I guess injury occurs?
A: It does.
Q: Okay.
A: Until they get to the OR.
Q: Okay.
A: Right.
Q: But that's in general, I mean, time is of the essence?
A: Absolutely.
Q: So I mean, if you had pulled over -- if you find a safe spot to pull over. Have the paramedic come out of the ambulance, switch places with the EMT, do anther assessment because you don't have your personal observation of the patient and then make the appropriate treatment call. I mean that's

wasting a quite a bit of time, isn't it.
A: He's got a stable -- I mean, he was stable. He was showing signs of stability.
Q: He ---
A: Total stability. He was showing no signs of decompensation at all.
Q: But if he were to decompensated?
A: Well, if you got into a wreck at a red light, it would be bad.
Q: That's a good point.
A: I mean the number one issue in ambulances these days is wrecks.
Q: What's that?
A: The normal is wrecks. One of the worst patient cares that's taking place now are ambulances that are being involved in accidents going to the hospital or going to the scenes. And that will delay care a lot more?
Q: So you -- you feel ---
A: So ---
Q: You feel like that's more of significant threat than providing preventative care for this?
Q: We don't do preventative care. Our job is pre-hospital emergency care.
A: Okay. So, a principle of pre-hospital care is

not to prevent the preventable?

Q: You do prevent the preventable, but if somebody goes into shock, you can't prevent it. Somebody goes into shock, hemorrhagic shock you can't prevent it. It's going to happen. It's inevitably.

Q: But you can prepare for it.

A: But it doesn't prevent it.

Q: Well, can you prepare for it?

A: Everybody can prepare for it. We do it in our house.

Q: Okay. So, I think it was your testimony that the reasons to established IV's when fluids or medications is needed.

A: Yeah. Continuous infusions and medications need to be administered.

Q: Now, this patient was going to require IV access, correct?

A: For what?

Q: Surgery.

A: I would say so.

Q: Now I -- I mean I understand the concern about administering too much fluids and breaking the clotting. I'm not sure if I'm using the correct vernacular. But, I mean, there's

alternatives, you could do the heplock or do the saline drip pace I suppose.

A: Well my experience, like I said, we have a level one -- we've got a UAB. UAB is one of the top ten in the country for a level one trauma. And my experience is when I ride in with a trauma patient 'cause I'm a lead medic. Sometimes I am required to ride in with significant trauma 'cause I cannot turn over my care. So my experience is, even when we ride UAB, they're gonna start the new IV to go to the OR. They're not going to use what we have because -- so, it's questionable about the septic of it. The aseptic piece of it. It could not be a good IV. They want to use their own, so they know they have good IV access.

Q: You said something interesting. You said, for all trauma patients, you have to ride the call in Alabama. Is that ---

A: Significant trauma.

Q: Okay.

A: Life threatening trauma.

Q: Life threatening?

A: Life threatening trauma.

Q: All right.

A: If we trauma alert them, a paramedic rides even though there's a paramedic in the back of the ambulance.
Q: I'm sorry?
A: See we don't transport. So there's already a paramedic in the back of the ambulance just our city policy, we continue care so we have continuation of care.
Q: Right.
A: For anybody who's decompensating.
Q: And this gets back to the non-transport, transport distinction.
A: Uh-huh.
Q: The only time you would -- I mean, when you ride there you ride there in a fire truck. Is that correct?
A: We drive up to the house fire truck, yes.
Q: QRV's, do y'all have those?
A: No.
Q: So it's only fire trucks?
A: Yeah. We have on our fire trucks -- in Homewood, we have at least four people on a fire truck at time and at least three paramedics. The only thing we don't carry is the transport of ambulance.

Q: Okay. So the transport vehicle shows up and y'all already have -- I mean, if there on the scene first --

A: Right.

Q: --- you've already established assessment.

A: Correct.

Q: Tried to do some kind of stabilization procedure?

A: Correct.

Q: And then you're on to loading the patient up.

A: Right. We make the decision whether or not to continue care or not continue care.

Q: So sometimes you end your care at the scene. You don't ride?

A: Correct.

Q: How often do you ride the call in?

A: I would say -- well I trying think in my head right now. One of us rides in probably three times this shift. Four times this shift.

Q: Three times a shift.

A: Yeah.

Q: So I mean for every call you run ---

A: Depends on if it's significant or not. It's all about significance.

Q: So that's what you make a determination on?

A: Right, right.
Q: It's a discussion with, I guess, the EMT? Again, I'm saying EMT generally.
A: Yes.
Q: EMT aboard the transporting agency as far as who is riding it in?
A: Yeah. It depends on severity.
Q: Okay.
A: For which one of us rides it.
Q: Right.
A: And mainly it's so we can continue care. And also we have another paramedic in the back assist us. But we maintain control of the call. If it's significant.
Q: Okay.
A: So it -- I'm the one who makes the decision for the last -- since 2003 on significant calls 'cause I'm the lead medical on my truck. Oh my. I'm the highest ranked and based on our state laws, I have to make decisions on significance.
Q: Okay. Are you familiar with the CDC trauma triage guidelines?
A: Yes, sir.
Q: Are they accepted within Alabama?

A: It's an acceptable practice, yes.
Q: Are you aware that that guideline lists abdominal penetrating injuries as a trauma injury requiring trauma transport?
MR. ROTHSTEIN: Your Honor, if he's gonna characterize ---
A: We have.
MR. ROTHSTEIN: --- the guideline, I think he's gotta hand it to the witness. And I don't he ---
MR. WICEVIC: I'm just asking him ---
A: Yeah.
MR. WICEVIC: --- if he's aware ---
THE COURT: I'll allow the question.
A: I'm kind of lost on what you mean by trauma transport.
Q: If that is a trauma injury that would require transport to a trauma center?
A: Oh, that. Well I mean, if you break your ankle, that's a trauma and you need to go ---
Q: Yeah. But I'm talking ---
A: --- to the hospital. I mean ---
Q: I'm talking about trauma alert.
A: Oh okay. You didn't say that. Okay. Trauma alerts, they go to level one.

Q: Right. But a penetrating abdominal injury, would that be something that would require a trauma alert according to the CDC guidelines?
A: Yes. If it's significant, yes.
Q: Okay.
A: But now let's take a -- let me just describe penetrating traumas. If I take a thumb tack and I stick it in your abdominal, that's penetrating trauma.
Q: Right.
A: That's not significant.
Q: Yeah. I mean that's a little obvious. So ---
A: Definition of penetrating trauma is anytime you break the skin with hard object. Okay? If I stick a thumb tick in your stomach, that is not significant abdominal trauma, but it is penetrating trauma. That would not be a trauma alert. That would probably fire. If I showed up at UAB level one, your doctor would just eat me alive for trauma alerting him.
Q: So I mean, how long does the knife does the knife have to be to be a significant penetrating trauma?
A: It depends on the patient.
Q: It depends on the patient?

A: It does.
Q: I mean, and again, you don't know the length of the knife?
A: No.
Q: So ---
A: Yeah. We look for signs. Signs of that shock.
Q: Okay.
A: Yeah.
Q: So you can move into a different subject. Behavior and verbal interactions. Would you characterize Mr. Davenports language to actions as being rude not professional?
A: I would say he was rude. Yes.
Q: Okay. Would this raise a concern with you if you saw one of your co-workers ---
A: It would be an employee supervisor issue.
Q: Okay. And what would you do?
A: Basic remediation.
Q: Okay. I mean you never spoken to a patient like this before, have you?
A: Not that I'm aware of.
Q: Now, you'd agree that the way you interact with the patient consists in gaining that patient's confidence?
A: True.

Q: And to establish that confidence is something important.
A: True.
Q: And that's something you teach at school, correct?
A: That is correct.
Q: You want the patient to communicate with you?
A: True.
Q: Did you see that appropriate communication in this particular incident?
A: Well that's why I watched it the first time with no audio to see -- I'm looked at it objectively from a patient care. Did he do the right steps in his patient care. And he did. The patient care was okay. The interaction, he probably needs remediation.
Q: Okay.
A: I think it's more of an employee issue than a licensing issue. This is not a license -- the way somebody talks to a patient is not licensing issue. I mean ---
Q: Well you're not a part of the licensing authority, are you?
A: No, sir. But I do give advice about it.
Q: Okay. And you're not familiar with DHEC's

procedures?
A: No, I'm not.
Q: All right. The ambulation of the patient. Now you have experience transferring these patients from the scene of the accident or illness to the ambulance?
A: Yes, sir.
Q: Okay. Now, at this patient -- at the scene of the injury. Patient already suffered a serious bodily injury or would you disagree with that characterization?
A: Based on objective -- I can't say it was significant 'cause we'-- like I said, we don't we length of the knife. It could've been a one inch knife but he had no signs instability at all.
Q: Okay.
A: He was not unstable and he was showing no signs. Matter of fact, the guy, I mean if I had a knife in my stomach I'd probably be a little more upset than he was. I mean, he was looking pretty relaxed to me with that knife stuck in his stomach. And I've seen that before. It, you know, with somebody else stuck a knife in their stomach, so.

Q: But the bottom line is you don't know, and there's no way to know ---
A: Yeah, we don't know about.
Q: All right. So, I know you talked about moving a patient, hands on, whether they're among other things you said ambulatory.
A: Correct.
Q: How do you know a patient is ambulatory?
A: They have the ability to walk under their on will.
Q: I mean, how do you make that call?
A: You ask them.
Q: You ask them? Did you see Mr. Davenport ask this patient before?
A: No. He got up and started walking.
Q: Okay. So you say, get up walk ---
A: Uh-huh.
Q: --- and then you make a call? I mean ---
A: Yeah.
Q: --- isn't that kind of after the fact?
A: Yeah, but if I couldn't walk, I'd tell you I couldn't walk.
Q: Okay. Now, stabilizing the knife. That's the first thing he did.
A: Right.

Q: Now ambulating the patient after stabilization ---

A: Uh-huh.

Q: --- now don't they go at logical odds? I mean, getting up, increasing your movement. That puts significant risk of destabilizing the knife, correct?

A: Less than me moving him. And I can demonstrate. We can put you in a chair or something, and I promise you, you're not gonna like the way we move you. This what these patients do. They feel uncomfortable. We move them in stair chairs and backboards 'cause they don't have control of their own body. If you allow somebody to have control of their body, they're gonna move what works for them without causing their harm.

Q: Yeah.

A: I can't feel what he's feeling.

Q: Okay.

A: I rely on his moments and the way he moves, I'll let him move him carefully so we don't create harm. And you know, it's -- when you move somebody, you're taking a lot of risk.

Q: Right. Now I thought you said you wanted the

patients feel some harm.
A: Say that again?
Q: Didn't you said you want the patient to feel some harm?
A: No, no, no.
MR. ROTHSTEIN: Your Honor, he said pain.
A: No, no, no. no, no, no.
THE COURT: Yeah, I ---
A: You don't remove the pain. You don't remove pain. I don't pain, but I don't remove the pain. So he can move under his own will and he knows what's hurting or not. Pain is a good indicator of how people move. I mean, if you sprain your ankle, you're gonna walk differently on that ankle than you normally would. You're gonna walk so you don't create more injury. But if I move you, I can create more injury because I don't feel your pain. So we let patients move ambulatory if they're ambulatory.
Q: Okay. So I mean, if you have a way to avoid pain, you don't utilize that manner?
A: What do you mean?
MR. ROTHSTEIN: Your Honor, it's after 5:00 o'clock. I've got one more witness who's out of state.

I don't know how -- I mean Mr. Wicevic seems to be going around and around in a circle. And I'm got Mr. Deason, and Mr. Crus has been here for two extra days from out of state and think this taking interminably long. I'm not trying to rush Mr. Wicevic. He's had four days to put on his case and now we're confined to less than a day to put on ours. And I think it's ...

THE COURT: How much longer do you anticipate taking Mr. Wicevic?

MR. WICEVIC: Not that long, Your Honor.

THE COURT: Okay.

A: All right. You want me to address the pain? I'm kind of like Mr. Douglas on the pain. You have a lot of risk when you start using opiates on people. They can be allergic too. You can put them in anaphylactic shock and actually kill them. It's a risk to it. And also pain, again, is a good indicator of whether or not we're causing harm. If we remove somebody's pain from them, and I move them with a traumatic injury, I can be creating greater harm because you're not responding to my actions like I need you to.

Q: With this patient, I mean, it's harmless

readily apparent. Wasn't that correct?
A: Oh, yeah. He had a knife in his stomach.
Q: So wouldn't you want to take every step to avoid pain for this patient?
A: He didn't look like he was in very pain.
Q: Well he was in some pain, correct. I mean reviewed the patient care reports.
A: I looked at risk. What if I give him morphine and put him in anaphylactic shock and killed them? Then you're sending different levels of -- he kind of -- you brought harm on to that patient. Removing the patient -- pain management, it is only if the pain is hindering the patient care. His patient care was not being hindered by his pain.
Q: All right.
A: It was not creating harm to him.
Q: We talked about the stair chair sometimes. It sounds you don't use the stair chair all that often. Is that correct?
A: No, I do. We do use it.
Q: Under what circumstances?
A: If we're up several flights of stairs, that's what it's designed for. To move the non-ambulatory who's conscious.

Q: Isn't designed for transporting down stairs?
A: Yes. That's what it's designed for.
Q: Well you said ambulatory patient.
A: Non-ambulatory, I'm sorry, non-ambulatory. The non-ambulatory. You move the non-ambulatory with it.
Q: So if a patient is on the second floor but he or she is ambulatory, you wouldn't use the ---
A: No. I'd walk them down the stairs.
Q: Now doesn't that increase movement for the patient?
A: I don't think there's any research on that, no. Never seen ---
Q: Well it's just common sense. I mean when you're walking, you're using a lot of muscles, correct?
A: You ever been on a stair chair?
Q: No. But I seen pictures of ---
A: They're not smooth. Now, if you pay $3,000, you can have those tracks on there. And no they're still -- and still, you're moving that patient. And what happens is, if you slip or move, you're gonna create more harm by your actions.
Q: You can slip and fall a walking patient, right?

A: Well I can, yeah. But the patient won't ...
Q: Well the patient can slip and fall too.
A: Sure.
Q: You said you need three people. At least three people to utilize the stair chair? Do you know how many people were on scene for this?
A: Looked like four or five.
Q: Now the straps, you said that was an obstacle for the stair chair. The straps can be -- I mean if it -- you can manipulate them to use -- -
A: Yeah. You can do different things.
Q: Okay.
A: Yeah. You can do different things. It depends on the chair. Anytime that you alter -- you gotta be careful. Anytime you alter you alter something -- anytime a mobilization equipment or movement equipment and you alter and something does happen, now you fall under a different liability.
Q: What do you mean liability?
A: If you hurt the patient because you altered that equipment. We're not really allowed to altered equipment.
Q: You're talking about negligence?

A: No. It can be. It depends on how you alter it. Yeah.
Q: Let me read through my outline. I think that might be might everything. Let me ask you this. Significant trauma, you agree -- I know you don't consider this significant trauma injury. That being said, if there was significant trauma injury, who would have to ride in the back of the truck, the ambulance truck.
A: Significant, would be the paramedic.
Q: Okay.
A: Now that's in Alabama.
Q: Okay. What about the national standards?
A: National standard, highest level.
Q: Highest level?
A: Yeah. Now let me caveat this. I've actually been called to doctors offices in the hospitals in Birmingham, where doctors turn over care to us all the time because we're emergency care providers and we're viewed as a lesser level but -- let's say if I go to an internist's office and I have a patient with chest pain or something. That physician is gonna turn over care to us and we're lower level but we're more trained at that type of care ---

Q: Yeah.
A: --- or equal.
Q: So you're talking about at a hospital?
A: I have been. Yes, sir.
Q: Okay.
A: I mean the hospital rooms and transporting patients out of hospital rooms.
Q: All right. That's all I have for you. Thank you, Mr. Deason.
THE COURT: Okay. Do you have anything on redirect?
MR. ROTHSTEIN: Just a few questions.
MR. DEASON - RE-DIRECT EXAMINATION BY MR. ROTHSTEIN:
Q: Have you ever heard of a requirement that EMT's need to carry all of the equipment into the house or into the scene of a -- where they have to treat the patient?
A: No. You can't carry all of it.
Q: Is that a feasible or reasonable requirement?
A: No.
MR. ROTHSTEIN: Okay. No further questions, Your Honor.
THE COURT: Thank you. Thank you, Mr. Deason. Mr. Rothstein, before you move to your next, let's take just a five minute ---
MR. ROTHSTEIN: Okay.

THE COURT: Because it's been awhile.

(Off the record from 5:10 p.m. until 5:21 p.m.)

THE COURT: Okay. Mr. Rothstein, you can go ahead and call your next witness.

MR. ROTHSTEIN: I call Sergeant Derrick Crus.

THE COURT: Okay. If you'll raise your right hand, the court reporter will swear you.

FIRST SERGEANT DERRICK CRUS, having been duly sworn, testifies as follows:

FIRST SERGEANT CRUS - DIRECT EXAMINATION BY MR. ROTHSTEIN:

Q: I didn't mean any disrespect. First Sergeant Crus. Can you please state your name for the record please?

A: It's John Derrick Crus.

Q: Okay. Where do you currently live, Mr. Crus.

A: Birmingham, Alabama.

Q: Do you go by Deek?

A: Yes.

Q: Okay. What do you do in Birmingham, Alabama?

A: I am a residential builder.

Q: Okay. Do you have any military positions?

A: Yes.

Q: Okay. How long have you been in the military?

A: 27 years.

Q: Okay. Are you currently in the military?
A: Correct. In the national guard.
Q: Okay. And what functions do you serve in the national guard?
A: I am a First Sergeant for a Special Force Medical Company. I think ---
Q: Can you lean up a little bit.
A: Sure, sorry.
Q: And tell The Court what a Special Forces Medical Company is.
A: Within our group we have what we call a battalion. It's a group support battalion. Within that battalion we have companies. And one of these companies is a medical company. We have PA's, veterinarians, RN's, medics, dentists. And I manage those individuals.
Q: Okay. And can you describe to The Court what your position as First Lieutenant is?
A: First Sergeant.
Q: I'm sorry. First Sergeant.
A: You demoted me again.
Q: As a First Sergeant. Can you explain to The Court what your duty is as the First Sergeant? Are you a team leader, a Special Forces team leader?

A: No. That was previously to this position.
Q: Okay. I'm sorry.
A: I manager where people go to do contingency operations within the scope of large strategic defense of the country.
Q: And that was my -- do you know James Davenport?
A: Absolutely.
Q: And how do you know James Davenport?
A: I served with James Davenport from roughly 2006 to 2012.
Q: Were you and Mr. Davenport on the same Special Forces Team?
A: That is correct. At that time, I was an ODA Team Sergeant for the Senior Enlisted Advisor for the ODA for the operational detachment.
Q: And how big was the -- it probably changed from time to time, but give The Court an idea of how big a Special Forces Team is that you were the ---
A: Doctrinally it's six to twelve.
Q: Did you work closely with Mr. Davenport during those six or so years that you were on the same team?
A: No choice.
Q: Okay. And what was Mr. Davenport's role on the

team?

A: Mr. Davenport was the senior medic on the ODA.

Q: Okay. How did you first meet Mr. Davenport? I mean, did you select him for the team or was he sort of put on your team?

A: It's a little bit of both. I had another 18-Delta that was assigned to my ODA who would have graduated the Special Forces qualification course just prior to James Davenport. And he had a wreck and we had a deployment that was coming and he had recommended James for another position on our team and vouched for him. So I said yeah, we'll give him a shot.

Q: You know how James -- was this right after James finished his Special Forces training?

A: Correct.

Q: Okay. Do you know how James did or faired in his Special Forces training?

A: He was tops of his class.

Q: All right. Continue on how Mr. Davenport ended on your team?

A: So we met in Fort Bragg, North Carolina. I was in civilian clothes. He didn't knew who I was. He knew my name. And he was in uniform. And we ran into each other in some barracks

building as we showed up. And I looked -- James was in uniform and his name tag was on his uniform. So I walked up and I say, you must be James Davenport. And he glances over and he says, well, that's what the name tag says. And I looked at him. Look down at his feet, looked back at his eyes and I said, well you're gonna fit right in.

Q: In your interactions with Mr. Davenport -- and my wife has often accused me of lacking a filter from my brain or my mouth. Do you understand what that means?

A: Absolutely.

Q: I've got two kids and some of the things I say, she looks at me like my head's on fire. Does Mr. Davenport, in your interactions with him have sometimes difficulty with the filter between his brain and his mouth?

A: Never had a filter since day one.

Q: Okay. Is that sort of a running joke, or was that a running joke among the team members?

A: There's not too many of us that have filters.

Q: And how many different Special Force Medics have you worked with in your 27 years in the Special Forces?

A: That's hard to say -- directly with? Maybe up to 20.
Q: And can you explain to the Judge what sort of the team structure is? I know you said you had six to twelve members of a team. How is a team comprised?
A: Well, we've got a team leader who is an officer. He's responsible for dealing with people higher up in the ODA. And then you have the Team Sergeant which is the role I was in when James was on my ODA. And I deal with everything team related to include -- well, everything team related. Below me, you have an Operation's Assistant and intelligence guy. I have weapons. Two weapons guy on the ODA which they have various responsibilities. They're not just weapons guys, but they are familiar with all the weapons systems in the world. I have engineering guys who can build stuff and destroy stuff. And of course, communication guys who can let us communicate anywhere in the world.
Q: Okay.
A: That pretty much sums that up.
Q: And what about the 18-Delta. Can you explain

to The Court what an 18-Delta is.

A: His job is primarily to maintain the health and the condition of the ODA on CONUS on every mission. He is the medic on the team for everything from trauma to -- I'm not going to say band aids because they delegate that stuff to the individual.

Q: What does in CONUS mean. You used that term.

A: OCONUS?

Q: OCONUS.

A: OCONUS is continental or overseas. Outside of the continental U.S., excuse me. CONUS is continental U.S., so we have -- we do things CONUS, we call it CONUS, where it's training missions throughout the United States. Or if we do training missions OCONUS that's outside of the continent of the United States.

Q: Okay.

A: So it's the medic's job is take care if we're CONUS, everybody on the ODA. For OCONUS he's responsible for everybody on the ODA plus whoever we're working with.

Q: And when you say ODA, that's the same as the team or that ---

A: It's just the Americans.

Q: Okay. Just the Americans.
A: The six to twelve.
Q: Okay. So if you are actually deployed into another country, are there other, I guess foreign people or when you're there they're local people that you actually work with on the Special Forces team?
A: Correct
Q: Okay. And what is Mr. Davenport's role as the medic with regard to providing the local team member on your team ---
A: We're responsible for saving lives. He's responsible for saving lives in a critical scenario. Sometimes we're limited. It depends on the SOFA agreement between the United State and whatever country we're operating in. But if it comes to life, limb, or eye sight, he's able to make those call.
Q: Okay. Have you been in active deployments and sort of, I guess, Special Operations assignments with Mr. Davenport outside of the United States during that six or seven year period when he was on ---
A: Yes, sir.
Q: Some of those involved pretty hostile parts of

the world?
A: Yes, sir.
Q: I know we can't pinpoint everything. I'm sure it's somewhat classified. Can you give the court an idea of generally where you been assigned or deployed or signed on special assignments.
A: The last one was Iraq. And Operation New Dawn. And prior to that was a South American -- was operating Enduring Freedom -- it's central something central Americans. Oh we have CCA.
Q: Has Mr. Davenport ever rendered medical care or attention to you?
A: Yes.
Q: Okay. Has Mr. Davenport -- have you ever observed Mr. Davenport render medical care to either team members or enemy combatants or local affiliates for lack of better word during some sort of an assignment or mission?
A: Yes.
Q: Or training exercise?
A: Uh-huh.
Q: Can you explain to The Court your observations of Mr. Davenport's medical skills and competencies?

A: He's worked on every member of the team that we've ever been on together. We can be gruff outside the wire, but sensitive inside the wire. Sometimes need a little attention. We been on training missions where there was mass causalities, head traumas, broken femurs, broken ankles. Two to three inch trees going through the body. And those are training exercises. He's treated enemy combative that we rolled up on a target that we roll on the night. The guy jumped off of a house.

Q: Can you say what country you were in at that time?

A: That was Iraq.

Q: All right. And what happen?

A: This guy jumped off -- we were after him and he jumped off a roof of a building on his own accord. And we had to render him aid. And obviously we caught him but James rendered him aid.

Q: What type of injuries did that -- did you observe the injuries of the person that jumped off ---

A: I did. I was on the roof.

Q: Okay. And what type of injuries did that enemy

combatant sustained?
A: He broke his ankle and he had some upper torso blunt force trauma. I don't know the extinct of what that was but I know he broke his ankle.
Q: Did Mr. Davenport ever refuse to provide care to that enemy combatant?
A: Absolutely not.
Q: What ended happening to that enemy combatant after Mr. Davenport rendered care?
A: He treated them, actually casted the guy. He set the bone, casted him. We maintained control of the guy and stayed in his care and we went about our task at hand.
Q: Was Mr. Davenport on your team at the time of his first significant injury in battle?
A: No.
Q: Okay. You know about that situation he described? I think it was on the interview where he had piece of metal stuck on the back of his leg. How do you know about that?
A: I was called ---
Q: Okay.
A: --- directly.
Q: Now, a medic on a Special Forces team, is that just the guy that kind of trials behind

everybody and carries a bag of like a bag full of medical supplies?

A: No, sir. That's just a primary military occupational skill. However, we all have different tasks that we're assigned to accomplish. James happened to also be a long range target intervention specialist. He was advanced third in combat instructor. He led combat patrols with he and another guy in Iraq. So there was -- his sole function on an ODA was not to be a medic. Everybody's part of the team and we operate as a team. Move as a team. Accomplish goals as a team. We just each have a different skill set for a specialty.

Q: How would you describe Mr. Dave- -- I may have asked you this. Compared to other SF medic that you worked with in your 27 years, how would you rate Mr. Davenport's skill and knowledge base?

A: Top.

Q: I'm going to hand you a document. Let me mark this Respondent's Exhibit 15. You recognize some of those documents?

A: Yes, I do.

Q: And can you tell The Court what those documents

are?

A: These are service awards. Time in combat and for other operations.

Q: And did you recommend Mr. Davenport for any awards for his con- -- conduct and performance during his assignment to your ODA?

A: I've authored some of these.

Q: Give The Court an idea of what some of the more significant orders and recognitions that Mr. Davenport's earned from the military.

A: He's got a Bronze Star medal in Iraq during operation New Dawn. We were in Iraq. That's for meritorious service and or achievement. He's actually received two Bronze Stars. He got one while he was in Afghanistan and got injured. That one I was not part of and did not author. Did author his Legion of Merit, which was exceptionally meritorious service throughout his time in the SF regiment. I believe the Merit is one medal below the Silver Star. And it's the only -- it's one of two neck metals worn on the dress ASU uniform. The other one being the Medal of Honor.

MR. ROTHSTEIN: Your Honor, I move Exhibit 15 into evidence at this time.

MR. WICEVIC: Your Honor, I'm just trying to figure out, looks like many of these narratives and recommendations are incomplete. I'm seeing like a one of two or one of three and two of three. So that's my first concern. And then Mr. Crus or Sergeant Crus has said that he wasn't the author to all of them. I have no problem allowing the ones he was an author to into evidence but as far as the ones that he wasn't, I don't think it'd be proper.

The Court: I'm going to admit the -- subject to your objection but I am admitting the exhibit.

(Respondent's Exhibit Number 15 was admitted into evidence.)

MR. WICEVIC: Thanks you.

Q: Mr. Crus, I'm going to hand you Exhibit Sixteen and ask if you recognize that document.

A: Yes, I do.

Q: As part of your responsibilities as the Sergeant of the ODA, did you evaluate the members of your team on a regular basis?

A: Correct. I would be on every NCO evaluation. Everybody on ODA as the senior enlisted guy.

Q: And does Exhibit 16 contain NCO evaluation reports that you performed on Mr. Davenport

during his time on your team?
A: There is, I don't think all these are mine, but ...
Q: At least during the time that you evaluated him, did he ever did anything less than an outstanding report from you?
A: Not that recall. I glanced through these but I don't recall ever having less than excellent evaluation report on James.
MR. ROTHSTEIN: Your Honor, I'll move Exhibit 16 into evidence.
MR. WICEVIC: Just a similar objection.
THE COURT: Okay. Thank you. It's admitted.
(Respondent's Exhibit Number 16 was admitted into evidence.)
Q: Mr. Crus, if you were involved in a significant trauma walking out of a building today, would you have any hesitancy in Mr. Davenport rendering pre-hospital emergency care to you?
A: Absolutely not.
Q: Okay. Would you have any hesitancy to Mr. Davenport rendering pre-hospital emergency care to any of your family members?
A: Absolutely not.
MR. ROTHSTEIN: No further questions, Your Honor.

THE COURT: Okay.

MR. WICEVIC: Just like five minutes.

FIRST SERGEANT CRUS - CROSS-EXAMINATION BY MR. WICEVIC:

Q: Sergeant Crus ---

A: Yes, sir.

Q: --- you have a significant past relationship with Mr. Davenport. Y'all were in the military. Imagine y'all grew close like family, right?

A: We're pretty close.

Q: Okay. How often do you communicate?

A: Maybe once every three weeks.

Q: So y'all are pretty good buddies?

A: Yes, sir.

Q: Did you observe Mr. Davenport provide civilian pre-hospital care?

A: I don't think I've seen him do civilian, except in a foreign country.

Q: That's all the questions I have, thank you.

THE COURT: Okay. Anything on redirect.

MR. ROTHSTEIN: No, Your Honor.

THE COURT: Okay. Thank you, Sergeant Crus, for coming and for your patience.

MR. CRUS: Yes, ma'am.

THE COURT: Your other witnesses, I'm assuming that they will be called tomorrow.

MR. ROTHSTEIN: That's fine. We can do a short one now or we could do it all tomorrow, Your Honor.

THE COURT: If we can do them all tomorrow, let's do them all tomorrow.

MR. ROTHSTEIN: Okay.

THE COURT: It's been a rather long day for all of us. It's been a long week actually. Thank you all and just to be on the safe side, we will convene again tomorrow at 9:00 o'clock.

(Whereupon, the hearing adjourned at 5:43 p.m. and was reconvened on Friday, July, 28, 2017 at 9:12 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

****

Friday, July 28, 2017
9:12 a.m. - 4:40 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 28th day of July, 2017 before Travis McLeod, Court Reporter and Notary Public in and for the State of South Carolina.

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EXHIBITS

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

Respondent's Exhibit Number 4 234
(Suspension Letter of 3/22/2016)
Respondent's Exhibit Number 5 243
(Reinstatement Letter of 3/25/2016)
Respondent's Exhibit Number 8a 95
(Email from Stoller to Alier 3/25/2016 11:32 a.m.)
Respondent's Exhibit Number 10 95
(Email from Stoller to Alier 3/25/2016 5:19 p.m.)
Respondent's Exhibit Number 12 236
(Text Messages Between Davenport and Aiken)
Respondent's Exhibit Number 14 152
(Photo of Recording Device in Kaiser's Office)
Respondent's Exhibit Number 25 23
(Investigation Packet)
Respondent's Exhibit Number 27 96
(Email from Stoller to Alier)
Respondent's Exhibit Number 28 97
(Redacted Email)
Respondent's Exhibit Number 29 134
(Email from Alier to Naugler)

(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.

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

THE COURT: I'm going to call the hearing to order. Mr. Rothstein, we're ready to hear from your next witness.

MR. ROTHSTEIN: Good morning, Your Honor. One of our witnesses on our list was Scott Stoller. Mr. Stoller is the Anderson County EMS Director.

THE COURT: Uh-huh.

MR. ROTHSTEIN: We had him under subpoena from Monday to Wednesday of this week. I was informed yesterday by an Anderson County attorney, Leon Harmon, that Mr. Stoller's not available today. So instead of calling him, I've gone through. There's a hand full of deposition excerpts that I want to read into the record from the deposition. And I'd like to hand these up. I think -- they're very short. It'll take about three minutes.

THE COURT: Okay.

MR. ROTHSTEIN: But I think I would like to read them on the record. And I do have the full deposition including the -- I think I have the sealed copy of his. But there are a lot of

patient names and things that are HIPAA protected or privacy protected information, and my intention is not to put the whole deposition into the record, but I do have it available if Your Honor needs it. So this is from the deposition from Scott J. Stoller from June 8th of this year. And is starts on page 24 line 17. Question, how long have you known Arnold Alier? Answer, since approximately 1991. Question, how did you first come to know him? Answer, he was a paramedic at Greenville EMS. Question, was he ever your partner at Greenville EMS? Answer, yes, sir. Question, how long was he your partner? Answer, it might have been about a year. Next page starting at line 1. Question, do you consider him a personal friend of yours? Answer, he's a friend. I'm going to go to page 154 of the deposition line 3. Question, did you ever have any type of conflict with Mr. Davenport prior to March 22nd of 2016? Answer, define conflict. Question, either conflict at work, a personality conflict or. Answer, well we're both strong headed and we had a friendship, but yeah, we hit heads, you know, figuratively.

Question, were you ever aware of Mr. Davenport had made some complaints about your performance or management of the Anderson County EMS Department? Answer, I've heard the rumors of it. Question, okay when did you hear rumors about that? Answer, well I heard rumors of it in the community, fire service and so forth. Question, what were the nature of the rumors? Answer, Scott is a bad leader, and he wouldn't do this, he wouldn't let me do that, things like that. Question, was there ever any rumor that Mr. Davenport had complained about your using department either funds, or assets, or medications for either your personal use, or your families use? Nexy page. Answer, yeah, there was a DHEC complaint. Question, when did you first become aware of the rumors in that regard? Answer, well there wasn't a rumor about that. That was at DHEC. I was up in New Jersey in the hospital with my Father-in-law dying, and the Bureau Chief of DHEC called me and said, you're under investigation. I'm about to send you an email with the letter. Question, who was that? Mr. Wronski? Answer, Mr. Wronski. I want to say it was like January

6th or so, but the letter would spell it out probably. Question, prior to receiving the actual complaint from DHEC had you heard that Mr. Davenport had complained about mismanagement or misuse of department funds or property? Answer, not in any detail. I heard that he was complaining about me, or that he had concerns. Something came up about a grievance, but I've never seen or heard about it. Then on page 167, this questioning by DHEC's attorney Ms. Susan Nelson, who was present -- or questioning for DHEC. Line 14. Question, this summery says that you have knowledge about your mismanagement and misuse of department funds and assets. Is that the rumor you were speaking about when you heard that Mr. Davenport was? Answer, there were some rumors, yes. There were some rumors about spending money on a fence, for instance, for the dog, a bomb dog that belongs to the county. There were some things along those lines. Question, Okay, did that come up before or after you sent your email to Arnold Alier at DHEC? Answer, this was going on long before. That's it Your Honor.

MR. WICEVIC: And Your Honor, the Department would just ask that we just got these excerpts, that we would be able to review the transcript, and submit any excerpts, and maybe hold that record open. We just haven't had the opportunity.

THE COURT: We'll do that.

MR. WICEVIC: Thank you.

THE COURT: I think that's going to be the fair thing to do.

MR. ROTHSTEIN: I don't have any problem with that Your Honor. I put these excerpts together after 11:30 last night, so there was no way to obviously communicate that to Mr. Wicevic.

THE COURT: Okay.

MR. ROTHSTEIN: Your Honor at this time, we call Richard Naugler to the stand.

THE COURT: Mr. Naugler, if you would face the court reporter, raise your right hand, he will swear you.

RICHARD NAUGHLER, having been duly sworn, testifies as follows:

MR. NAUGHLER - DIRECT EXAMINATION BY MR. ROTHSTEIN:

Q: Good morning Mr. Naugler. I don't know if we've ever met before in person.

A: I'm not sure.

Q: Okay, can you state your full name for the record.
A: Richard Carter Naugler.
Q: And I understand that you were the primary investigator for DHEC in this matter. Is that right?
A: Yes, sir.
Q: How long have you been an investigator for DHEC?
A: My position is Inspector 3 and November will be four years.
Q: Okay. What does Inspector 3 mean?
A: Inspector 3 means like preform investigations, do compliance checks, inspect the ambulances, inspect the agencies, and pretty much anything else covered underneath my purview as far as DHEC's concerned.
Q: Can I get you to lean forward, and talk into that microphone if you don't mind.
A: Yes, sir.
Q: How long have you been at DHEC in total? In the inspector type position?
A: Three years, some months.
Q: Okay. Were you hired on an Inspector 3?
A: Yes, sir.

Q: Okay. Are there different levels of inspector, like Inspector 1, Inspector 2, Inspector 3?
A: It's a large area. We haven't quite figured out what Inspector 1 or Inspector 2 are, but in our area, the Inspector 3's are the ambulance inspectors.
Q: Okay. And I'm just -- is the designation 3 after inspector, is that like a job, state job classification?
A: I believe so.
Q: Or is that the part of the region that you're an inspector for?
A: No, sir.
Q: Okay. So that sort of indicates a level of job classification. Is that fair to say?
A: We have not figured out what the 3 stands for.
Q: Did you ever receive any training on conducting investigations when you were hired on -- or on the job training at DHEC?
A: Yes, sir.
Q: Okay. And what were you trained on on how to conduct an investigation?
A: Part of mine comes from my previous history. I was a law enforcement Officer and another is part of CLEAR where I'm a basic certification

investigator, national certified investigator.
Q: Okay. What is your understanding generally of the purpose of a DHEC investigation of a complaint against a paramedic or EMT?
A: Against a paramedic or EMT?
Q: Right. What is the purpose of an investigation?
A: To get to the truth. To see if there is any violations of regulation type.
Q: Okay. When you say get to the truth, what's involved in your experience as an instigator getting to the truth?
A: Taking an investigation, getting statements, taking a complaint, get any investigation material that we can acquire.
Q: And is important to get all the facts before you make a conclusion?
A: Yes, sir.
Q: In part of your training, have you ever been trained to go into an investigation with a primary goal, or primary objective in mind other than getting to the truth?
A: No, sir.
Q: Do you think it would be an improper use of an investigation to set somebody up?

A: Ask it again please.
Q: Do you think it would be an improper use of ans investigation to set somebody up?
A: Are you talking about entrapment?
Q: Yes.
A: Are we talking about law enforcement, you talking about EMS?
Q: Either one.
A: Okay, well --
Q: Is it legal to do that in law enforcement?
A: I'm not a law enforcement expert, I can't answer that, I'm sorry.
Q: Did you conduct this investigation for DHEC the same the way that you would have conducted a law enforcement investigation when you were in law enforcement?
A: I had a strategy. I do believe we have a strategy, Yes, sir.
Q: Now you had a strategy for the interrogation of Mr. Davenport, right?
A: I pretty much think you would go into any case with a strategy, so yea, we probably had a strategy of what we were going to do.
Q: Okay. But did you have a strategy -- I'm not talking about the interview, I'm talking about

for the investigation as whole. Did you have a strategy for the investigation as a whole?

A: To find out if there was any misconduct, or violations of regulations.

Q: Okay. Now I understand that you are generally assigned to a specific geographic region. There's more than one investigator or inspector for DHEC, is that right?

A: Yes, sir.

Q: Okay. In what geographic region are you assigned to?

A: Midlands.

Q: Okay. Is it just called the Midlands?

A: It has changed, but in the Midlands area I go from Aiken to York, Barnwell to Abbeville.

Q: How many different regions are there across the state for various inspectors?

A: Right now there are four different regions.

Q: Okay. And what counties does your territory cover as the midlands Inspector Investigator?

A: Columbia, Richland, Lexington, McCormick, Abbeville, Edgefield, Barnwell, York, Chesterfield, Fairfield.

Q: That's a pretty big spot in the center of the sate isn't it?

A: Yes.
Q: And does it include Anderson County?
A: No, sir.
Q: And what region is Anderson County in?
A: That would be in the Upstate.
Q: Okay. And who was the Upstate inspector for DHEC on April 13, 2016?
A: I believe Kristen McConnell.
Q: Okay. Do you know if she's an inspector 3 as well?
A: Yes, sir.
Q: Okay. Why didn't the inspector or the investigator for the Upstate region handle an investigation involving an Upstate matter?
A: Because I do believe she had some history in the area, and possibly worked in the area. We weren't sure of any prior knowledge. I have no knowledge of anything in Anderson County.
Q: But wouldn't the Upstate inspector, did you know where she lives?
A: No, sir.
Q: Okay. Wouldn't the Upstate inspector who's in charge of inspecting the Upstate, have some ties to EMS and agencies and departments in the Upstate?

A: Yes, sir.
Q: Are you a certified paramedic?
A: Yes, sir.
Q: How long have you been a certified paramedic?
A: I became a paramedic in 1998.
Q: And when you went through paramedic training school, do you recall that mantra O2, IV, monitor?
A: Actually it's IV, O2, monitor.
Q: Okay. I'm sorry.
A: That's okay.
Q: When was the last time you actually worked on an ambulance responding to an emergency call?
A: Actually, in January I backed up a Lexington County truck in my neighborhood, loading a patient up to a stair chair, to get him outside of the house.
Q: Okay. January of this year?
A: Yes, sir. And then after that about two weeks later, I was in the back of a truck at Bi-Lo helping them hold down a treated seizure patient that we rode into the hospital.
Q: Okay. You may have misunderstood my question. My question wasn't when did you actually respond to a scene, it was when was the last

time you actually worked on an ambulance?
A: It would have been probably, I began in November 2013, so probably October 31st probably.
Q: Of 2013?
A: Yes, sir.
Q: So it's been almost four years sense you worked on a truck? It would be four years in October sense you worked on a truck?
A: Worked on a truck? I've been on a truck. But are we talking about working on a truck or --
Q: I'm talking working, not like working on your garage on a truck. I'm talking about working as a paramedic in an ambulance, responding to emergency calls.
A: I did that is January of this year. As far as officially working as a paramedic full-time, that would have been in October 2013.
Q: Okay, what agency was that?
A: It was either Midlands Med Tech, or Trustus.
Q: Okay. Were those private ambulance services?
A: Private, Yes, sir.
Q: Have you ever had any time of disciplinarian action against you as a paramedic or EMT?
A: No, sir.

Q: Now let's talk about this investigation about Mr. Davenport. Let's see if we can find Exhibit 3 here. Do you recognize Exhibit 3?
A: Yes, sir.
Q: Okay. And what is Exhibit 3? I think that's already in the record, but an you tell The Court what you recognize that as?
A: These are the progress notes made during the investigation.
Q: Okay. And this is a three page document that Mr. Wicevic asked me to supplement the last two pages. Do you understand that?
A: Uh-huh.
Q: Now when this document was first provided to Mr. Davenport, it wasn't three pages long was it?
A: I believe it was filled out up until the point that he came and picked it up.
Q: Okay. And on the first page of Exhibit 3, there's an entry about when it was copied and made available for him to pick up, and then there's a later entry about when he actually picked it up, right?
A: I'm looking at it. Mr. Davenport picked up investigation packet, signed and receive. Yes,

sir.
Q: Okay. So, the time it was copied and placed into a confidential envelope, the log ended at April 28, 2016 at 9:40, right? Everything that's below that was added after Mr. Davenport was given the copy of the investigative packet, right?
A: Actually, I do believe he picked up on 4/29/16.
Q: Yeah, but you had to copy it first and put it into a sealed packet, right?
A: Yes, sir.
Q: Okay. So everything on the copy that was given to Mr. Davenport would have been before the entry where he picked it up. You agree with that?
A: I believe so. Yes, sir.
Q: Okay. I'm going to show you a group of documents and I'm going to ask if you recognize that as the packet that was provided to Mr. Davenport when he picked it up on April 29th, 2016.
A: I'll take your word on it. Yes, sir. It looks like it.
Q: Okay. Sitting here today looking at it, do you see anything that's missing from that packet

that was provided to Mr. Davenport? I know you're just seeing that for the first time, but ---

A: I have no idea.

Q: Okay. Where did that information come from that was in that packet? Was that from your investigation?

A: From the investigation. Yes, sir.

Q: Now we heard a couple of different witnesses talk about this thing. I'm sure you learned it in paramedic school as well, this adage that if it's not written down on the record, it didn't happen. Have you ever heard somebody say that?

A: For medical records, yes.

Q: Okay. Did you realize the importance of keeping an accurate and complete log of your investigation?

A: Yes, sir.

Q: And you believe that you did that in this case, kept an accurate and complete log of your investigation?

A: Most of the notes. Yes, sir.

Q: Now the first entry on that log looks like it's got the initials AA on the side of it, the right.

A: Yes, sir.
Q: There's a chart at the bottom that sort of identifies whose initials are whose, right?
A: Yes, sir.
Q: Okay. And do you recognize the initials AA as Arnold Alier?
A: Yes, sir.
Q: All right. And that entry says that after 5:00 o'clock in the afternoon on the 13th of April, Mr. Alier -- I'll just read it. It says, secure email and file sent to Dr. Alier from Scott Stoller at Anderson EMS with investigation material they had gathered and performed on an Iva Rescue Squad paramedic. Investigation initiated by Bureau and file started. Who actually typed that entry into that log?
A: I would have no idea. I don't know.
Q: Do you know who generally types the entries in the logs? Is it like a secretary or a ---
A: No, sir. It'd be one of us.
Q: Okay. One of the investigators would put that in there?
A: It could be Arnold, it could be Rob, it could be me.

Q: Okay. Who has access to making entries into a log?
A: Investigator, the Director of EMS, and the Bureau Chief.
Q: Okay. Did you write that first entry?
A: I cannot recall if ---
Q: Can't recall?
A: --- typed that. No, sir.
Q: Okay. The first entry I see with your initials on it looks like it's the next one down, April 14th, 2016 9:00 o'clock. Investigation folder started. You see that?
A: Yes, sir.
Q: Okay. CIS printed and secured in desk drawer.
A: Yes, sir.
Q: At the time you open the folder, did you put anything into the folder that you received from Mr. Alier?
A: It would have been the CIS profile, it would have been progress notes like this, and whatever else that was there, but that would have been probably about it to start the folder.
Q: Okay. What is CIS mean?
A: It is our credentialing system that we have,

sir.

Q: Just sort of demographic information about Mr. Davenport?

A: If I may?

Q: Yeah.

A: This back here in this ---

Q: In the packet?

A: Yes, sir. If you look back here (indicating). That right there is our CIS profile. That's the credentialing system we use for the State to identify paramedics and EMT's, track their certifications, background checks, addresses, telephone numbers. Essentially our Rolodex for all EMT's and paramedics for the State.

Q: Excuse me just one second.

MR. ROTHSTEIN: Your Honor, I'd like to mark that document as an exhibit. I need to figure out which one we're on. James, I'll just use his sticker. Your Honor, I move that Exhibit 25 be admitted into evidence.

(Respondent's Exhibit Number 25 was marked for identification purposes.)

MR. WICEVIC: May I?

THE COURT: Yes. You've not taken a look at it?

MR. ROTHSTEIN: Sorry. It's the only copy I have.

MR. WICEVIC: Your Honor, my only objection is some of this documentation concerns Anderson Investigation. Again, we've talked about this multiple times before. I feel like those issues are not germane to this matter. As far as the Department receiving this and things we obtained in our investigation, I think it's fine.

THE COURT: Okay. Let me take a look at it. Now, Mr. Wicevic, you indicated that these are documents that you all obtained during the process of investigating this matter?

MR. WICEVIC: That's correct, Your Honor.

THE COURT: Okay.

MR. WICEVIC: I just question some of the relevance of the whole Anderson County investigation.

THE COURT: Okay. Thank you, but I'm admitting it.

(Respondent's Exhibit Number 25 was admitted into evidence.)

Q: Mr. Naugler, I know you discussed that CIS thing that you printed and put into the folder. What else was in the folder when you secured it in the desk drawer on April the 14th, 2016, if you can recall?

A: It would have been the CIS, then progress

notes, any hand written notes, but I don't see any in here.

Q: Okay. And I think we in some questioning yesterday with Mr. Wronski, I think we determined that April 14th was a Thursday, April 14th of 2016. That sound about right to you?

A: I have no idea. I don't have a calendar in front of me, sir.

Q: Okay. And I don't see any other entries in there from the 14th through the 18th, which I guess would be the following Monday. Did you do any investigation between 9:00 o'clock on the 14th when you put the file in the desk drawer and the next entry on Monday, April the 18th of 2016?

A: To the best of my knowledge, not that I can recall. I'm not sure.

Q: Okay. On that Monday there's an entry -- actually first of all, let me head back up. Did you call Mr. Davenport or try to call Mr. Davenport once you printed out the CIS to let him know that you wanted to speak to him about the investigation?

A: I may have. Yes, sir. I'm not sure.

Q: Okay. Do you recall having some difficulty reaching Mr. Davenport on the phone number that was in the CIS?
A: Yes, sir. The telephone number wasn't correct.
Q: Okay. Did it take a day or two to track him down before you could finally ---
A: Yes, sir.
Q: --- get a hold of him?
A: I do believe I had to contact Iva Rescue Squad, give them my contact information 'cause I didn't want them to release anything via phone because you never know who you talking to over the phone. So I have them my contact information so they could pass it onto Mr. Davenport.
Q: Okay. So if you look back at the log, April 14th, 2016 the entry says, phone and email contact made Iva PD. That's the Iva Police Department?
A: Yes, sir.
Q: In reference to records for incident and formal request via email for incident reports and records pertaining to stabbing call.
A: Yes, sir.
Q: And it has your initials to the right.

A: Yes, sir.
Q: Okay. Is the email that you sent to the Iva Police Department in that packet?
A: I'd have to look. I'm not sure.
Q: Is that something you'd normally put in the packet?
A: Yes, sir. Probably.
Q: Okay. Do you recall who you spoke with at the Iva Police Department to request the video?
A: There are some notes here. I talked to Jason Hawkins.
Q: Okay.
A: Chief. These look like my hand written notes right here I scratched. And he gave me John Bench, Iva PD was apparently their administrative person for Mr. Hawkins. And that's who I sent the email to.
Q: Okay. When you spoke to the Chief, did you -- what did you ask him?
A: I asked him if he was familiar with the stabbing call that Iva Police Department had handled.
Q: Okay. And what was his response?
A: I'm not sure.
Q: Did he immediately put you in touch with Mr.

Bench?
A: No I do believe he said he was familiar with it. I don't know his exact words, sir.
Q: Okay. Did you ask him for an official copy of the body camera footage?
A: Yes, sir.
Q: Okay. How did you know about the body camera footage?
A: Because of the video that was sent to Arnold Alier.
Q: I beg your pardon?
A: Because of the video that was sent to Arnold Alier.
Q: Okay. All right. So you called Iva Police Department, asked for the incident report and the video on the 18th. Do you recall what time of day you called them? Is that indicated in your notes?
A: I don't believe I put the time on there. No, sir.
Q: Okay. And at some point you were able to get in touch with Mr. Davenport once you found out a correct number for him, right?
A: Yeah. I do believe, by my notes here it appears that I called at 9:34, got a voice

mail.
Q: Voice mail ---
A: And then called and I think he called me back.
Q: Okay. And when you finally hooked up with Mr. Davenport, what did you tell him?
A: I talked to Mr. Davenport and told him, I identified who I was and that we were doing an investigation in reference to some concerns with his being a paramedic at Iva. I do believe wanted to see if he would come down and talk to us.
Q: Okay. Did you tell him that a complaint had been filed against him?
A: I don't remember the exact conversation.
Q: Okay. Did you tell him that y'all were reviewing a QA matter?
A: I don't remember the exact conversation, sir.
Q: Did you tell him how many calls were at issue?
A: I don't remember the exact conversation. It was a conversation to get Mr. Davenport to come in and talk to us if he wanted to come in and talk to us.
Q: Okay. Did you tell Mr. Davenport you had reviewed a body camera video footage of the incident?

A: I don't recall.
Q: What was Mr. Davenport's response?
A: He said -- I'm not sure. I don't remember the -- he agreed to come in and meet with us.
Q: Okay. Was he fairly cooperative?
A: Yes, sir.
Q: Okay. Did you have any previous interactions with Mr. Davenport prior to that call?
A: No, sir.
Q: Okay. To your knowledge, have you ever met Mr. Davenport prior to that?
A: I don't believe we ever have. No, sir.
Q: Okay. Your notes indicate what time of day it was that you were finally able to get Mr. Davenport to call you back?
A: I'd have to look through again. I don't believe so.
Q: Was it after you spoke to the Iva Police Chief?
A: I don't recall.
Q: So then the next entry looks like April 19th, 2016 at 10:00 o'clock. Shows an interview with James Davenport at Columbia Mills. Is that where the DHEC offices are?
A: Yes, sir. We call it Cola Mills. Yes, sir.
Q: Cola Mills, sorry.

A: Yes, sir.
Q: With R. Wronski, R. Naugler, R. Wiznuski, and Bently White were present?
A: Yes, sir.
Q: The interview was recorded and saved to t-drive along with jump drive attached to investigation folder. Right?
A: Yes, sir.
Q: And your initials there as well?
A: Yes, sir.
Q: At the time you interviewed with Mr. Davenport and these other individuals that are identified in that meeting, did you have the official version of the body camera footage?
A: I don't believe so.
Q: Okay. In fact, when you talked to Mr. Bench at the Iva Police Department, the administrative guy ---
A: Uh-huh.
Q: --- he told you he'd have to overnight mail you or email you -- I'm sorry, snail mail you or overnight mail you an actual hard copy CD ---
A: Yes, sir.
Q: --- of the video?
A: Yes, sir.

Q: Okay. And he was able to email you some of the documents, like the incident report and that kind of thing ---

A: Yes, sir.

Q: --- and the arrest report? Okay. And when did you actually -- how did you get a copy of the body camera video footage?

A: As far as the investigation?

Q: Yeah. I mean, how did you first -- well actually, have you ever had it in your possession?

A: Yes, sir. I have the -- we took the file. I do believe it all was sent, and put it into a jump drive and then I have the copy that was sent to us by Iva Police Department.

Q: All right. Let me get the ... I'm going to hand you a document marked Exhibit 26. Do you recognize that document?

A: It appears to be a shared folder.

Q: Okay. And if I can just -- it looks like an email from Scott Stoller through a Google drive account to Naugler comma Richard on April 14th, 2016 at 9:54 a.m. You see that?

A: Yes, sir.

Q: The subject is AC 2013 invitation to

collaborate, right?
A: Yes, sir.
Q: Okay. Do you know whether that email was sent to your DHEC email account?
A: Not by this. I have no idea. This just says Richard Naugler.
Q: Okay. Do you recall receiving an invitation from Mr. Stoller to join some sort of Google shared folder?
A: This was probably when we talked about the protocols I imagine.
Q: Okay. So you think that was the protocols that were sent to you?
A: Yes, sir. I do believe so.
Q: Didn't Mr. Wronski say you already had the copy of the protocols?
A: We have a copy of the protocols there and saved to our t-drive, but we also like to see if there's any updated protocols that may not have been to our t-drive.
Q: Okay. So did you print out the protocols Mr. Stoller sent to you?
A: I do not recall.
Q: Okay. There's a -- if you look back at the packet, it looked to me like there was a number

of Anderson County EMS protocols in there, right?

A: Yes, sir.

Q: Can you identify for The Court what protocols were in the materials that were sent by Mr. Stoller?

A: It appears to be general trauma T-1,

Q: Hang on one second. Let me write these down. All right. T-1, you said general trauma.

A: Yes, sir.

Q: Any others?

A: T-3, T-10, M-6.

Q: Well let's go back a second. What is the title for T-3?

A: Multiple trauma shock protocol.

Q: Okay. What was T-10?

A: T-10 is extremity trauma protocol.

Q: Are you familiar in your training as a paramedic what the term extremity trauma means?

A: Yes, sir.

Q: Okay. What does extremity trauma?

A: Trauma to the extremities.

Q: Okay. What's an extremity?

A: Something that's not on your main torso.

Q: Okay. So an arm or a leg?

A: Yes, sir.
Q: Is your head considered an extremity
A: By true definition, I'm not sure.
Q: Okay. What about the abdomen? Is the abdomen an extremity?
A: No, sir.
Q: All right. What's after T-10?
A: After T-10?
Q: Yeah. Off your list.
A: M-6, medical hypotension protocol.
Q: Medical ---
A: Hypotension.
Q: Okay. In your medical training, what does hypotension mean?
A: Low blood pressure.
Q: Okay. Is there a difference between, like a, chronic low blood pressure and like a single incident of having a low reading on a blood pressure cuff?
A: Please clarify.
Q: Yeah. Does hypotension refer to like a chronic condition or say you have normal blood pressure and then you have a reading that was substantially lower than it was before. Is there a difference in that term, hypotension?

A: Hypotension is just low blood pressure.
Q: All right. What's next?
A: Adult airway management protocol. GP-1. I'm sorry.
Q: GP-1.
A: Yes, sir.
Q: All right. What else?
A: Pediatric airway management protocol. GP-2.
Q: Okay. Any others?
A: Intravenous access protocol. GP-3.
Q: Okay. Any others?
A: P-8, but the top is blanked out. I apologize. I'm not sure ---
Q: You see some hand written notes in there about pediatric seizure?
A: It appears to be ped. seizure. Yes, sir.
Q: Okay. Any other Anderson County EMS protocols?
A: Not that I can see. No, sir.
Q: Okay. Are those the only Anderson County protocols that were anywhere mentioned in your investigation packet?
A: As far as this that you handed to me right now?
Q: Yes.
A: These are the only ones that are in this that you handed to me.

Q: In the conduct of your investigation did you actually pull the full book of Anderson County protocols for the EMS department?
A: We don't keep them in a book. We keep them on a t-drive.
Q: Okay. Did you pull up the entire t-drive?
A: I'm sure we looked at the t-drive. Yes, sir.
Q: Now I think there were actually more than just the stabbing complaint in the initial pack that you got, is that right, in the investigative packet?
A: In the initial packet. Are the other two calls in here?
Q: Well that's what I'm asking. Is there information about more than just the stabbing patient in that investigative packet?
A: Yes, sir. It appears that the internal review that Anderson County did is in here. Yes, sir. And a statement from Ms. Aiken. And their review.
Q: All right. And did one of those involve a pediatric patient?
A: Yes, sir.
Q: Okay. You understand that the gentleman you saw, you wouldn't consider the gentleman in the

stabbing video to be a pediatric patient, would you?

A: No, sir.

Q: Okay. So did the pediatric airway protocol apply to the stabbing patient?

A: No, sir. It probably went a long with the internal review that they did.

Q: Okay. What about the pediatric seizure protocol. Did that have anything to do with the stabbing patient?

A: No, sir.

Q: Okay. What was the date of the stabbing incident? Does it indicate on there?

A: I believe from what -- are you talking about the stabbing call?

Q: I'm sorry. The pediatric call. What was the date of the pediatric call? Well let me ask you this way. Your investigation initially involved not just the stabbing call but two other calls involving Mr. Davenport. Is that right?

A: My investigation. Are we talking about the Bureau's investigation, the investigation I did?

Q: I'm talking, yeah, the investigation that you

did.
A: My investigation came from the video.
Q: That's all you considered was the video, is that right?
A: That's all I needed.
Q: Okay. You didn't speak with the actual Medical Control Director for Anderson County, Dr. Kickham, at any point during your investigation, did you?
A: No, sir.
Q: Okay. You also did not obtain or print out a complete copy of the Anderson County EMS employee handbook, which contains policies, procedures, protocols, and standing orders for all EMS departments acting under Dr. Kickham's medical control, did you?
A: No, sir.
Q: Okay. You also didn't speak with Anderson County EMS Director Scott Stoller about the Davenport matter as part of your investigation, did you?
A: No, sir. He wasn't there that night.
Q: Okay. You didn't speak with anyone at the Iva Rescue Squad about Mr. Davenport?
A: No, sir. We had Ms. Aiken's statement. She

was the only one that was there that night other than her husband who was in the law enforcement, I do believe.
Q: Okay.
A: He drew his weapon.
Q: Did you talk to Ms. Aiken?
A: No, sir. We had her statement.
Q: Okay. Did you ask Ms. Aiken whether the statement was coerce?
A: I believe Mr. Davenport brought that up.
Q: That wasn't my question. My question is did you ask Ms. Aiken if her statement was coerced?
A: No, sir.
Q: Okay. Did you speak with the Officer that took the body cam video from Iva Police Department?
A: I have spoken with him since. Yes, sir.
Q: As part of your investigation ---
A: Uh-huh.
Q: --- did you speak with the person that took the video that's shown in the body worn camera?
A: No, sir.
Q: Did you speak with Craig Lawless?
A: No, sir.
Q: Do you know who Craig Lawless is?
A: No, sir. He wasn't there that night.

Q: Are you familiar -- when you were a paramedic, did you ---
A: I'm still a paramedic, sir.
Q: I'm sorry. When you were working for an agency as a paramedic, or a private ambulance service ---
A: Yes, sir.
Q: --- were you familiar with the QA process?
A: Yes, sir.
Q: Okay. And what is the QA process?
A: Quality assurance.
Q: Okay. Did your ambiance service have a QA Officer, quality assurance Officer or somebody in that function who reviewed calls for compliance with protocols?
A: Yes, sir.
Q: Did you talk to the QA Officer for the Iva Rescue Squad about Mr. Davenport's three calls that were apart of your investigation?
A: No, sir. I investigated the video that I saw.
Q: Okay. Did you talk to the Anderson County Training Officer, the Anderson County EMS Training Officer about this matter?
A: No, sir. She wasn't there on that call.
Q: Did you speak to the Chief of the Iva Rescue

Squad, Sandy Sutherland about Mr. Davenport's call?

A: Also was not there at the call.

Q: Did you obtain Mr. Davenport's personnel file from Anderson County to see whether he had any type of history or pattern of misconduct or inappropriate or deficient care as a paramedic?

A: I did not. No, sir.

Q: Did you speak with Mr. Davenport's partners in the other two calls, the pediatric seizure patient? Well let's start with that one first. I won't ask a compound question. Did you speak with Mr. Davenport's pattern on the pediatric seizure call?

A: Was not part of my investigation.

Q: Okay. Did you even find who that patient or who that EMT basic was that was on that call with Mr. Davenport?

A: No, sir. But I don't believe she was at the stabbing call.

Q: Okay. Did you speak with anyone named Jennifer Brickle? That name sound at all familiar to you?

A: No, sir. I don't believe she was at this call either.

Q: Okay. You speak with Tommy Miller, the Assistant Chief of the Iva Rescue Squad?
A: No, sir.
Q: Did you speak with anybody who helped Mr. Davenport or was on a crew with Mr. Davenport with the elderly gentleman that was taken from the nursing home to the hospital in the second of the three calls that were part of your investigation?
A: My investigation was about the video, sir.
Q: Okay.
A: My misconduct is in the video.
Q: Okay. Did you speak with anyone else on the scene that night about what you saw or thought you saw on the video?
A: No, sir. I had a witness. I had video.
Q: Did you speak with Officer Burns who took the photographs with the still camera? Did you speak with him?
A: No, sir.
Q: Did you obtain any medical records from the hospital Emergency Department of AnMed as part of your investigation?
A: I believe Rich Wiznuski obtained those, sir.
Q: Okay. Did you as the lead investigator obtain

those records?
A: Rich Wiznuski, who is the Trauma Director has access to those records and obtained them for us.
Q: I'm not trying to be difficult. But my question's a little simpler than that. Okay. Did you as the lead investigator in this matter contact the AnMed Emergency Department to get medical records?
A: We often work together in our office and he obtained them for me. So, no. I did not directly contact them. No, sir.
Q: Okay. Did you direct anyone to get records from AnMed Emergency Department about this matter?
A: I believe our Bureau Chief, Mr. Wronski, answered that earlier that he directed Rich Wiznuski to do it.
Q: Okay. If you look in that investigative packet that we marked. I think it's 25.
A: There's not a number one it.
Q: On the bottom left, Exhibit 25?
A: Yes, sir.
Q: Are there any medical records from AnMed hospital Emergency Department in that packet,

sir?
A: This packet that you gave me?
Q: Yes.
A: I don't see any. No, sir.
Q: Do you see any entries under log prior to the date Mr. -- Exhibit 3, the log of your investigation, prior to Mr. Davenport picking up the copy of the packet. Do you see anything in there about obtaining records from AnMed Hospital?
A: No, sir. I do believe they were received after that.
Q: Okay.
A: So they wouldn't have been available.
Q: So they would have been received after the initial interview you had with Mr. Davenport, right? Or that you participated in at the Cola Mills, is that correct?
A: Repeat the question.
Q: You just mentioned that the AnMed records were received after that. You're talking about after Mr. Davenport picked up the packet from you. And my question was, so at the time you met with Mr. Davenport at Cola Mills, for the initial interview, you didn't have records from

the AnMed Hospital, right?
A: I'd have to listen to the audio recording just to verify. I'm not sure.
Q: Did you obtain any operation room record from AnMed Hospital?
A: Did I?
Q: Yes, as part of your investigation?
A: I did not. I do believe Rich Wiznuski did, sir.
Q: Have you ever seen the operating room records from AnMed Hospital?
A: As part of -- I do believe they're in here.
Q: Do you recall when you saw those for the first time?
A: I don't recall. No, sir.
Q: Was it within the last say month?
A: May have been. I'm not sure.
Q: Okay. Now you mentioned everything you needed to see was on the body camera video. Did you see the patient's wife in the trailer?
A: Yes, sir.
Q: Did you ever talk to the patient's wife about the stabbing call?
A: No, sir.
Q: Did you ever speak to the patient himself about

the stabbing call?

A: No, sir. I do believe he said he had psycho-social history. So I do believe we wouldn't have gotten anything reliable. And what I needed was in the video.

Q: Do you know of anyone from DHEC, either you, Mr. Wronski, or Mr. Wiznuski ever spoke to the patient?

A: As far as myself. I can speak for myself. No, sir. I did not.

Q: Did you ever direct anybody to go speak with the patient to see how he interpreted the statements that you saw in the video?

A: No, sir.

Q: To your knowledge, did the patient ever file a complaint with DHEC against Mr. Davenport for the conduct that was displayed in the video?

A: To my knowledge, no, sir.

Q: Okay. To your knowledge, did anyone in the patient's family ever file a complaint with DHEC about the conduct that was displayed by Mr. Davenport in the video?

A: No, sir.

Q: Now, Mr. Wronski talked about sort of a little strategy meeting that occurred prior to the

interview or interrogation of Mr. Davenport. Do you recall that testimony from Mr. Wronski?

A: Prior to the interview we probably sat down and talked a little bit. Yes, sir.

Q: Okay. Who was involved in that sort of strategy discussion?

A: I believe probably just me and Mr. Wronski. Maybe Mr. Wiznuski. I'm not sure.

Q: Okay. How many times have you viewed the video before you sat down with Mr. Davenport and had that meeting on April the 19th of 2011?

A: Probably like two or three times, sir. Actually maybe more than that 'cause I took actually some -- yeah, probably more than that.

Q: Okay. Tell me about the context in which you viewed that video. Were you sitting by yourself looking at your computer screen in a cubical?

A: Yes, sir.

Q: Okay. Did you ever look at the video with any other people prior to meeting with Mr. Davenport?

A: I believe I might have been there when Dr. Ed saw it.

Q: Who's Dr. Ed? Dr. Ed Deschamps?

A: Yes, sir.
Q: Okay. Were you here when he testified earlier in the case?
A: Yes, sir.
Q: Okay. You recall him saying he didn't know whether he saw the video before Mr. Davenport saw the video?
A: Yes, sir.
Q: Okay. Can you clear that up?
A: Not for him. No, sir. I can't clear it up for him.
Q: Okay. Well you just said you believe that you were in the meeting with Dr. Ed ---
A: But I'm not sure if that was before or after the interview. I just remember I'm pretty sure I was there when Dr. Ed viewed the video, sir.
Q: Okay. Were you ever present when Mr. Wronski viewed the video?
A: Yes, sir. We viewed it together.
Q: Okay. Were you ever present when Dr. Alier viewed the video?
A: I think so. Yes, sir.
Q: Did that occur prior to the interview with Mr. Davenport on April the 19th?
A: Yes, sir.

Q: You recall discussing -- I think Mr. Wicevic called it the ultimate objective of meeting with Mr. Davenport? You recall that?
A: Yes, sir.
Q: Okay. What was the ultimate objective in this case?
A: To get to the truth. To find out if there was any misconduct or regulation violations.
Q: And I think y'all discussed some type of a strategy or like a game plan before you brought Mr. Davenport down. Is that right?
A: Sir, I've been a firefighter, police Officer, paramedic. We don't go into anything -- we have game plans and strategies just like you do.
Q: Your conclusions were already reached in this case before any investigation was done, isn't that right?
A: My conclusions?
Q: Your conclusions.
A: My observations.
Q: Your investigation was completed before it started, isn't that right?
A: No, sir.
Q: Okay. You just said you saw the video and

that's all you needed.
A: If we'd have just done that we'd have never called Mr. Davenport in. We would have just sent him a letter. We always bring people in and have them try to explain their actions because, number one, it's patient advocacy. There's no patient advocacy that night on that scene. So I became that patient advocate. Still brought Mr. Davenport in for him to explain why would you mock a patient like this. Why would you treat a patient like this.
Q: How do you know Mr. Davenport was mocking that patient?
A: I've worked the streets. I read people. He was mocking that patient.
Q: And did you see Mr. Davenport facial expression in the reflection of the mirror when he said, did anybody ever tell you that you're an idiot?
A: As a matter of fact I looked at it again last night. He did not smile. There was actually a part where he actually mocks him at the back of the truck.
Q: When you say he mocks him at the back of the truck, what do you mean he mocked him?
A: When they were standing at the back of the

truck after -- I believe you testified they walked him gingerly to the truck.

Q: I haven't testified. I'm a lawyer.

A: I apologize. That they walked him to the truck. Mr. Davenport actually walked in front of him to the rear of the truck, opened the door, they're unloading the stretcher. The patient, I don't want to say his name, was talking to the police Officer about his wife, the concentrator, depression. The police Officer's talking to him and Mr. Davenport turns around and you can hear, yeah, yeah, yeah as if mocking the patient.

Q: Okay. Do you know what Mr. Davenport was referring to when he said, yeah, yeah, yeah?

A: I know what it appeared to be.

Q: Okay. You're just going by what you saw on the video right?

A: That he verified it was him calling him an idiot during the interview, Yes, sir.

Q: Have you ever worn a body worn camera as a police Officer?

A: I worn a body mic, not a body camera. No, sir.

Q: Okay. Does that camera generally go on the front of the Officer's body?

A: I believe if you look at the video, it is centered on his bullet proof vest. Yes, sir.
Q: Okay, and you can see that in the reflection of the mirror, right?
A: Yes, sir.
Q: So, do you know what the scope of view of that camera picks up?
A: It varies upon camera. That one, I'm not sure. Cameras pick up a variety of area.
Q: Have you seen more than one view of this scene, in terms of body camera footage?
A: No, sir.
Q: Okay. So, the camera doesn't show us going behind the Officer, does it?
A: No, sir.
Q: Okay. It doesn't show us going on far to the right outside of the view of that camera, does it? It doesn't show us going on to the left of the scene.
A: No, sir.
Q: Okay. It doesn't show us going on below the frame of the camera, right?
A: No, sir.
Q: So, a lot of time in that video, you see just the patient's head in the -- you don't even see

the knife in some of that video when the Officer's standing there, and Mr. Davenport's providing care to him, right?

A: Until the Officer moves down and the knife comes in to view, Yes, sir.

Q: Okay, but you can't see what Mr. Davenport is doing below the frame of that camera, can you?

A: No, sir, but in this particular part, Mr. Davenport's face is right there because the camera is pointing straight at him.

Q: Your testimony is that you can see everything that Mr. Davenport was doing on that scene?

A: No, sir. I'm talking about the one part, right there.

Q: Now, you were here when we listened to sorta snippets from that interview, remember?

A: Yes, sir.

Q: Was that you that sort of raised your voice at Mr. Davenport.

A: Yes, sir.

Q: Okay. And at some point Mr. Wronski had to say to you, whoa no no, calm down, let's not get mad. Do you recall that?

A: Yes, sir. Can I explain?

Q: Well -- you also said to Mr. Davenport when

asked for a response, oh that's what you're going to go with now. Do you remember saying that? Was that your voice that said that?

A: I'd have to listen to the tapes.

Q: Okay. I think the discussion was about why Mr. Davenport laid the patient flat on the stretcher.

A: Uh-huh.

Q: And Mr. Davenport's response was, he didn't want the patient looking down at the knife on the ride to the hospital, right?

A: I'd have to listen to it sir, I'm not sure.

Q: Okay, and your response to that was, oh that's what you're going to go with now.

A: I'd have to listen to the tape. You're telling me, I'm not sure.

Q: Okay. Who was it in the interview that actually said you harmed -- you deliberately hurt that patient James. Was that your voice or Mr. Wronski's voice?

A: You would have to play the tapes sir, I'm not sure.

Q: Have you ever had a knife in your belly?

A: I've had a dog bite into my belly, Yes, sir.

Q: Have you ever had an impaled object in your

belly?
A: No, sir.
Q: Have you ever treated a patient that had an impaled object in their belly.
A: Yes, sir, I do believe so.
Q: How many times have you done that in your career?
A: Mr. Rothstein, I've run thousands of calls. To tell you exactly, I have no idea. But yea, I know I've bandaged, and I do remember mobilizing something in somebody's stomach one time and transporting them the best that I could, Yes, sir.
Q: Was it early in your paramedic career, or toward the end when you were hanging it up and moving to DHEC?
A: I'm sorry, hanging it up and moving to DHEC --
Q: I'm sorry, in your clinical career.
A: I'm still a clinical paramedic sir.
Q: Can you recall when in your career you saw a penetrating abdominal wound, stomach where the object was still impaled in the victim?
A: It could have been five years ago, it could have been seven. I'm not exactly sure.
Q: Doesn't stick out in your mind? You don't

remember?
A: There are a lot of calls that stick out in my mind, but for other reasons.
Q: Okay. Particularly like a critical trauma would stick out in your mind?
A: No, I've had a lot of violent trauma. I've worked a lot of trauma.
Q: Okay. Did you work as an EMT basic at some point in your career?
A: Six years, Yes, sir.
Q: Okay. Was the stabbing calls you can recall or the impaled objects in abdomen calls that you can recall, were you the paramedic or the EMT on that?
A: I was paramedic.
Q: Okay. During your career as a paramedic or EMT, have you ever heard a first responder, paramedic, EMT on the scene use language that you thought was offensive.
A: Oh yea, always. And I've always corrected them too.
Q: Okay. Have you ever filed a complaint against their paramedic or EMT certificate after that.
A: I have not filed against their certificate. I went to my supervisor, and we let them handle

it from there.
Q: That's the proper way to handle this, right? Is to take Davenport aside as supervisor, take Mr. Davenport aside and say James, you can't talk to patients like this. That's not a certification issue is it?
A: It can be, yes.
Q: But that's not how you handled it when you heard inappropriate language in the field.
A: I wasn't in the office where I'm at now.
Q: I've got one other thing. There's a white notebook with the DHEC exhibits in it. Let me ask you, you mentioned those two private ambulance services that you worked for at the end of your career. Were those emergent called, or were those transport?
A: Actually, both. I've actually -- the Midlands MedTech we took patients, responded to 9-1-1 calls in the Sumter area.
Q: Was that a BLS truck, or an ALS truck?
A: It was an ALS truck.
Q: If you'll turn to tab 8.
A: 8?
Q: 8.
A: Yes, sir.

Q: Do you recall participating in an Investigative Review Committee meeting over Mr. Davenport's situation?

A: Yes, sir, and if I may, Your Honor, just to make sure. My nickname Naugy, and I do believe you might see this in the transcript. I think Dr. Deschamps calls me Naugy instead of Richard Naugler, just to make sure.

THE COURT: Yes, sir, go ahead Mr. Rothstein.

Q: I'm going to ask you to turn to page 4. And again this is one of those things that's got reduced page, and I said four pages on each page. Big page 4, little page 13, okay?

A: Yes, sir.

Q: There's a discussion. You see your name down there starting on line 19?

A: Yes, sir.

Q: Okay. And I'm just going to have you read along silently as I read it. It says, Mr. Naugler the other two calls that we had a whole QA packet that was originally sent to us. This is the whole QA packet. Dr. Deschamps says, and there was multiple. And you responded, there were multiple, right? Do you recall that discussion in the IRC meeting?

A: Yes, sir.
Q: Okay. So you were trying, you and Dr. Deschamps are trying that there are more than just one call against Mr. Davenport's situation, right?
A: No, I think we were answering Dr. Clanton, and so there are these other charts. We were trying to clarify what the other charts were.
Q: Okay. And you were trying to imply that Mr. Davenport has a pattern of misconduct. This is not just a single event, this is more than one event, right?
A: No, sir, I wasn't trying to imply anything. I was just explaining that there were more than one chart.
Q: But more than one chart was discussed at the IRC, isn't that right?
A: I'd have to look at the notes, I'm not sure.
MR. ROTHSTEIN: I don't have any further questions, Your Honor.
MR. WICEVIC: I just have a couple -- thank you, Your Honor.

MR. NAUGLER - CROSS-EXAMINATION BY MR. WICEVIC:

Q: Mr. Naugler, here at the beginning there's a mention of your training of inspecting. You

mentioned that thing CLEAR.
A: Yes, sir.
Q: What is CLEAR?
A: It's a counseling licensor that certifies investigators and compliance Officers.
Q: Okay. So you're certified by them?
A: Yes, sir.
Q: What did you have to do for that?
A: It's a pretty aggressive course that you take. I did it in Raleigh. It was about a three day coarse, and you have to test and be certified by them.
Q: Okay.
MR. ROTHSTEIN: Mr. Naugler, I'm having a little trouble hearing you.
MR. NAUGLER: I'm sorry.
MR. ROTHSTEIN: Thanks.
MR. NAUGLER: Uh-huh.
Q: This is Exhibit 3 the DHEC investigation log. Can you just give the court a general explanation of how you complete that?
A: As things come in, we try to log them as best possible, and just keep up with notes. Try to keep a pattern going as far as our investigation.

Q: Does it act like a timeline?
A: It can be a timeline. Yes, sir.
Q: I think that's all I have for you.
A: Okay.
THE COURT: Anything Else?
MR. ROTHSTEIN: Not with this witness, Your Honor.
THE COURT: Okay, thank you Mr. Naugler.
MR. ROTHSTEIN: Next call Arnold Alier to the stand Your Honor.
THE COURT: Mr. Rothstein, before you get to your next one, so we don't have to interrupt, let's take our ten minutes here before we get into it.

(Off the record from 10:16 a.m. until 10:30 a.m.)

THE COURT: We're going to call the hearing back to order. And you can get the witness up to the witness box to be sworn in.
DR. ARNOLD ALIER, having been duly sworn, testifies as follows:

DR. ALIER - DIRECT EXAMINATION BY MR. ROTHSTEIN:

Q: Good morning, Dr. Alier. I'm David Rothstein. I don't know that you and I have ever actually met before. I guess we introduced each other at IRC meeting.
A: Yes, sir. I think we did.

Q: Okay. Could you state your full name for the record please?
A: Arnold Alier. No middle name.
Q: Okay. And I noted we've been referring to you as Dr. Alier. You're not a medical doctor, is that correct?
A: No, sir. I've got my doctorate in education.
Q: Okay. And where did you get your doctorate of education?
A: Bob Jones University in Greenville.
Q: Okay. Is that in the paramedic education or EMT education?
A: It was in adult education. There was a process by which I got my masters first in education and then my doctorate. I had a bachelor's degree when I started in EMS in an unrelated field. And once I switched over from the career that I was in, 'cause I was a Public Safety Officer for the university, I took the EMT class, and sort of like a lot of people, the bug bit me. In 1985 I switched over to Greenville County, went back to school, got my associate's degree in EMS. Worked the street in Greenville for 21 years. When I was promoted to the Training and Education

Coordinator even though I had two degrees I felt I needed to validate that as adult education. So I went back to school, got my masters in education, and then proceeded on and got my doctorate in education.

Q: Okay. So that was to assist with your, I guess, instilling education in as a part of your Training Officer role. Is that a fair -- at Greenville County EMS?

A: That's correct. As well as at the time I sort of had a duel career like a lot of folks in EMS do. So I taught EMT classes at the Bob Jones University Program, the Greenville Tech Program, as well as in Tricounty Tech.

Q: Okay. And you said you had got your associate's degree in EMS from Greenville Tech in 1985?

A: I started in '85, finished in '87.

Q: Okay.

A: We were the first graduating paramedic class in that program in the State.

Q: And then you went from there to Greenville County EMS, right?

A: In '85 I had started working for Greenville County while I was going to school. I was

first what they call a comspect dispatcher prior to the 9-1-1 system where you dial the 9-1-1. So I did that for about a year before going to the field as an intermediate. And then a year later I graduated as a paramedic and stayed in the field as a paramedic.

Q: I understand that while you were a field medic for Greenville County you were partners at one point with a gentleman named Scott Stoller?

A: That's correct. Sometime probably around '94 I think. '94, '95.

Q: How long were you and Mr. Stoller partners?

A: I don't remember exactly but it's probably about a year 'cause usually what they do you change partners about every six months or you change -- I should say you change at that time stations about every six months. And we worked two stations, one in Simpsonville first and then we went to the one in Gantt, which is the lower west side of Greenville area.

Q: After your partnership, did you remain friends with Mr. Stoller?

A: We were acquaintances. I mean we never ate lunch or visited each other or anything like that. I knew him. We had a lot of people in

Greenville County, and you sort of develop a, I would say a longtime friendship with all your partners. I still keep up with folks that I had worked with in the past. Some are in Spartanburg, some are in Anderson. The EMS community is a very tight knit community. That's good for a lot of reasons. There's a lot of support when somebody's hurting or somebody dies, we all see each other at funerals. So everybody knows each other pretty much.

Q: Okay. Would you consider yourself to be -- Mr. Stoller to be a friend of yours if I said ---

A: That's a good characterization. Yes, sir.

Q: Okay. Would you consider him a close friend of yours?

A: Close friends are the ones that would come to my house, we would have dinner, we go to church. That's a very small group. Is he friends with me on FaceBook, yes. But I've got well over 400.

Q: Do you keep in touch with Mr. Stoller on a regular basis?

A: We do professionally. We are both members of a Law Enforcement Officer's Team. We started

that program back in January of 2016 as a result of the Fifth Circuit Colicitor's Office initiative. He brought three agencies, DAODAS, Solicitor's Office, and EMS. And at the time when we started looking at the training program we specifically were looking at not just paramedics doing the teaching. The law enforcement community is very distinct although we share a lot of things with the first responders. So we wanted to get paramedics that were also Officers. And so Sergeant Jeff Ward with the Sheriff's Office was one of the ones that we invited to look at materials as well as Scott Stoller 'cause he's both a Officer as well as a paramedic, and he's got a bomb dog. I know that was a real concern with the program of K-9 Officers.

Q: Okay. Would you say you speak with Mr. Stoller regularly more than once a month?

A: Yes, sir. We have training usually about once a week or once every couple weeks. Not everybody on the team makes it to every single session. We try to do that for the large agencies. So we have all hands on deck. But not necessarily every day. Usually our

trainings are on Fridays, and so I will send out a memo or Assistant Solicitor Shankar will send out a memo or an email to all of us. So that's sort of the communication we have. We're going to be doing a class in Charleston or we're going to be doing a class in Sumter. That's the normal chitchat that we usually have. Or when we have a save, an Officer save someone, there's a group text that goes around kind of celebrating the success of that.

Q: How many people would be in that group text?

A: Five.

Q: Okay. You have Mr. Stoller's cell phone number in your phone contacts?

A: Yes, sir. I do.

Q: Okay. Do you regularly communicate with Mr. Stoller by email?

A: Not that frequently. He has sent me a couple of packages in the past on my DHEC mail. That's usually the extent of our communication.

Q: When was the last time you spoke with Mr. Stoller?

A: Probably a couple days ago. I think he asked me when I was going to be testifying, and I said I didn't know.

Q: Do you call Mr. Stoller Scotty? Is that ---
A: No, sir.
Q: Never called him Scotty?
A: No.
Q: Okay. What does he call you? Dr. Alier?
A: No. He calls me Arnold. Unless we're in a public meeting. Whenever we're doing the LEON class, that's the acronym for the classes, he may refer to me in public when he's talking to the Officers as Dr. Alier, but for the most part within the group it's just Arnold.
Q: Okay. So Mr. Stoller became EMS Director for Anderson County. Has he frequently run things by you relating to the operations of his office?
A: I would say maybe once every six months he'll run something by me, but that's pretty common. Other agencies do that. In fact yesterday while we were here at trial I got the same courtesy from an agency in the Upstate last week, one from Lexington.
Q: What kinds of things does he run by you since you've been DHEC EMS Director?
A: Well he kind of wanted to get in and find out when we were going to be publishing the new

protocols so they can look at them, adopt them. The last time that the State had protocols done was around 2009, so they were long overdue. We have received packages from him where they did an internal QA. He wanted me to review it to make sure they didn't miss anything. Very similar to what I get from other EMS agencies. Berkeley County did the same thing, Greenville County, Pickens County. But they look to us for leadership and just to put eyes on things to make sure that something was not missed.

Q: How many QA packet reviews would you say you've discussed with Mr. Stoller since he became Anderson County EMS Director?

A: I don't know. More than two, less than ten.

Q: Okay. Has he ever run anything more serious by you other than say a QA review?

A: I don't recall. I think we had a conversation after the shooting at the elementary school. That was not necessarily a QA situation. He just needed someone to talk to and so he called me.

Q: Is providing sort of oversight of -- actually how many EMS agencies or rescue squads around the State does DHEC monitor?

A: I'll have to check because they change daily. But either 247 and 268. It varies. We've had some losses.
Q: Okay. Do you regularly at DHEC serve as an oversight body for QA reviews on some or any of the 240 something?
A: It's not an official capacity, but people do run stuff by us all the time.
Q: Okay. Does DHEC get involved in personnel matters, like human resources type matters?
A: No, sir. That's outside of our purview.
Q: Okay. Do you agree that those are local problems and need local solutions?
A: I believe those were my words. Yes, sir.
Q: Did Mr. Stoller in his discussions with you ever tell you he was having any problems with particular paramedics in his office at Anderson County EMS?
A: Not prior to this investigation.
Q: Okay. He never called you up and told you he was having difficulty with a guy named James Davenport that just came back from military service?
A: No, sir.
Q: Let me hand you a document. It's not in

evidence, but I'll represent to you that that's DHEC's interrogatory responses in this case. Do you see that?

A: Okay.

Q: And in the first interrogatory he was asked to identify the witnesses. Do you see your name on the witness list from DHEC?

A: Yes, sir.

Q: Okay. And then the second interrogatory states to summarize what the witnesses identified in interrogatory number one might know about the case or what they might testify to. You see that?

A: Yes, sir.

Q: Okay. Do you see your name down there in the summary of what you were expected to testify about?

A: Hold on a second. Okay. There we go.

Q: If you'll follow along, I think it states, Dr. Alier received a complaint which alleged regulatory violations against Mr. Davenport and initiated the investigation. Did I read that sentence correctly?

A: Yes, sir.

Q: Okay. And then it says, Dr. Alier recused

himself from the investigation into Mr. Davenport.

A: Yes, sir. I see that.

Q: Okay. Did I read that one correctly?

A: Yes, you did.

Q: Okay. We'll look at the receipt of the complaint in a minute. But is it true that you recused yourself from the investigation of Mr. Davenport?

A: In the true sense of the word, no. I received a complaint, so I'm the boss. I have to do something with it. So I assigned an investigator and then I had very limited access. I could go to the file because I have the password to get into it, permissions. I did not review the video after we reviewed it with Dr. Deschamps. And I think the next time I saw it again was at the IRC. I was invited to the IRC because I was germane to the investigation receiving the initial QA package that later turned into the investigation when we got the video tape. But I was not in the decision process for any of the interviews as well as any of the consent orders or any of the subsequent administrative orders.

Q: Okay. Let me back you up to one thing you said, and make sure I understood it correctly. Did you say that the first time you reviewed the video was with Dr. Deschamps?

A: No, sir.

Q: Okay. When was the first time you reviewed the video?

A: It was the day that I received it. I often work late in my office. Mostly because, well a couple of reasons. The phone usually stops ringing at 5:00 o'clock. So I get my best work done between 5:00 and 7:00. So he had called me, said he was going to send me something. But it was a large file and DHEC has kind of a filter that if something's over I think ten megabytes that it won't come through. And so I gave my email address for my personal email address, which has a larger capacity. And so he sent me the video, and that's the first time I saw it once I downloaded it and looked at it.

Q: Okay. Had Mr. Stoller communicated with you in any way about Mr. Davenport prior to that video?

A: Nothing other than that package that I'd received, that QA package ---

Q: Okay.
A: --- that was sent to me. I believe the QA was done by Mr. Eudy.
Q: You know Mr. Eudy?
A: I do. He had worked in Greenville about the same time as I did.
Q: Were y'all ever partners?
A: We were never partners. We had that summer between 150 and 200 employees. I remember him going through the paramedic program. I may have been his preceptor once or twice that he rode with me. But he was never my partner.
Q: Okay. Would you consider Mr. Eudy one of your friends?
A: I don't have his phone number. I don't know where he lives. I would consider him a friend, but again, somebody who we had a past.
Q: Okay. When was the last time you spoke to Mr. Eudy? I mean other than -- did you see him in the courtroom here?
A: I saw him in the courtroom.
Q: Prior to that.
A: I'm trying to think.
Q: Prior to that, when was the last time you spoke to him?

A: I may have seen him at the symposium and prior to that I believe at the funeral of a paramedic.
Q: Is Mr. Eudy one of your FaceBook friends as well?
A: No, he's not.
Q: Did you ever tell anybody that you were going to recuse yourself from this investigation?
A: I don't recall if I did or not. That's usually our internal policy. If we have a history with an agency or an individual for purposes of appearing transparent and being accountable ---
Q: Was this one of those instances where you felt like maybe I should not be involved in this?
A: Yes, sir.
Q: Okay. And when did you make that determination that this may be a little too close to home. I better stay away from this investigation.
A: As soon as I saw the video.
Q: Okay. Did you ever review those interrogatory answers before they were submitted or sent to me? Or is this the first time you've ever seen those ---
A: That's the first time I've see this.
Q: Now did anybody tell you that you should not be

part of the investigation, or did you say, look I think I better step back from this one because of my relationship with Mr. Stoller?

A: That was my decision with my boss.

Q: Okay. If you recused yourself from this matter, why'd you participate in the IRC meeting?

A: Again, they asked me to come in and they were asking me about the initial QA that I had reviewed. And they asked me how I received the video.

Q: Okay. So wait. Your testimony is that you were a witness in the IRC?

A: I was a participant in the IRC. They asked me how I got the video.

Q: You were actually part of the IRC, right? I mean the statute defines who's in the IRC ---

A: I had no decision making process in that, sir.

Q: Okay. Well why did you participate in the executive committee session after Mr. Davenport and I were excused from the meeting?

A: They called me in because I had Mr. Stoller's phone number.

Q: Okay.

A: I believe they asked me to call him because

they had some questions for him. I came in, did that, and then stepped out.

Q: Now, you were here when Mr. Naugler was testifying a few minutes ago. Have you ever seen the investigative packet that was provided to Mr. Davenport?

A: No, sir. I've not reviewed it.

Q: Okay. I'm going to ask you to look at Exhibit 25.

A: Okay.

Q: Would you expect the actual complaint to have been part of the investigative packet that was provided to Mr. Davenport?

A: I would say that the video tape was really the complaint itself. It kind of spoke by itself. We didn't have a formal written complaint, please look at this in relationship to that.

Q: Let me show you Exhibit 3. Do you recognize Exhibit 3?

A: Yes, sir.

Q: And do you recognize that as the investigative log in the matter?

A: Yes, sir.

Q: Okay. And you see the first entry on Exhibit 3 dated April 13th, 2016 at 5:04?

A: Yes, sir. I made that entry.
Q: Okay. And those are your initials over there to the right, is that right?
A: That is correct.
Q: Okay. So you would have set up this entire template of this document. Is that correct?
A: All I did was put in the first entry, initial it, and then hand it off to the investigator.
Q: Okay. Well you would have had to fill out the subject of the thing before you started typing, wouldn't you? The first line says, 16-4-126-Davenport. Did you put that in there on the log?
A: I don't recall if we did that or -- I'm not sure. We did usually have our Compliance Officer assign numbers.
Q: Show is the compliance Officer?
A: Ryan Nix.
Q: Ryan Nix. How long has he been the Compliance Officer? Would it be since you've been at DHEC?
A: Yes, sir. I'm just trying to remember if it's been two or three years. Something to that effect.
Q: Okay. On the top right after subject it says

region and then it says region one. What is region one?

A: Region one is the Upstate.

Q: Okay. Start date April 13th, 2016. Then it says Inspector Richard Naugler. Who assigned this to Richard Naugler?

A: Both Rob Wronski and I did.

Q: Okay. When did that happen?

A: That was the morning after we got the video.

Q: Now if you'll look down on the entry that we were just -- the first entry, April 13th, 2016, 5:04. Is that the afternoon or the morning?

A: That's in the evening, sir.

Q: Okay.

A: As I explained, I'm often in the office late. I'm not an early bird. I am a late bird, so --

Q: Okay. I just saw a lot of these things in military time. I was just wondering if you were a military time person or a standard time person.

A: Usually I'm military. My watch is military time. I think what I wind up doing was looking at my either the email I had received or the phone call just before I go the email. That's

where the time came from and that's what I typed out.

Q: Okay. Is there a reason you didn't put the email you originally received from Mr. Stoller in the packet that you gave to Mr. Davenport?

A: There was no text. It was just the file itself.

Q: Okay. And the entry you wrote says, secure email and file sent to Dr. Alier from Scott Stoller at Anderson EMS with investigation material they had gathered and performed on an Iva Rescue Squad paramedic. See that?

A: Yes, sir.

Q: Did I read that correctly?

A: Yes, sir.

Q: Okay. Then it says, investigation initiated by Bureau and file started.

A: Yes, sir.

Q: When did you actually type that entry? Was that before you left for the day on the 13th?

A: No. We typed that the next morning.

Q: Okay. The next day. Now I see the word secure in front of email.

A: I think the email had a password if I remember right.

Q: Okay. Was this email sent to your DHEC email or was it sent to your personal email?

A: No, sir. As I stated before, It was sent to my personal email, my gmail account because it accepts larger downloads or attachments. I think the DHEC system will automatically kick out if you have anything. And I want to say that the ceiling is ten megabytes.

Q: Let me ask you this. Prior to the 5:04 when you got this on your personal email, how did Mr. Stoller know to send it to your personal email rather than your DHEC email?

A: As I stated previously, he called me and said, I'm going to send you something related to the QA package, or something to that effect.

Q: Okay.

A: I don't remember the exact words.

Q: All right. And did he call you back later and said, hey I tried to send this to your DHEC email and it got kicked back. It wouldn't work?

A: No, sir. He said it was a large file. I said, you're going to have to send it to my gmail account because my account will kick it out if it's larger than ten megs. And I asked him how

large it was, and I don't remember what the size of the file, but he said it was larger than ten megs.

Q: Okay. I've got a gmail account. They're great. Is that the free service you use for gmail or do you have something more advanced?

A: It's the free service.

Q: Okay. Do you know whether -- are you familiar with a law called HIPAA?

A: Yes, sir.

Q: Okay. And what is your understanding of the law HIPAA when it comes to protecting private information about medical patients?

MR. WICEVIC: Your Honor, I don't know how this is relevant. DHEC's Regulation Bureau is a health oversight agency, number one. So HIPAA doesn't apply to our Bureau of EMS. It might apply to Mr. Stoller and Anderson County EMS. More importantly, it's not relevant to this case.

THE COURT: I think it is. Your objection's overruled.

Q: When you put secure email down there, were you intending to indicate that that was somehow HIPAA compliant?

A: Yes, sir.

Q: HIPAA's a pretty serious statute, isn't it?
A: I understand, yes, sir.
Q: Okay. And you're a paramedic and an EMT, and you understand that the privacy for patients is very important under this federal law, right?
A: Yes, sir.
Q: Okay. And you have a duty as a medical provider to protect under HIPAA that patient's personal health information or personally identifiable information, right?
A: Yes, sir.
Q: Okay. Would you agree with me that the video contains personally identifiable information about that patient?
A: Yes, sir. But ---
Q: It has his face on it?
A: Let me please finish my statement.
Q: Okay. Sorry. Didn't mean to cut you off.
A: We often get information, videos, sound, pictures that may violate on the initial view from the public side because they provide protected health information. But again, we as the regulatory body have to view those to come to an determination. I believe if you look at the HIPAA statute of the federal law, it talks

about there are instances and exceptions when conducting investigations for the purposes of billing, for the purposes of quality assurance by Training Officer, and so forth. And I think my function as the Director of EMS for the State would be covered under that.

Q: Okay. Was Mr. Stoller -- is he a certified paramedic covered by DHEC?

A: Yes, he is.

Q: Okay. At the time he sent you this gmail invitation, was he a certified paramedic through DHEC?

A: Yes, sir.

Q: Okay. As the EMS Director of Anderson County, was he somewhat involved in the provision of care to this patient for the review of this patient's care?

A: I think he reviewed the QA and he reviewed the video. Yes, sir.

Q: You agree that he has a duty under -- you understand HIPAA to protect personal health information of that patient?

A: Yes, sir. But again, he sent that -- he didn't broadcast that video to anybody. He sent it directly to me in a secure email.

Q: Okay. Did you have any concerns that about whether gmail is compliant with HIPAA?

A: No, sir. That didn't enter my mind. We just wanted to make sure that I got that video in a secure fashion.

Q: Okay.

MR. ROTHSTEIN: Can we switch onto my computer screen?

Q: Did you even bother to Google whether gmail is HIPAA compliant?

A: No, sir.

Q: Okay. I pulled up Google on my computer. Is gmail HIPAA compliant? You see the second entry down here, says, gmail is not HIPAA compliant?

A: Can you move the mouse? It's kind of ...

Q: Oh, sorry.

A: Yes, sir. It says that but it doesn't mean that it can't be. And I understand by looking at the first entry up there that you can encrypt and you can put password on a file.

Q: Okay. And you see this HIPAA compliance g-suite support through Google?

A: Yes, sir.

Q: Okay. Did you ever -- have you ever had the g-

suite from Google, or did you just use the standard gmail that's free? We talked about that earlier, right? You told me you have the free service.

A: I have the free service.

Q: So you never gotten the PAA through gmail that would encrypt the data to make that personal health information comply with HIPAA, right?

A: I don't recall I've ever done that.

Q: And Mr. Stoller actually sent you this on what's called a shared Google drive. Isn't that right?

A: I believe that's correct.

MR. ROTHSTEIN: Can we mark this as the next exhibit?

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

Q: Dr. Alier, I'm going to hand you Exhibit 27. Do you recognize that as the email that Mr. Stoller sent you to your gmail account?

A: Yes, sir.

Q: Okay. Arnoldalier@gmail.com, right?

A: Yes, sir.

Q: Okay. And it's an invitation that says, Scott Stoller has shared the following video, see

that?
A: Yes, sir.
Q: And it was sent from Scott Stoller via Google drive, right?
A: Yes, sir. That's what it says.
Q: What did you do with the video after you got it?
A: I downloaded it to a jump drive, put a password on it, secured it in my desk, and then the next day offered it to the Bureau Chief, and then we called Richard Naugler in to view it as well.
Q: How many times did you view it before you opened an investigation on the matter?
A: Twice.
Q: Did you discuss it with Mr. Stoller after you viewed it?
A: No, sir.
Q: You didn't call him up and say, Scott I got your email, and talk to him about it?
A: Not to my recollection, sir.
Q: You believe Mr. Stoller committed misconduct as defined by the statute when he sent you that unsecured document to your unencrypted gmail account?
A: I don't think so. No, sir.

MR. ROTHSTEIN: Can we get the Elmo up?

Q: Dr. Alier, are you familiar with regulation 61-7?

A: Yes I am, sir.

Q: Okay. And that's the emergency medical services regulations for the State of South Carolina, correct?

A: Yes, sir.

Q: Okay. And section 1100 subsection B defines misconduct.

A: Yes, sir.

Q: You see where it says misconduct?

A: Uh-huh.

Q: I'm going to ask you to look down to item number nine. It's misconduct for the holder of a certificate to reveal confidences entrusted to him in the course of medical attendance unless such revelations are required by law or is necessary in order to protect the welfare of the individual or the community. Did I read that correctly?

A: Yes, sir.

Q: And do you believe that Mr. Stoller, by sending an unencrypted email to you or sharing that video with other people in the public revealed

confidential information about ---

A: No, sir. He did not share that with anybody that I'm aware of other than myself at that point.

Q: Okay. If you became aware that Mr. Stoller had shared that with multiple people in Anderson County, not even connected with the EMS department, would that be misconduct under the statute?

A: I'm not aware of him sharing that with ---

Q: Okay. I understand you're now aware of it. But if you did become aware if it, wouldn't that be misconduct under the section I just read of the regulations?

A: Yes, sir. I could see how that would be a problem.

Q: Okay. Now when I noticed the first entry on the log that said, secure email sent to Arnold Alier about the complaint, I requested a copy of that email from DHEC. Are you aware of that?

A: Yes, sir.

Q: Okay. And I got a response about the email that started the investigation, Exhibit 28. You recognize Exhibit 28?

(Respondent's Exhibit Number 28 was marked for

identification purposes.)

A: I don't have that in front of me. Thank you.

Q: You got it now?

A: Yes, sir.

Q: Okay. You see what all those black lines are?

A: It's redacted information.

Q: Okay. Do you know what is redacted out of that email?

A: I would have to look at the original email, sir. I'm assuming that from is from Scott.

Q: Do you recognize that email as the email that Mr. Stoller sent you on March 25th, Friday at 5:19 p.m. about summary of QA action? Do you recall receiving an email from Mr. Stoller about that?

A: I believe this was the QA package perhaps. And this was sent to I believe my DHEC account.

Q: Do you know who put those black lines on that email?

A: I do not, sir.

Q: Okay. And do you know why those black lines are put on that email?

A: To redact information.

Q: Because the statute said that the information was private or protected, right? Because it

related to a paramedic who's certified by DHEC?

A: Yes, sir.

Q: Okay. And that paramedic is Scott Stoller, isn't that right?

A: I would assume that that's the email we're talking about, the QA package. Yes, sir.

Q: I'm going to hand you Respondent's Exhibit 10.

MR. ROTHSTEIN: And this is in the exhibit notebook, Your Honor, Respondent's Exhibit 10.

Q: That's Mr. Stoller's side of that same email that we just had with the redactions. Isn't that right?

A: Yes, sir.

Q: So the stuff that was blacked out was the fact that it came from Scott Stoller, and had his name and Anderson County or aceme.us email address, right?

A: Yes, sir.

Q: Okay. Is his email address a confidential matter?

A: I was not the one that redacted that information, sir.

Q: Okay. I also didn't see on the redacted version, an attachment. Do you see at the bottom of Exhibit 10 there's an attachment

called jdavenport.pdf?

A: Yes, sir.

Q: Okay. What was jdavenport.pdf?

A: That was the QA package that I received on that date?

Q: Okay. Why did Mr. Stoller send you a QA packet from Anderson County after 5:00 o'clock on a Friday about Mr. Davenport?

A: I'm not sure why that has relevance. I receive packages around the clock.

Q: Okay. What did you do with the packet after you got it from Mr. Stoller?

A: I believe I read it, reviewed it the next day.

Q: Okay. Did Mr. Stoller call you and give you a heads up that, hey, I'm getting ready to send you something on your DHEC email?

A: Not to my recollection, sir.

Q: Okay. I'm going to show you Exhibit 25. Do you recognize the jdavenport.pdf QA packet in that exhibit?

A: Is it the one that starts with Anderson County cover letter? Or am I supposed to be looking at something else?

Q: You recognize portions ---

A: That one?

Q: You think it was just a one page document?
A: No, sir. I believe ---
Q: You believe it was the whole QA packet, right? It had patient run reports in it, it had a statement of Ms. Aiken. Does that sound familiar?
A: That does sound familiar, but I don't see ---
Q: I mean, if all you got was a letter from Mr. Stoller saying, we're either initiating an investigation or we're closing an investigation, you can't review what Anderson County did with regard to that investigation. Isn't that right?
A: I look at the -- I believe at the end of that particular package there was some directives of what they were going to do. They were going to do the standing orders test and I don't recall what else was exactly in there. Review of the standing orders and then take the standing orders test. Again, this has been well over a year since I looked at these documents 'cause I was not involved in the investigation, sir.
Q: Okay. Is it your recollection that the email you got from Mr. Stoller after 5:00 was the first conversation you ever had with him about

James Davenport, or the first information you knew about a QA matter with James Davenport?

A: To the best of my recollection. Yes, sir.

Q: I'm handing you Exhibit 8, Respondent's Exhibit 8. Does that refresh your recollection? You remember getting an email from Mr. Stoller -- I'm sorry. I think I have you the wrong thing.

A: I was going to say my name's not in here anywhere.

Q: Sorry. I gave you the wrong document. Let me pull the other file. Can you give me that 8 back?

A: There you go.

Q: Thank you. It's actually 8a. I apologize for the confusion. All right. You recognize Exhibit 8a?

A: Yes, sir.

Q: Okay. It's an email you got that same day at 11:32 on that Friday, right?

A: Okay.

Q: And it says it's from Scott Stoller. It says, Arnold I would like to enroll paramedic James Davenport in the next Principles of Ethics and Personal Leadership class. Thank you, Scott. Right?

A: Yes, sir.
Q: Okay. Are you the registrar for the Principles of Ethics and Personal Leadership class?
A: I am.
Q: Okay. How does somebody go about enrolling a medic or an EMT into the PEPL class?
A: Into the PEPL class?
Q: PEPL class.
A: I have to go to the national NAEMT website and put the person's name in. I think I put their name in and perhaps an email address.
Q: Okay. And you responded to Mr. Stoller later that day at 1:18, and said, PEPL class, it'll be the first full week in June, probably at the beach, right?
A: Yes, sir.
Q: Okay. It said, more details to follow later. Did you ever follow later with more details to Mr. Stoller about when the next PEPL class would be?
A: Not to my recollection.
Q: Okay. Did you ever enroll Mr. Davenport in the next PEPL class?
A: No. I did not.
MR. ROTHSTEIN: Your Honor, I'd like to move Exhibit

10 and 8a into evidence.

MR. WICEVIC: No objection, Your Honor.

(Respondent's Exhibit Number 10 was admitted into evidence.)

(Respondent's Exhibit Number 8a was admitted into evidence.)

MR. ROTHSTEIN: I don't know if I moved that gmail email into evidence either. I'd like to make sure that's Exhibit 26 into evidence.

THE COURT: Now which one is that?

MR. ROTHSTEIN: I'm sorry. Exhibit 26 is ---

COURT REPORTER: 27.

MR. ROTHSTEIN: 27. That's right. I was looking at the wrong one. 27.

MR. WICEVIC: No objection.

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

MR. ROTHSTEIN: 26 is -- yeah, that's right.

THE COURT: Is it this one?

MR. ROTHSTEIN: Yes. And that one needs to go in too, Your Honor. That's -- I just marked that one. I apologize. I'm getting a little ---

THE COURT: Now which one are we talking about?

MR. ROTHSTEIN: Exhibit 27 is the gmail.

THE COURT: Okay.

MR. ROTHSTEIN: That one's in. And the redacted version I marked it 28, Your Honor. I move that into evidence as well. 28 is the redacted version.

THE COURT: Okay. 27 and 28. Now I've got a problem. This one does have an address on it.

MR. ROTHSTEIN: Okay. I'll redact it.

THE COURT: Yeah. I don't have a problem with it going in with the address redacted.

MR. ROTHSTEIN: Is that sufficient, Your Honor?

THE COURT: That's good.

MR. ROTHSTEIN: Okay.

THE COURT: Okay. It's admitted with that change.

(Respondent's Exhibit Number 28 was admitted into evidence.)

Q: All right. Back on track. Before Mr. Stoller contacted you about the possibility of enrolling Mr. Davenport into a PEPL class, did you know who Mr. Davenport was?

A: I think we may have met once, probably four years before this.

Q: Okay. Did Mr. Stoller ever communicate with you about why he wanted to send James Davenport to the PEPL class prior to this email, Exhibit 8a?

A: I'm not quite certain of the timeline. I know we had talked at some point after I had received the QA package that you were referring to, and the findings that Dr. Kickham had had, or the discussion that he had had with Dr. Kickham. If there was anything else that the Bureau would suggest. And I think I probably suggested the only thing I could see is perhaps PEPL class. I had looked at previous packages that they had sent us, and other agencies, and we do that on a regular basis as part of the package. I, myself have taken the classes. It's a professional ethics and leadership class.

Q: It sounds like a pretty worth while class, but I mean for you to evaluate whether Dr. Kickham and Scott did the right thing with regard to Mr. Davenport's medical care for that patient, wouldn't you have to know something about the medical care that was provided to that patient? Or those -- there were actually three patients at issue at that time, isn't that right?

A: I think at the time I had reviewed the package and the patience care reports. Yes, sir.

Q: That's what I'm getting at. So you had the

patient care reports at the time you decided this was a local problem, needed a local solution, right?

A: Well, as far as how we determine whether it's going to be through that, we look at several things. First of all we try to make a determination there was a compliance issue with the law or the regulation. So that would involve protocols, some sort of a violation of a protocol whether it's minor or major. We look at was there care that was less than acceptable or unacceptable care. We look at possible misconduct. And then any other violation of the reg or the statute. We also take into consideration intent. Was there an intent to violate the protocol or to conduct misconduct. So that comes into the consideration. Sometimes that's evident on the report, but many times you have to dig further. So then we look at and review the investigation or the QA or the review that the local agency did on a particular chart or on a particular individual, or particular incident. See what the facts are, see what they gathered, to see if it was complete. Then the next thing we

look at is we look at what sort of action did the local agency take, was it measured, was it appropriate, does it address the deficiencies.

Q: That sounds like a lot of stuff. You do that for every QA review that comes in from an agency around the State?

A: Well it's more or less a decision tree, like a protocol. But that's the mental process I go through. And then if we still can't resolve or come to our conclusion, then we'll usually bring in the EMT and find out their side of the story. If there appears to be something that was not addressed by the local Med. Control Physician. We put a lot of strength or authority of what the local Med. Control said. It's actually hardwired into the regulation that the Medical Control Physician will have independent authority to oversee quality patient care for an agency.

Q: So you give, in this case, Dr. Kickham the Anderson Control Medical Control Physician the deference or the -- he has the authority to determine whether paramedic care under his license was appropriate, right?

A: I don't do that. The regulation does that.

Q: Okay.
A: So ---
Q: When I say you I didn't mean you personally. I meant DHEC does that.
A: Correct.
Q: Okay.
A: So, once we begin to determine what has happened we look at if there's a history of compliance with the agency, there's a history of compliance with th department. And then we determine if we're going to invest resources into an investigation or if we feel that what the local agency did, their actions are adequate.
Q: Okay. So the first email you got with the QA packet, you made a determination Anderson County handled this appropriately, right?
A: Yes, sir. At that time before the video we felt that there were issues, but it appeared that Dr. Kickham had addressed the issues. And then ---
Q: And you think you had all the information you needed to make that determination? You had the run reports for those three cases, right?
A: Yes, sir.

Q: You had some protocols that were attached in the QA packet from Anderson County, right?
A: I don't recall if there were protocols attached to that or not.
Q: Okay. And you had a statement from Mr. Davenport's partner about the call, correct?
A: I don't recall if I had that or not. I probably did.
Q: And you had a chart review done by your friend Keith Eudy, right? That had a review of the three cases.
A: I would not characterize Mr. Eudy at that point as a friend.
Q: I'm sorry.
A: He was serving ---
Q: You had a chart review from Mr. Eudy ---
A: Yes, sir.
Q: --- of these three cases, correct?
A: Yes, sir.
Q: So you had everything you needed to determine whether the medical care provided from Mr. Davenport was appropriate and compliant with the protocols?
A: Up to that point.
Q: And you made the determination Dr. Kickham's

decision looks fine to DHEC, right?

A: The corrective actions that he was taking to the alleged protocol violations appeared to be measured ---

Q: Okay.

A: --- and appeared to be appropriate. And so we let his decision stand at that point.

Q: Okay. So at that point you knew the patient's vital signs from the patient care report, right? And you could tell that the patient was stable?

A: It appeared so. Again, it's been a long while since I reviewed that.

Q: Okay. And you knew from the narrative in the patient care report and also from Ms. Aiken's statement that the patient was walked out of the house to the ambulance, right? You knew that the patient was walked?

A: Yes, sir.

Q: Okay. You knew that Ms. Aiken, the basic on the call, rode the call in the back of the truck, and Mr. Davenport was the driver, right?

A: Yes, sir.

Q: Okay. You knew no IV was placed on that patient, right?

A: Yes, sir.
Q: Okay. You knew no heart monitor was hooked up to that patient during the call, right?
A: Yes, sir.
Q: And you knew no supplemental oxygen was provided to that patient?
A: Yes, sir.
Q: Okay. Did you bother to see if this patient had a good outcome when he got to the Emergency Room, or did you know that?
A: I didn't know that at the time.
Q: Okay. What about the other two patients that were in the packet? Based on your review of the protocols and the medical evidence, it appears Mr. Davenport provided good medical care in accordance with what DHEC expected of paramedics under their certificate?
A: I wouldn't characterize it good patient care. There were issues. There was some slips in the protocol if I recall.
Q: Did he deviate from what DHEC considers acceptable standard of care for a South Carolina paramedic or EMT?
A: As I said, there were issues. Again, I felt that Dr. Kickham was trying to take corrective

action to make sure that the paramedic in question had reviewed the protocols, knew of sure if it was that -- the only thing we didn't have at the time was intent. You're going to have to take the physician's and the QA Officer's word of intent, that there was no ill intent. And that really kind of came to light when we saw the video.

Q: Okay. How can you tell intent by looking at a video?

A: The demeanor, the actions. A picture is worth 1,000 words. So 1,000 pictures is worth multiple. There's a lot you can tell from a video. Now granted, it is not perfect evidence, but it was enough that we determined that there were serious issues with this call.

Q: All right. Back to Exhibit 3 a second in the receipt of your complaint. Who actually filed the complaint in this case? You say that Mr. Stoller filed the complaint?

A: He sent me the video.

Q: Okay.

A: I believe the Department started -- I guess if you're going to take the video as the initial complaint, Mr. Stoller would have.

Q: I though Mr. Wronski testified that the Department doesn't file complaints against paramedics.

A: Again, the video was, I guess you would call it prima facie evidence that something had occurred. And so we took that as a complaint. We often get letters that are anonymous that won't have a name. And there appears to be some misconduct, and we have to investigate by regulation.

Q: Okay.

A: All complaints and anything that comes in.

Q: Let's look at the regulation, Dr. Alier. Section 1100, you see that?

A: Yes, sir.

Q: It's the section for revokation or suspension of certificates of medical emergency technicians, right?

A: Yes, sir.

Q: All right. Section A, the Department shall upon receiving a complaint of misconduct as herein defined initiate an investigation, right?

A: Yes, sir.

Q: Item number one, the initial complaint shall --

what does that word shall mean to you?

A: It means shall.

Q: Okay. It's ---

A: It's not may; it's shall.

Q: Okay. It's a command, right?

A: Appears so. Yes, sir.

Q: Okay. The initial complaint shall be in the form of a brief statement dated and signed by the person making the complaint which shall identify the person or service who is the subject of the complaint and contain a summary as to the nature of the complaint. Okay. Did that gmail meet the regulatory definition of a complaint?

A: If you look up further, it says the Department is also authorized to initiate an investigation based upon information acquired from other sources.

Q: Okay. And I think Mr. Wronski said that the Department doesn't initiate the complaint, it received the complaint. Do you remember him saying that?

A: So the complaint would, if you want to be I guess literal, the video would have been the complaint.

Q: How did you know the video wasn't doctored? That's not the official body cam video, right? I mean what you got was a shared Google file that had a -- I don't know what computer extension it has on it, but it's like a jpeg or a wav video or something like that.

A: It's an mp4.

Q: Mp4. How did you know that was the actual body camera footage?

A: We took the video at face value and then requested an official copy to verify that.

Q: Okay.

A: We got the official copy, we compared the two and it was a faithful copy.

Q: Yeah. But you had already made the decision that Mr. Davenport should be either suspended or revoked at that point. Isn't that right? Before you even ---

A: No, sir. No, sir. As was said before when there appears to be intent we bring the EMT, the person in question in to find out their side of the story.

Q: Okay. Well let me get back to this file. Do you know what the purpose of providing the paramedic, who's the subject of the complaint,

providing him the identity of the person making the complaint, the nature of the complaint, and a summary of what is being alleged against them? What's the purpose of it requiring that kind of information to be in a complaint against a paramedic?

A: So they know what the complaint is about.

Q: Fair and due process, right? You want to provide someone notice of what they're being accused of, right? And an opportunity to be heard to defend against what they're being accused of, right? And this gmail video doesn't have any of that information, does it?

A: No, sir.

Q: Okay. Were you involved in that strategy meeting?

A: No, sir. I was in Washington.

Q: Okay. So you weren't involved in the first time Mr. Davenport came down to the Cola Mills?

A: No, sir.

Q: Okay. Did you know what the ultimate objective was at that point?

A: Well all our interviews, the objective is to get to the facts of what actually happened.

Q: Didn't Mr. Stoller tell you he wanted Davenport

gone from Anderson County EMS?
A: No, sir.
Q: Have you been involved in -- since you've been at the Department have you been involved in other enforcement actions against paramedics and EMT's?
A: Yes, sir.
Q: Some of those involve complaints where patients were actually died in the care of paramedics or EMT's?
A: Yes, sir. But there is a difference between someone missing a skill and having a bad outcome, and someone intentionally doing a bad skill and having a bad outcome.
Q: Okay. And before you even met with Mr. Davenport to get his side of the story, y'all made a determination that he shouldn't be a paramedic in South Carolina based on what you saw in the video, isn't that right?
A: We did not make that determination, sir. We --
-
Q: Wasn't that the objective?
A: We had concerns obviously when we saw the video, and that's why he was asked to come in.
Q: Did you compare punishments or enforcement

actions that DHEC had taken against other paramedics in deciding what was appropriate for Mr. Davenport?

A: I was not part of that decision making process, sir.

Q: Did you talk about the fact that there was no bad outcome in any of these three cases with regard to the patients that were being complained of?

A: At the end of the day, other than my first review in which I had accepted the recommendations from Dr. Kickham, I had no decision making process in the case.

Q: Did you consider the fact that Mr. Davenport had made complaints about Mr. Stoller, and that Mr. Stoller might have had a motivation to get rid of Mr. Davenport?

A: No, sir. We do not get involved in human resource or personnel issues.

Q: Okay. So takings somebody aside and saying a paramedic who used some rough language, I mean would you consider that a human resources issue or a local disciplinary issue?

A: We do not get involved in personnel issues with agencies, sir.

Q: Okay.
A: And that's not just with Anderson, that's with any agency. We don't get involved in billing complaints. It's outside of our purview.
Q: Now you talked about the IRC briefly a little while ago. Do you recall participating in the IRC with regard to Mr. Davenport?
A: Very limited.
Q: Okay. Was that the second one that y'all had done within an 18 month period, or was Mr. Davenport's the first?
A: It was the second one.
Q: Second. So you had had, or at least Mr. Wronski had gone through a -- so this was his second rodeo so to speak, second IRC?
A: That would be a good characterization of that. Yes, sir.
Q: And you learned from the experience of the first IRC who made have made mistakes or done things differently. So this was -- Mr. Davenport's was the sort of IRC 2.0, right? I mean it was the second version under Mr. Wronski's leadership.
A: Yes, sir.
Q: And in that white notebook, I think it's

Exhibit 3 I think is the IRC. Is that right? Or is it 8? Sorry, it's 8, Exhibit 8 in the white notebook.

A: Okay. I see it.

Q: Before we get to that, do you recall -- on the first page of Exhibit 8, it looks like the IRC meeting was on June the 23rd of this year, or, I'm sorry, 2016, right? Thursday, June 23rd, 2016.

A: Yes, sir.

Q: And the day before the IRC meeting you sent an email ---

MR. ROTHSTEIN: Let me get you to mark this.

(Respondent's Exhibit Number 29 was marked for identification purposes.)

Q: I'm going to hand you what's been marked as Exhibit 29. Exhibit 29 is an email the day before the IRC meeting, right? The first part of that says -- I'll put it up on the screen. The top part of it is from Arnold Alier to Richard Naugler, here's the QA package that we got, right?

A: Yes, sir.

Q: Okay. Have you provided the QA package to Mr. Naugler prior to this?

A: I believe I had. I have no recollection of the timeline here. I believe that was part of the original package.
Q: Okay. That's that jdavenport.pdf that we're talking about, right?
A: I believe so.
Q: Okay. And that's the thing that had the patient care reports and the protocols, and Ms. Aiken's statement, right?
A: Yes. I believe so. And I believe I had to give them the password because it was password protected.
Q: Okay. Well do you see it says, sent from my iphone? You see that? Right here, sent from my iphone.
A: Yes, sir.
Q: Okay. Is your iphone HIPAA compliant?
A: I would say not probably.
Q: Okay. Now let's scroll down to the prior part of this email string. You sent an email on your DHEC email to Mr. Wicevic and copied Mr. Wronski?
A: Yes, sir.
Q: And you're forwarding summary of QA action. That's the same subject line from Mr. Stoller's

email to you from Friday, March the 25th after 5:00 o'clock, right?

A: Where are we looking at? Okay. I see.

Q: Okay. And you say, here's the original package that was sent to me for review 19 days or so before I received the video. I took no further action believing that it was a quote local problem local solution handled by their Medical Control and QA process, right?

A: Yes, sir.

Q: Then it says, my only verbal recommendation to Scott was perhaps to include a PEPL class, right?

A: Yes, sir.

Q: Okay. So let's get back to the IRC meeting a second. I'm going to ask you to turn that Exhibit 8 and turn to page 35, Bates page 35 and it's page 139 of the transcript. Okay? And this is toward the end of the IRC meeting and the executive session part of the IRC meeting?

A: Yes, sir.

Q: Okay. And do you see on line 3, Dr. Alier, two things on that. Number one, we are planning on doing at least another two PEPL classes between

now and December. One in the Upstate early while I'm here. And the second thing was if you look at the original recommendations that we got of the initial packet from Dr. Kickham at Anderson County, one of the recommendations was for him to take some kind of trauma course, right?

A: I see that.

Q: Okay. And Mr. Davenport didn't mention any kind of trauma remediation that Dr. Kickham was requiring, did he?

A: If you read on further, you'll see that Dr. Deschamps corrected me.

Q: Okay. But why were you participating in the IRC meeting if you had recused yourself or you felt you had to step away from this matter because of whatever you felt uncomfortable with in handling this investigation in light of your relationship with Mr. Stoller?

A: I believe I was answering questions from the IRC.

Q: Couldn't you just say to the IRC, you know I don't think I should be involved in this given my relationship with Mr. Stoller?

A: Again, I had limited responsibilities that I

had to fulfill. One of which was going to the IRC to inform them of the package that I had originally received.

Q: Okay. And that original recommendation from Dr. Kickham didn't say anything about Mr. Davenport needing trauma remediation, did it?

A: No, sir. That was actually in an earlier package that I had received in another investigation where they had recommended a PHDLS class, I believe.

Q: Have you ever served in the military?

A: No, sir.

Q: Okay. Are you familiar with the training that a Special Forces Medic is required to undergo?

A: No, sir. The closest I ever came, I took a TCCC class.

Q: Okay. And Mr. Davenport taught that class, didn't he?

A: He was one of the clinical instructors in that class. Yes, sir.

Q: When did you take that class from Mr. ---

A: I believe that was July of 2013.

Q: Mr. Davenport seemed to know what he was doing?

A: Yes, sir.

Q: Okay.

MR. ROTHSTEIN: Okay. I have no further questions, Your Honor.

THE COURT: Mr. Wicevic.

MR. WICEVIC: Thank you, Your Honor.

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

Q: Dr. Alier, I think we skipped over your title with the Department. What's your title?

A: I am the Director of the Division of EMS for the Bureau of EMS and Trauma.

Q: Okay. And I think you testified you joined the Department in April of 2013. Can you explain your roles and responsibilities?

A: I am responsible for the oversight of the division of EMS. That includes inspections, certifications, licensing, as well as any actions that the agency would take on individuals as well as agencies. I also, as part of my duties now, have other public relations things that I do with the communities, such as the LEON program and the community paramedic program, several other infinitives that we have started.

Q: Okay. Well DHEC receives a lot of information. What would prompt the Department to initiate I guess a formal investigation?

A: Kind of as I answered before. We look at the possibility of infraction of the reg or infraction of the statute. And then we consider intent, then we consider a local investigation and local actions to see if there were, again I mentioned before, measured, appropriate addressing the deficiency. And what I mean with that, if somebody has an issue with violating the protocols, we make sure the protocols are reviewed, that they're tested against those. If it's an issue with a skill, such as one package that I had reviewed, there was a missed intubation, and that individual was demoted until they went through an airway class. We felt that was measured and that was appropriate. We read another package where someone had an issue with a trauma call. And in that particular case it was determined it was a knowledge issue, so that particular individual was sent to one of the trauma classes. So we look at the actions that the local Med. Control does, and if we still don't have a firm grasp of what happened, then we'll bring the individual in to tell his side of the story. If we feel that we have not cleared

initial step, then there's a possibility that a reg or the act was breached.

Q: You mentioned the Med. Control Physician's responsibility or role in the decision of whether or not to investigate, and how that's prescribed by the regulations?

A: Yes, sir. The Med. Control Physician has independent authority to oversee quality patient care for the agency. One of my duties as the Director of EMS is at least once a year, sometimes twice a year, we do a workshop for all new Med. Control Physicians in the State, which is a requirement for them to practice as such. And we go over their quality assurance and their oversight duties so they fully understand the gravity of what they do and their responsibility. The statute and regulation place a lot of responsibility on local control. The State would step in if we feel that, again, the actions taken were not -- the remediation actions by the local agency were not measured or appropriate.

Q: How many EMT's are in the State of South Carolina?

A: We have almost 10,000 certified. It varies

from day to day, but it's right around 10,000. And that's all EMT's. That's basic EMT's, advanced EMT's, and paramedics. Just collectively they're called EMT's.

Q: Okay. Before we move on I want to make sure we're clear about your reference to the reg.

MR. WICEVIC: Ms. Hazel, could I please get the monitor?

Q: Section 402, is that what you were referring to, Dr. Alier?

A: Yes. 402b, the Medical Control Physician shall serve as the medical authority for the licensed provider. C, the Medical Control Physician shall have disciplinary action sufficient to oversee the quality of patient care for EMT's and retain other responsibilities that may be negotiated agreement with the service.

Q: Okay. Now tell The Court what your typical involvement with investigation of EMS's is.

A: You mean investigations of EMT's? Well it depends on the source of the investigation. If the individual inspector, which is usually how these things come in, gets a phone call or an email, or witnesses an infraction, they would usually call the compliance Officer who assigns

it a number, and then we begin the investigation. They usually inform me, we're opening an investigation on such and such, and this the fact gathering. If, again, it meets that first criteria we talked about, something that appears to be an infraction of the statute of law, then we try to determine intent. If there was no investigation local, if there as no, because they were not aware, then we bring the EMT in to get their side of the story. I do sit in in most of the interviews with few exceptions. If I'm away on duties or for some reason I'm aware of if I had a history with this individual, then I usually don't sit in on those.

Q: Okay. And why did you not initially investigate this matter when Mr. Stoller sent a QA package?

A: Well it appeared ---

MR. ROTHSTEIN: Your Honor, I think he mischaracterized -- I mean I asked him those questions, and he said he reviewed the QA packet. But I think Mr. Wicevic's question mischaracterizes the prior testimony. It's been asked and answered as well.

Q: Did you investigate the initial QA review?
A: I reviewed it and felt, again, the actions taken by Dr. Kickham were consistent with the regulation 402c.
Q: And, I mean, if you've already explained it, but what tipped it over the scale after receipt of the actual body cam footage?
A: The disturbing images, the language, all seem to be consistent with ill intent. So that began the process for us to get to the bottom of what had actually transpired.
Q: Okay. And was the video the actual complaint, when you refer to complaint?
A: I would say so.
Q: Okay.
A: And again, the video was not acquired in a vacuum. It was given to Scott as I understand by the Chief of Police. Once an individual gets information, and this is not just talking about the Department, I'm talking about in general. Once an EMT or somebody that we certify gets information that somebody has done poor care, they have a duty to report that. Otherwise they might be complicate. So I could see why we got the video from Scott once he

received it. I'm not really certain why the Police Chief didn't sent it directly to us. But, again, that's outside of our control.

Q: Did you have concerns with authenticity of the video you received from Mr. Stoller?

A: I did not have any questions of it, but we wanted to be certain. We wanted to compare with the original. And once we did that they appeared to match. We didn't see where it was edited or where something was muted. It appeared to be a faithful copy of the original.

THE COURT: Dr. Alier, Mr. Wicevic, he is actually going over testimony that we've already heard. Could we move on to ---

MR. WICEVIC: Sure.

THE COURT: --- something else?

MR. WICEVIC: Sure.

THE COURT: Because we're short on time today.

Q: Dr. Alier, do you have Exhibit 27 up there with you?

A: Yes, sir.

Q: You know there's a discussion about whether that would fall into DHEC's versions of misconduct, is that correct?

A: I'm sorry?

Q: Mr. Rothstein in asking questions of you ---
A: Yes, sir.
Q: --- implied that the sending of this mail was a misconduct as defined by the EMS act and EMS regulation?
A: I would not characterize that as being that.
Q: Well let's look at section 1100, and you tell me why it would not fit with ---
MR. ROTHSTEIN: Your Honor, he's leading the witness. And we've already been over this. I mean I actually had him read the statute into the record, or the regulation into the record. This is asked and answered.
MR. WICEVIC: I don't recall him explaining why he doesn't feel like this is misconduct. I can move on if you don't ---
THE COURT: Yeah. I mean Mr. Stoller is not here, so let's move on.
MR. WICEVIC: Okay.
Q: Exhibit 28, do you have that, Dr. Alier?
A: No. Thank you.
Q: Okay. And this is a redacted copy of the initial summary of QA action?
A: Yes, sir.
Q: Now do you know why the Department redacts

certain information?

MR. ROTHSTEIN: I asked him that exact question, Your Honor, about the redaction of this document. And he said it was to protect the identity of the paramedic, which is confidential under the statute. This is asked and answered.

Q: Are there other justifications?

A: If we have a public individual that wants to remain anonymous. Sometimes that name will be redacted.

Q: Are you familiar with the provisions of Freedom of Information Act?

A: Yes, sir.

Q: Okay. Let's look on the screen. Can you identify that statute?

MR. ROTHSTEIN: This is improper. He testified about why the thing was redacted. Now Mr. Wicevic ---

THE COURT: Let's let him move on.

MR. WICEVIC: Your Honor, I don't know why it was brought up in the first place. I just feel like I had an obligation to explain why this information was redacted. It's making it look like the Department's hiding information from

somebody under investigation. And there's actually a basis for redacting such information pursuant to South Carolina Code of Laws.

THE COURT: Okay.

MR. ROTHSTEIN: Well that's Mr. ---

THE COURT: Very briefly.

MR. WICEVIC: And he's not a lawyer. He doesn't make these decisions ---

THE COURT: We understand. If you'll just proceed.

Q: Okay. Can you read subsection 15?

A: The identity or information tending to reveal the identity of any individual when in good faith makes a complaint or otherwise discloses information which alleges a violation or potential violation of the law or regulation to a State regulatory agency. I believe part of that is also in our Regulation or in our statute that if a complaint comes in, that we will maintain that information in confidentiality.

Q: Okay. Talk about, when there's inappropriate language for EMT's. When does the Department get involved with conflicts such as that?

A: When it's considered battery, verbal battery against the patient. Obviously.

MR. ROTHSTEIN: Your Honor, there's no such thing as verbal battery. Battery is a physical touch. Verbal battery -- this is ...

DR. ALIER: Can I finish my statement?

THE COURT: Yes. Go on.

A: Okay. Legally it might be called something else. But if I were to address a patient in a demeaning way, cuss them out or use inappropriate language in response to either their gender, their race, their sexual preference, or any other thing that would be a protected class, we would see that as a serious infraction. We're supposed to protect those who can't defend themselves. One of the reasons why we do criminal background checks is because we take that very seriously. Not anybody can be an EMT or a paramedic in this State. And so it goes to the whole general conduct of an EMT. So that's, again -- in and of itself, yes. Do paramedics and EMT's swear or use cuss words on the scene? Yes. But when they're directed at their patient, then I believe it crosses a line.

Q: Okay.

A: Had I been on the scene where someone used foul

language? In general, yes. You work that many years on the street, you see that.

Q: Okay. General enforcement process, what's your role?

A: Well once an investigation is complete, usually we come to an conclusion, and I usually participate in generating either an emergency suspension order or suspension order, a consent order or an administrative order. In this case I did not participate in any of those.

Q: Okay.

A: Many of the consent orders I write as a part of my duties. And then they're signed by the Bureau Chief and the Deputy Director.

Q: Okay. That's all I have. Thank you, Dr. Alier.

MR. ROTHSTEIN: I have a couple of very brief re-direct.

THE COURT: Okay.

MR. ROTHSTEIN: Less than two minutes, Your Honor.

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

Q: Dr. Alier, did I understand you to say that you may have redacted that document because Scott is a public official and may have wanted to remain anonymous?

A: I did not do the redacting on this document. I'm not entirely sure who did.
Q: Okay. And this document wasn't redacted to hide something under FOIA. I didn't make a FOIA request, did I?
A: Again, I wasn't involved with the investigation, so I'm not entirely sure what you're getting at.
Q: Mr. Davenport didn't make a FOIA request to get the information that was in the investigative packet, did he?
MR. WICEVIC: Asked and answered. He doesn't know what request this is.
A: I'm not sure.
THE COURT: He can answer. If he doesn't know he can say in his answer.
Q: There's no evidence that Mr. Davenport treated this patient the way he treated this patient based on any type of discrimination, is there? Like race, or religion, or gender, or other protected classed that you talked about.
A: It appears from the video -- again, I ---
Q: My question was there's no evidence that Mr. Davenport treated the patient in the stabbing video for some discriminatory purpose, is

there?

A: You can't determine that by just looking at the video. You have to talk to the individuals.

Q: Okay. And the word idiot is not a swear word or cuss word, is it?

A: It's a demeaning word.

Q: It can also be a term of endearment, right?

A: Not in this context. I would never call a patient ---

Q: I can't count the number of times my wife said, you're such an idiot, to me.

A: But you have a relationship with that individual. She's your wife.

Q: And you don't know what Mr. Davenport's relationship with this patient is, do you?

A: He has a patient clinician relationship, and you never call a patient an idiot. That's just not appropriate.

Q: Now the example of the QA review that you did a minute ago. You said there's a missed intubation in Anderson County, right?

A: I believe it was Anderson County. Yes, sir.

Q: Okay. And there was a girl that died after a fire because the paramedic didn't perform the intubation properly, isn't that right?

A: I believe that's correct.
Q: Okay. And you had all that information when Mr. Stoller sent it to you, that there was a paramedic that didn't have the right skills. A little girl died in the fire, and you didn't take any action against that paramedic's license or certification, did you?
A: As I stated before, there was no ill intent. It was a bad skill. The individual was subsequently sent by Dr. Kickham to remediate. She went to simulation center. Had to do a comprehensive airway class one on one with Aaron Dicks who does the simulations and training there. She was demoted to an EMT until she completed that class. I subsequently contacted Aaron Dicks to find out how this individual did, what was her attitude, was she teachable. She was very much willing to take the discipline as it came. And so we felt after reviewing the remediation, after reviewing the actions of Dr. Kickham and the actions of the agency, we felt that was measured, appropriate, and addressed the deficiencies. Anybody can have a bad day and miss an IV. Anybody can have a bad day and

miss an intubation. That does not necessarily rise to misconduct.

Q: Anybody can have a bad day and have an off word to a patient, isn't that right?

A: You don't demean a patient. That's the bottom line.

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

THE COURT: Thank you. Thank you, Dr. Alier. Now if anyone thinks we need additional time, I am going to actually adjourn for 45 minutes. Do you all think that would be sufficient to maybe get something to eat?

MR. WICEVIC: Yes, Your Honor.

MR. ROTHSTEIN: Yes, Your Honor.

THE COURT: Okay. So let's reconvene at 12:45.

(Off the record from 12:06 p.m. until 1:03 p.m.)

THE COURT: Mr. Rothstein, are you prepared to call your next witness?

MR. ROTHSTEIN: Yes, Your Honor. I want to make sure I formally move all that evidence actually into evidence.

THE COURT: Okay.

MR. ROTHSTEIN: I mean I think I want to make sure Exhibit 10, Exhibit 8a, and Exhibit 28 were

actually formally in. Can we check with the court ... I want to make sure they're formally moved into evidence. If not, I would like to hereby move ---

THE COURT: You did 10 and 8a.

MR. ROTHSTEIN: Okay.

THE COURT: Yeah. They have been admitted.

MR. ROTHSTEIN: Is ...

COURT REPORTER: 28 is what you ---

MR. ROTHSTEIN: 28. I want to make sure 28 is in, and 29 Your Honor. 28 and 29. I want to move them into evidence formally. 28 is the redacted email ...

THE COURT: And 29 is the -- okay.

MR. WICEVIC: No objections.

THE COURT: No objections. They're admitted.

(Respondent's Exhibit Number 29 was admitted into evidence.)

MR. ROTHSTEIN: Our next witness is Sheila Kaiser, Your Honor.

THE COURT: Ms. Kaiser, if you'll go to the witness box and before being seated, face the court reporter, raise your right hand, he'll swear you.

SHEILA KAISER, having been duly sworn, testifies as

follows:

MS. KAISER - DIRECT EXAMINATION BY MR. ROTHSTEIN:

Q: Good afternoon, Ms. Kaiser. Will you please state your full name for the record?

A: Sheila Marie Kaiser.

Q: And where do you currently live?

A: I live in Anderson, South Carolina.

Q: And what do you do in Anderson?

A: I'm the Training Coordinator for Anderson County EMS.

Q: How long have you been the Training Coordinator for Anderson County EMS?

A: Since January of 2015.

Q: Are you currently a paramedic?

A: Yes.

Q: Okay. How long have you been a paramedic in South Carolina?

A: Since August of 2005.

Q: Okay. What are your job duties as the Training Officer for the Anderson County EMS Department?

A: I do all the in service training for -- I offer in service training for the squads that attend. Plus we have several EMT's that are like with the fire department and the sheriff's department that come to our training. I also

do first responder training for the sheriff's department and for the fire department. And CPR training around the County.

Q: As paramedics or certified paramedics, are you required to take a certain number of continuing education hours between periods of certification?

A: Yes.

Q: Okay. How many hours are certified paramedics required to get in a certain period of time?

A: It has recently just changed to where we have got certain criteria in the national section for recertification. So it's very broken down and specified. Like there's an hour of ELVAD training, there's an hour of say artificial ventilation training. So it's broken down into different categories. Plus there's 15 hours of local subject matter and 15 hours of individual subject matter every two years.

Q: Had Mr. Davenport ever assisted you in the in service training offered through Anderson County?

A: Yes.

Q: What types of courses has he helped teach other paramedics?

A: He has taught how to teach the incident command and triage, and he's also helped with, we did head trauma, and he did help do that. And then he also helped do multi-casualty trauma.

Q: Did you attend any of the trainings that Mr. Davenport did on trauma?

A: Yes.

Q: And did Mr. -- or can you just explain more observations of Mr. Davenport's knowledge base on trauma.

A: He seems to be very well educated on trauma. He appears to know what he's talking about very well. We've had multiple conversations on this.

Q: Does Anderson County EMS have -- we've talked a lot in the trial. I know you haven't been here the whole time, but a lot of discussion about Anderson County protocols. I forget the formal name for it. The Anderson County Standards of Care and Treatment Protocols. Are you familiar with that document?

A: Yes.

Q: Okay. In your role as the Training Officer, do you have any insolvent in reviewing the protocols or coming up with recommendations for

new protocols, and that type of thing?

A: I mean, the last revision that we had done -- well before we just recently are going through this new one, and I've not been involved in the changes going on now to a great extent.

Q: Have you ever been involved in some sort of committee ---

A: Yes.

Q: --- or group that reviews protocols?

A: In the past we had had a committee where we got together and we would go over all the protocols and review them and then try to update them into the new standards.

Q: Okay. Did Mr. Davenport have any role on the protocol committee?

A: He had started off on that committee.

Q: How often would the committee meet?

A: It wasn't a regular meeting because it was whenever Dr. Kickham was available. So whenever he would call and say, get them together, I'm available this day. Can you get everybody, send out an email and get everybody to meet. I would send out the email, so it was really kind of whenever Dr. Kickham was available.

Q: This is a diagram over here, this visual aid. I don't know if you can see that from where you are, but this is what's called a Venn diagram. Do you recall ever seeing a Venn diagram when you were in school?

A: I don't remember.

Q: And I kind of created this, so it's a little odd looking, but the green circle was intended to represent protocols, okay? It's just sort of a visual representation of protocols, all right? And then I used this little red circle as orders. Do you understand the -- or in your training experience, do you understand the difference between general protocols and physician orders?

A: Yes.

Q: Okay. Explain to The Court what the distinction between a protocol and an order is.

A: My understanding, like a standing order would be if a diabetic has a blood sugar below 60, you will give 25 grams of D-50. It's very specific, in this situation you will do this. Whereas protocols are guidelines. So you'll place the patient in the position of comfort is a protocol. Well there's some room for

interpretation. Yes, you will place them in a position of comfort. It could be sitting up, it could be leaning back slightly. The same standard's there, you want to place them in a position of comfort, but there's a little bit of leeway as to, you know, what's their position of comfort. It leaves a little bit of room for that interpretation.

Q: Okay. Well other than the standing orders, are their other times when paramedics either ask for or receive physician orders?

A: Yes. Especially there are certain drugs where you have to call in and get direct online medical control order before you can administer. Or if you're not sure if what you're doing, if you're ever unsure, you know, should I or should I not, you can always call in and ask the doctor, what do you think, should I? And the doctor will give you direct online medical control orders on yes do this or do that.

Q: Okay. And I have over here SO for standing orders in red within the limits of the protocols. You see that?

A: Uh-huh.

Q: And then the OL is for online physician orders. And those are things that are outside the protocols that you have to call and ask for help. Is that a fair representation of how you understand? Some orders are not in the protocols, but some orders are in the protocols. Is that ---

A: Not really because even your online orders are within your protocols because I can call the doctor and he can give me online orders to give 100 milligrams of morphine. That doesn't mean I can give it. I still have guidelines that I can't go outside of. So I still can't give 100 milligrams of morphine even if a doctor tells me, give that. I still can only give what's within that guideline. So even with online orders, you still have to stay within ---

Q: Well let me ask you this. What if you come up on a scene and there doesn't appear to be a protocol in the book about how to handle that particular patient. Is there a mechanism that you could call the Emergency Department or call the Medical Control Physician and say, here's what I've got. Can you help me through ---

A: Yes.

Q: Okay. Is that a type of an online order if the doctor tells you what to do?
A: Yes.
Q: And if you'll look at exhibit -- there's a white exhibit notebook binder. That's it. If you'll look at Exhibit 1. Do you recognize that, I mean we've been using them, do you recognize that as the Anderson County Standards of Care and Treatment Protocols with a revision date of 2013?
A: Yes.
Q: Okay. And I think it's already been established that that was the set of protocols that was in existence as of the date of Mr. Davenport's suspension in March of 2016.
A: Yes.
Q: Did that document include a set of protocols for how to handle penetrating abdominal traumas?
A: Not specifically, no.
Q: Okay. After Mr. Davenport's incident, have the protocols been revised?
A: Yes.
Q: Okay. Did the revised protocols include guidance or protocol on how to handle

penetrating abdominal trauma?
A: Yes.
Q: Have you ever heard the new protocols for that penetrating abdominal trauma referred to sort of colloquially as the Davenport Protocol?
A: I have not heard them called that.
Q: Now as the In Service Training Officer for Anderson County, are you also involved in the quality assurance or QA process?
A: Sometimes.
Q: Okay. Are you familiar with the QA process in ---
A: Yes.
Q: --- Anderson County? At the time, Dr. Kickham, or whoever the new Medical Control Physician is now, do they regularly meet with QA Officers from the different agencies or rescue squads within Anderson County?
A: Yes. They meet every other month.
Q: Okay. Do you attend those meetings?
A: Yes.
Q: Before Mr. Davenport's separation or suspension, did he occasionally attend those QA meetings?
A: Yes, he has.

Q: Have you ever seen a representative of DHEC, or the Department of Health and Environmental Control attend one of those QA meetings?
A: I don't recall seeing them at a QA meeting.
Q: Have you ever seen Keith Eudy attend a QA meeting?
A: I don't recall seeing him at one.
Q: Do you know who Keith Eudy is?
A: Yes.
Q: Okay. Is Keith Eudy on the payroll at Anderson County?
A: Yes.
Q: Have you regularly seen him in the office at the Anderson County EMS Department?
A: No.
Q: Okay. Do you know if he receives a regular paycheck from Anderson County?
A: I don't know if it's a regular paycheck.
Q: Well have you seen paychecks ---
A: Yes.
Q: --- in the stack of paychecks ---
A: Yes.
Q: --- for the Anderson County EMS Department made payable to Mr. Eudy?
A: Yes.

Q: Okay. Do you see the stack of payroll checks from time to time ---

A: Yes.

Q: --- in the office? How close is your office at Anderson County EMS to Mr. Stoller's office?

A: Down the hall.

Q: At one point, was Mr. Davenport, did he also have an office in that building in that same area?

A: Yes.

Q: Okay. How close was Mr. Davenport's office to your office?

A: His was next door. We had a connecting door.

Q: Would you describe Mr Stoller as having a somewhat vindictive personality?

A: He can.

Q: Okay. Do you have any experiences where you observed him displaying what you thought was a somewhat vindictive personality?

A: I think the relationship deterioration between Scott and James has caused quite a bit of trying to turn opinions with comments. For instance, telling me that my husband did not like James, or telling me that James thinks I dress sloppy, or trying to turn my opinion.

Q: Okay. Do you consider yourself a friend of Mr. Davenport's?

A: Yes. I do.

Q: Okay. Do you believe that your late husband was a friend of Mr. Davenport's?

A: My husband committed suicide, so obviously I don't know everything he thought. But in my understanding, I thought he was.

Q: Okay. I know that's a touch subject for you, but can you tell The Court when your husband committed suicide?

A: January 22nd of 2016.

Q: Was Mr. Davenport supportive of you and your family after that? And I don't mean financially, but emotionally supportive of you and your family after that?

A: That night -- well my husband shot himself at the house. So obviously when we went to the hospital we couldn't go back home because our house became a crime scene. And James and his wife opened -- it was after midnight at that point and he opened his house and let me and my kids spend the night. And him and another friend of mine got together and got me and my kids, like tooth brushes, tooth paste, a change

of clothes and everything because we couldn't go home anything that night until they had gone through my house to find -- because my husband had a gun that I wasn't aware of, and they had to go through the house and find the ammunition and everything, and clear my house from being a crime scene first. And he allowed us to stay there have a place to stay that night. And in the time after that he's been there repeatedly, both emotionally plus he helped me lay floors in my house and different things at the house to help try and fix my house up.

Q: In your experience would you describe Mr. Davenport as a compassionate person?

A: In my experience he has been.

Q: Okay. Now I think you talked about some type of deterioration in the relationship between Mr. Stoller and Mr. Davenport. Did you witness any change in their relationship?

A: Yes.

Q: Okay. When did you start to notice a change in the relationship between Mr. Stoller and Mr. Davenport?

A: They began having arguments over James's beliefs that Scott was -- he would argue with

Scott over whether or not he felt EMS money was spent appropriately or whether or not a vehicle should have been used as a QRV or whether it should have been used as his vehicle. And then James would make up policies and then Scott would argue against them. So it became more and more they became divisive on issues. And they became more and more -- the whole relationship began to suffer from these divisiveness.

Q: What time frame would you say the relationship started to sour between Mr. Davenport and Mr. Stoller?

A: I think it started, I'm wanting to say it was like maybe September, August, September of 2015 is when I noticed that it was starting and progressively getting worse.

Q: Okay. At some point did Mr. Stoller ask you to write an incident report that was negative toward Mr. Davenport?

A: Yes.

Q: Okay. Can you describe to The Court what happened in that event?

A: James and I would get into discussions about things. And both of us are a little stubborn

and both of us are very passionate. We had gotten into one and evidently it had gotten overheard or something. I'm not sure.

Q: Did your voice and Mr. Davenport's voice get somewhat elevated?

A: Yeah.

Q: Okay. Were there any curse words exchanged ---

A: No.

Q: --- between the two of you? Never?

A: No.

Q: But it just sort of got loud?

A: Yeah. We both were very stuck on our side of the discussion.

Q: You remember what even the topic of that discussion was?

A: I really don't at this point.

Q: Did you have any like problems with the way Mr. Davenport conducted himself in that discussion?

A: No.

Q: Okay. Do you believe that you acted, even though you were passionate and loud, you believe that you acted appropriately as well?

A: Yeah. It was after working hours. We were at the office, but it was after working hours. We were just passionately -- I mean, yeah we got

loud and we probably shouldn't have.

Q: Do you know how that came to the attention of Mr. Stoller?

A: I am not sure.

Q: Okay. And what did Mr. Stoller do, or what did he request of you or ask of you after that loud discussion?

A: He asked me to write an incident report about it, and I told him that I didn't believe that it was warranted. And ---

Q: How many times did Mr. Stoller ask you to write an incident report about Mr. Davenport?

A: Several times.

Q: Okay. And what was your repeated response to Mr. Stoller?

A: I just didn't feel comfortable because I didn't feel that it was worth an incident report. I finally did write the incident report.

Q: How soon prior to Mr. Davenport's suspension did you write the incident report?

A: It was actually after.

Q: Okay.

A: It took several months for me to finally write the incident report.

Q: Okay. Did Mr. Stoller ask you to write the

incident report before Mr. Davenport was suspended?

A: Yes.

Q: Okay. And this altercation obviously Mr. Davenport was in the office with you after work, that was prior to his being suspended ---

A: Yes.

Q: --- is that right? Okay. At some point did you discover a listening device had been placed in your office?

A: It was a camera. I'm not sure if it was able to listen or not, but it was a camera hidden behind my bookshelf.

Q: I'm going to show you Exhibit 14. Do you recognize that photograph?

A: Yes.

Q: And could you tell The Court what that phonograph is?

A: That is the camera that was behind my bookshelf.

Q: Okay. And who discovered or noticed that camera?

A: I'm a little bit OCD, and I noticed that my bookshelf was crooked, and couldn't figure why my bookshelf was crooked. And so I went to go

straighten my bookshelf up against the wall because I have it flush with the wall, and it was pulled back on side. And when I went to -- it wouldn't push back against the wall, and I could figure why it wouldn't. So I looked, and that's when I found the camera behind the bookshelf is why it wouldn't push back against the wall in that corner. There was a camera back there. And so I'm the one that discovered it.

Q: Is Exhibit 14 a fair and accurate representation of what you saw where the camera was placed?

A: Yes.

Q: Okay.

MR. ROTHSTEIN: Your Honor, I move Exhibit 14 into evidence.

MR. WICEVIC: And, Your Honor, you know my objection. I object on relevance.

THE COURT: What's the relevance of that camera?

MR. ROTHSTEIN: Well this was very shortly before Mr. Davenport was suspended. I think Ms. Kaiser actually made a complaint about it. I think somebody actually -- Mr. Stoller a couple days later came in and actually retrieved the

item from her office. I mean I think it is relevant to show that Mr. Stoller at the time was sort of looking for information to use against Mr. Davenport to get rid of him.

THE COURT: I'm going to allow it.

MR. ROTHSTEIN: Thank you.

THE COURT: It's admitted.

(Respondent's Exhibit Number 14 was admitted into evidence.)

Q: Was the camera, could you tell from the position of the camera, could you describe what's on the photograph what's to the right of the camera? The brown piece?

A: The brown piece would be the bookshelf.

Q: Okay. And what's the white piece on the left side?

A: That's the wall.

Q: And was that the position the camera was in when you found it?

A: Yes.

Q: Okay. Was the camera pointed at anything that you could tell in the room?

A: There's a cabinet that has got some of my training supplies in it. It was pointed towards that cabinet.

Q: Okay. Did that cabinet have a lock on it?
A: No.
Q: Okay. Was there anything valuable or secret that was kept in that cabinet?
A: Well let me rephrase. On the bottom cabinet there's no lock. On the top cabinet there is a lock. The bottom cabinet had some like old ET tubes, they're expired because I use them for training. So they're of no value. The top cabinet I think had some uniform t-shirts in it to give to people if they come up to the office asking for a uniform, and that's not really locked. And so there's nothing of real value there. So there's nothing in the cabinet of any ...
Q: Did you complain to anybody after you found the camera in your office?
A: Yeah. I was kind of freaked out. I didn't know who had put it there. I didn't know where it had come from. Scott was not in the office at the time. Taylor Jones was.
Q: Who is Taylor Jones?
A: He was the Emergency Manager at the time.
Q: Okay.
A: And we were in the same building as him. And

he was the highest ranking person that was there. And I went and said something to him because I asked him if he knew the camera was there and why.

Q: What was his response?

A: That no he didn't know it was there, and how long had it been there? And I'm like, I just found it. I don't know. I don't think it had been there long because I'm pretty OCD about things like that, and I notice when people move stuff in my office. So I don't think it had been there long. And then he came and looked and he said, well I need to know is there any chance, have you changed clothes or anything in this office? And I'm like, no. And he's like, okay so he could not have seen you undress or anything. And I'm like, no. And I'm like, I don't know where it came from.

Q: At some -- I'm sorry.

A: He said he thought he did.

Q: Taylor said he thought he knew where it came from?

A: (Nods head.)

Q: Okay what happened next with regard to the camera?

A: A couple days later Scott came in and ---

THE COURT: Ms. Kaiser, I do need you to give verbal responses to the question. I think you nodded and it was a yes to the last question.

MR. ROTHSTEIN: I'm sorry. Thank you, Your Honor.

MS. KAISER: I'm sorry.

Q: So, what happened next with regard to the camera?

A: Scott came in and took the camera out of my office.

Q: Okay. Were you in the office when Mr. Stoller took the camera?

A: Yes

Q: Did he say anything to you?

A: He just said that he had been called and tolled to take it out of my office, and I said, well I didn't know who had put it there. And he said, well I put it there. I was wanting to put it on that cabinet because I was thinking of putting narcotics in that cabinet. And I said, oh, I said, I didn't know because I just saw the camera, and nobody said anything, and I didn't know who had put it there.

Q: Do you know --

A: -- They were already taking it out.

Q: Do you know if that cabinet would meet DHEC regulation for storing narcotics?
A: Not in the way it is now.
Q: Okay.
A: To store narcotics it has to be double locked, and it is currently just a single lock.
Q: Did anything occur that led you to believe that Mr. Stoller may have been listening to conversations in your office with that camera?
A: We had talked about the fact that James had been over at my house doing another project of ours to lay flooring in my house, and Scott did come into my office and said something about the fact that he had been at my house that weekend.
Q: That James had been at you house?
A: That James had been at my house that weekend.
Q: Okay. Was Mr. Stoller part of the conversation where you were discussing Mr. Davenport and the flooring?
A: Now, I'm not positive he heard it on the -- I mean he could have been outside in the hallway and heard it, but he wasn't in my office when we were talking about it.
Q: Have you ever seen the body camera video

footage with Mr. Davenport's interaction with the stabbing patient and the rescue squad?

A: During the deposition, I was showed a couple minutes.

Q: Okay. Prior to the deposition -- Who at the deposition showed you that body camera footage?

A: One of the lawyers for DHEC. I forget her name.

Q: Okay. Have you ever seen the entire video, or the entire camera, or just snippets by the DHEC lawyer?

A: No, I have not seen the entire video.

Q: Okay. Has Mr. Stoller ever offered to show you the entire video footage?

A: He's offered, but I refused to see it.

Q: Okay. Tell me about his offer. What did he say to you when he offered for you took look at the video?

A: He just said that I -- that he would show me that, because it was worse than what James had told me, and I was like I'm not involved in it, and we are friends, therefore I don't need to see it. To me I don't think it's appropriate. I'm already biased anyway, because James and I are friends anyway, and I like Scott, and I'm

trying to stay out of the middle of it. I don't want to be in the middle of the whole thing, so I really didn't to see it, and I wasn't involved in the QA, I wasn't involved in any of it, so there was no reason for me to see it.

Q: Okay. Is Mr. Stoller still your supervisor at Anderson county EMS?

A: Yes he is.

Q: Okay, and has he been your supervisor sense you been the training Officer at Anderson County EMS?

A: Yes.

Q: Do you know if Mr. Stoller has shown the video to other -- the body camera video of the stabbing to other people outside of the EMS department?

A: There are two people that have told me that they have seen it.

Q: Who are those people?

A: James Howard Murphy, and Zan Taylor Jones.

Q: Okay, and Taylor Jones is the Emergency Manger, is that his position?

A: It was.

Q: OKay. What does he do now?

A: I think he is now an RN at the Emergency Room.
Q: Okay. Do you know when he left Anderson?
A: January of 2016.
Q: Okay. So. That was --
A: Or 2017, my apologies.
Q: 2017. Okay, do you know if Mr. Stoller him the video before or after he left his employment at Anderson County?
A: Before.
Q: Okay. One the other person you mentioned, Howard I'm sorry I missed the last name.
A: Howard Murphy.
Q: Howard Murphy. What is Howard Murphy's position in Anderson County?
A: He's a paramedic with us. He is also a professor at Anderson University, and I think he works part time with the Emergency management also.
Q: Okay. Have these three cases, the stabbing case, and the two cases of pediatric seizure case, and the nursing of a patient case, have these ever been discussed at any of the regular QA meetings at Anderson county?
A: No.
Q: Do you have any military service?

A: Yes.
Q: Okay. How long were you in the military?
A: Two years.
Q: And what branch of the service were you in?
A: Navy.
Q: Okay. In your experience in the military, have you had an occasion observe or hear your co service people engage in what you thought was sort of rude or offensive language?
A: Yes.
Q: Was that a fairly common occurrence in the military, in you experience?
A: Yes. Military people tend to cuss a lot.
Q: Okay. What about an emergency serviceman? Have you had occasion to see either paramedics or EMT's or fire-fighters, Police Officers engage in somewhat I guess offensive or rude behavior, language?
A: Yes.
Q: Have you yourself in your career as a paramedic used what you thought was I guess was an unfortunate chose of words?
A: Unfortunately, yes.
Q: Okay. Have you done that in connection with the care of a patient?

A: Unfortunately, yes.
Q: Okay. Are there instances you can think of in your career that you wouldn't want somebody to see on a body camera video footage in a courtroom?
A: I'm sure there are.
Q: I don't think I have any further questions, Thank you Sheila.

MS. KAISER - DIRECT EXAMINATION BY MR. WICEVIC:

Q: I just have a couple questions for you, and we'll get you out of here. You mentioned that you're a friend of Mr. Davenport, and you're a biased party, and that's why you didn't decide to review the boy cam footage when Shawn -- excuse me, when Mr. Stoller offered it to you?
A: That's correct.
Q: I believe during your deposition, Mr. Rothstein asked you how you would rate Mr. Davenport as far as the medics at Anderson County, and you said top five percent, something like that?
A: I believe my statement was, I would trust him to treat my family.
Q: Was it within the top five percent?
A: I don't recall using a percentage. If I did, I don't recall using that. I'm not saying I

didn't, but I don't remember.

Q: Well, would you characterize him as being in the probably top five percent, top ten percent?

A: I think with his experience, especially with trauma, he's probably got more experience dealing with that than most medics in Anderson County.

Q: Okay, fair enough. This is in spite of never being on an actual patient care call, is that correct?

A: That's correct.

Q: Mr. Rothstein mentioned you saw a portion of the body cam footage at the deposition with Mrs. Nelson, is that correct?

A: That's correct.

Q: Okay. For this particular patient based upon what you did observe, you did indicate that you would have established IV access correct?

A: May have. It was hard for me to tell with the portion I saw, I could not see the knife that everybody's referring to. I did not see enough. I've heard testimony about him walking the patient, I did not see that, so I did not see enough of the video for that. I saw enough to see him walking in, he bent down, I could

not tell what exactly he was doing. His back was to the camera, so I'm not sure, because I believe it was asked, would I have done things differently, and like I said in the deposition, without having all the details of the call, because I've never seen the patient care report, I haven't seen all the vital signs, I haven't seen how the patient was, the complete surroundings or anything. I can't say with any definitive answer what I would have done.

Q: Well do you recall being shown the video and answering the question whether you would establish an IV?

A: I recall being shown the little bit of video, yes.

MR. WICEVIC: Can we pull up on the monitor, Ms. Hazel?

Q: Can we back up a little bit? Were you deposed by the department on June 19, 2017?

A: Yes.

Q: Ms. Kaiser, I'm going to read page 56. It says, question, do you think that protocols addressed whether to start an IV on a trauma patients? Answer, it depends on the level trauma? You've got to know -- with a sprained

ankle you don't start an IV. It's kind of your discretion as to level of trauma. Question, do you think the protocols address whether to start an IV on a patient with this type of trauma, with penetrating abdomen trauma? Answer, for me, I would. Was that your answer during the deposition?

A: Obviously so, and if so then I probably would.

Q: Okay. And, I think you said you'd have an IV, but you wouldn't bolus the fluids, because if there were some kind of internal bleeding we didn't want to bust any clots loose, and make their internal bleeding any worse. Is that correct?

A: Yea, if you've got an abdominal wounds, you do not want to bolus any kind of fluids at all. You only want to maintain a blood pressure of about 90 because you can make bleeding worse into the belly.

Q: Right, I think you mentioned something about keeping the IV open at a keep open rate? Is that correct terminology?

A: Probab- -- Yeah, that sounds.

Q: Okay, and you said it was also important to start an IV in transit because if there was

something you needed to give blood or fluids at the hospital you'd already have the IV started, correct?

A: If it is a critical trauma, yes.

Q: Is that what you indicated at the deposition?

A: I believe I was asked very critical trauma, if I would, and I believe that I said yes. I believe if I remember correctly, all of this was with a critical trauma.

Q: Right, like the patient you saw during the video, correct?

A: If you will back up, I believe we had some discussion on the fact I could not say with any definitive answer on whether I didn't have enough details to say whether this was a critical patient or not, because I don't know. Nobody would answer, I've not seen the patient care report, I don't have vitals, I didn't see the skin, I didn't even see the wound well.

Q: Well let me ask you this. A patient with penetrating knife wound to the stomach, with an unknown length.

A: An unknown length of the knife?

Q: Yes ma'am, would that be a critical trauma?

A: If the patient appears critical then it would.

Now, would it be something that I would be concerned with, yes. If I don't know the length of the knife, then yes I would be concerned, and yes I would treat with an IV, I would.

Q: Okay, and then if the patients blood pressure began to drop, then you would have that ability to get the fluids, correct?

A: Yes.

Q: And get the pressure to rise, the blood pressure to rise again?

A: Yes.

Q: Additionally, again I know you don't know all of the details, but as a paramedic, you probably would have ridden the call for this type of patient, correct?

A: Without knowing all the details which you're giving me, then yes.

Q: And I think you characterized Mr. Davenport's language as being a bit rough, was hat correct?

A: It appeared to be, yes.

Q: Okay.

A: What I saw of it.

Q: That's all the questions I have for you, thank you.

THE COURT: Okay. Re-direct?

MR. ROTHSTEIN: Just a few questions, Your Honor.

MS. KAISER - RE-DIRECT EXAMINATION BY MR. ROTHSTEIN:

Q: Ms. Kaiser, just because you might have done something differently doesn't mean it's the only way to do it, right?

A: No.

Q: Would you agree that there's more than one way to practice good medicine?

A: There's different levels of experience. So my experience differs from say James.

Q: Okay.

A: Obviously he's got more experience dealing with trauma than I do.

Q: Are you trained as a paramedic and do you train other paramedics on how to recognize if a patient is heading toward shock?

A: Yes.

Q: Okay. Is blood pressure a good indication of whether a patient is heading toward shock?

A: Kind of a late sign.

Q: Okay. What do you mean?

A: You will actually see change in mental status before. You will see a change in mental status, you'll see a an increase in heart rate

way before even a drop in blood pressure. So there will be changes. You'll start seeing, you know, the skin get pale.

Q: Are you trained as a paramedic to recognize those signs of a patient heading towards shock?

A: Yes.

Q: Is shock something that just happens like stable, stable, suddenly you just drop off the table and you're in shock?

A: Not in the adult normal.

Q: Okay. Thank you.

THE COURT: Thank you, Ms. Kaiser.

MR. ROTHSTEIN: Your Honor, if we could take a brief break to let Mr. Davenport run to the restroom. He'll be our final witness.

THE COURT: He's your final witness? Okay.

MR. ROTHSTEIN: I'll keep it short.

THE COURT: Okay. We'll take a ten minute break.

(Off the record from 1:45 p.m. until 1:58 p.m.)

THE COURT: Okay. If everyone is ready, we'll call the hearing back to order. And please, take you seats. Okay. We're ready for your next witness.

MR. ROTHSTEIN: Your Honor, Mr. Davenport's our last witness. As you know he's already been sworn

---

THE COURT: Right.

MR. ROTHSTEIN: --- and is recalled to the stand.

THE COURT: Okay. Very good.

MR. ROTHSTEIN: May it please The Court?

THE COURT: Yes.

MR. DAVENPORT - DIRECT EXAMINATION BY MR. ROTHSTEIN:

Q: James, yesterday when your team leader, former team leader, Deek Crus was on the stand, he told a story about how the two of y'all first met. Was he completely -- I mean did he tell the truth, the whole truth, and nothing but the truth on that story?

A: I think he cut out a word or two, but.

Q: What did you actually say to Mr. -- or what was your recollection of that meeting like?

A: When I graduated from the Special Forces qualifications coarse after being there a while and had volunteered for a deployment right out of the coarse, or out of the gate as some people say. I had taken a week of leave after graduating to spend some time with family before disappearing for 9 months, and so I returned to Fort Brag as those guys were showing up, getting ready to leave country.

And so never having met Deek, or Master Sergeant Crus at the time, I was new guy to the team and there's a lot of initiation. And you know, so people call it hazing but we call it just paying your dues, so I was handing out pillows and pillow cases and I hear from the doorway of the supply room, you must be Sergeant Davenport, and I said well that's what the fucking name tag says, and I looked up and there he stood, and he goes well I'm Master Sergeant Crus, I'm your new team Sergeant, and I'm like, can I back up about 30 seconds and start this all over again? And he was like, no you'll do just fine, and I mean so --

Q: Did you realize at the time he said that, that he was your new team leader?

A: I didn't know when he called my name that that's who that was, no.

Q: Did your mouth almost get you in trouble on that, or did you think your mouth had gotten you in trouble in that situation?

A: Well, there would be some hazing that go along with my comments, but most, and by most I mean I can't think of one SF Soldier that doesn't say what he means, and means what he says, and

sometimes you know, we let our common vernacular on the team slip out in situations when it shouldn't.

Q: Now Dr. Deangelo was here, and has talked extensively about what the training and selecting process is for Special Forces team members and medics. I won't go through all that, but as part of that, can you give the court an idea of I think Dr. Deangelo didn't have it figured, but how -- what's the washout rate of someone who comes in the Army and applies, they say do you want to be in the Special Forces, and puts their name in the hat? What's the process from there?

A: Well, our Special Forces assessment and selection class, we class up to 495 guys. It's a 24 day selection process, that covers everything from your mental aptitude, your physical aptitude, your team work skills, your ability to problem solve, think on your feet, your ability to work under pressure, work while sleep deprived, hungry, hurt, you know, and they're really adept at putting you in every one of those situations. So, we start with 495 guys, and there was 106 guys that were selected

to move forward from that class.

Q: What's next after they've cut down that first selection class by about 75 percent or 80 percent don't make it, right?

A: Yea, about that much. It's about an 80 percent wash out rate at selection alone, then you have a litany of academic courses from, well while you're at selection you also get tested for a -- to see if you can learn to speak a foreign language, if you can't, if you don't have the ability to pick up a foreign language, you don't get selected no matter how well you do. So, moving forward from there, there's a bunch of leadership courses that you have to attend. They teach you how to be a leader, if you will. A combat leader, a professional leader, how to counsel people that may need improvement, how to conduce investigations, how to as someone else said today, fact find, and then council soldiers moving forward at the end of the end of the day an Sf guy, an SF soldier or Green Beret is a leader of soldiers, and if you can't address soldiers in how to make them better, you can't do your job.

Q: At the initial 24 day selection process, is

there another weed out period after that?

A: Well, throughout the course as a whole, you're constantly being evaluated, either by the students or by the cadre. You know, you have small unit tactics, which is like radings and ambushes, you know, learning to, if you will, hunt humans, and then as a medic then you, once you're done with that, you go to language school, you'll pick up at least one language.

Q: Why sir, why is that important in the selection process, or training process for a medic, a foreign language?

A: My job overseas is to teach unconventional warfare and a foreign internal defense to the host nation soldiers like working with the Afghan population. If you can't speak their language, you can't teach them; and my job in Afghanistan, aside from you being on patrols, and hunting down enemies of our nation, is to teach their soldiers to somewhat take care of their own country, so we can one day stop policing up their own problems. And, if you can't speak their language, you can't do that skill.

Q: How many languages have you picked up or

learned, or become fluent in during your Special Forces career?

A: In addition to English, I speak 4 languages.

Q: And what languages are those?

A: French, Spanish, Aerobic, and Pashto.

Q: Okay. In your language training, did they ever teach you how to speak sensitively or courteously to someone?

A: That's not usually a part of it. It's -- you know, when you're in combat, there's not any mincing words in those situations, and you kind of have to speak directly to the point.

Q: Okay, and during this weed out, or selection qualification process, is there any level of etiquette that you have to demonstrate, or politeness that you have to demonstrate to get past, to move on to the next round?

A: No, that is not something that is assessed for. They consider that a weakness. In training that is.

Q: And I know we've gone over a lot of stuff, in your earlier testimony, and I'm not going to rehash that, but can you tell us why you first decided to go into the armed services, or into the Army?

A: My wife was 9 months pregnant on 9/11. Sensitive subject. And, I would have a daughter born on the 29th of September.
Q: When did you decide to enlist?
A: 9/11.
Q: Okay. Where were you the day after 9/11 occurred?
A: Recruiters office.
Q: What did you sign up for?
A: I sign up for the infantry initially, because it would, you know, get me into combat quickest.
Q: And through your infantry training, did you catch the attention of any recruiters, or you trained the direction of how you wanted to go in the military.
A: Well, my goal was always to be an SF guy. For a number of reasons. I don't want to talk about here, but while I was in my basic Airborne course at Fort Benning, Georgia, which is after infantry school, there were a couple of us that caught the attention of the SF recruiter, and he offered us a path to you know kind of skipping going to the infantry, and going straight to Fort Bragg, to begin SF

training, or to go straight to selection at least, and if I hadn't made it through selection I'd just go back to the infantry. As luck had it, and getting selected is about 75 percent luck, well luck, and not getting injured, I got picked up to be an SF Medic.

Q: And what was your role on that, or what was your, I guess is it MOS, is that the right acronym?

A: Military Occupational Speciality.

Q: Okay. What was your MOS on the Special Forces team?

A: I was an 18-Delta, or Special Forces Medical Sergeant.

Q: And, I know Dr. DeAngelo went through a lot of it, but training, clinical training, is there sort of a continuing education, or making sure your skills continued to be maintained at the cutting edge level as part of being an SF medic?

A: Yes, every year we have to attend both trauma and non trauma modules. The non trauma modules consist of like dental medicine, OBGYN, vet medicine, radiology, lab, I think I said OBGYN once, sports medicine or orthopedics,

respiratory, cardiac, ENT, I mean it's a litany of rotations that we have to go through in a variety of different hospitals across the U.S., and then you know, trauma modules consist of pretty much the same thing. You work in a level one trauma center with the trauma surgery team. They bring patients into the ER, you scrub in just like a surgeon, and you're in th OR scrubbed in just like a 3rd year resident, doing everything a 3rd year resident would do.

Q: Have you been involved in actually performing surgery in the United States for the military?

A: Yes.

Q: How many surgeries would you say you have scrubbed in on, and actually put you hands inside of patients?

A: Well I was at Walter Reed for 14 months, healing from my own injuries, and was in the OR 59 times in 14 months, just doing surgery, from finishing amputations, to loop colostomies, suprapubic cath placement, arteriovenous shunt placement, which is where you, at the end of an amputation, they have to make a loop where the artery and the veins still have to connect, so blood doesn't just squirt out the end of the

limb, and so it's called arteriovenous shunt, completing those. I was never the primary surgeon of course, but any time you're in trauma surgery there's a team of surgeons that will work and each one has a little bit of a specialty. So, you may have, and it really depends on the case but, orthopaedics are working on the orthopedic injuries, like amputations, the trauma surgeons are more working on the core of the body or the trunk. Anything from the neck to the groin, unless it's gastrourinary, or reproductive in nature. And then there's a urologist that takes care of those parts, but. So, I've removed items from people, close people, put in drains, wound vacs, taking people to the OR electively while doing rounds on the floor. It's pretty intense. I mean you don't, I mean, you know the word Special Forces denoted that you aren't an average kind of, you pick up stuff on an average pace, so.

Q: Is part of your training as an SF Medic involve anatomy and physiology?

A: You can say that, yes.

Q: How did your training in the SF, in terms of

anatomy and physiology compare to your previously service as a, and I didn't get to that, but you were a paramedic before you went in to the Army, is that right?

A: That's correct. From 1995 until 2002.

Q: And I think Mr. Wicevic covered all that, but how did the training in anatomy and physiology compare to your paramedic, between your paramedic training and your SF Medic training?

A: The vast majority of paramedic training is all about acting with respect to anatomy and physiology, and by the majority, I mean, there are some places that do gross anatomy labs where you work on cadavers, and some places just rely completely on didactic, but the SF medic course is 80 percent hands on and 20 percent didactic. Teaching you from a book doesn't give you experience on where organs lie on the body, and for you to be proficient at opening people up, and taking things out of them, or putting things back in them, you have to have in depth working knowledge of what's in the body, not just a round about, I think it's in that part of the body.

Q: Are there more than 3 organs in the left upper

quadrant of the abdomen?

A: Yes.

Q: Have you ever been taught in your anatomy or physiology that the internal organs of the body are just sort of floating freely inside the body cavity?

A: No, that's a bit of a misnomer. All the organs are attached in the body by ligaments. I mean if all your organs were just kind of in a sack, they'd end up in your suprapubic area, and you know, you'd kind of be built like an apple. So, every one of them are suspended by ligaments in different places inside of the thorax or, which is the chest, or abdominal cavity, or pelvic cavity.

Q: As part of your training in trauma, are you trained on how to recognize the symptoms of a patient going into shock?

A: Yes.

Q: Do you teach people how to recognize the signs and symptoms of shock when you teach trauma courses?

A: Yes. I do.

MR. ROTHSTEIN: Okay. Can we get the screen over here on my computer please?

Q: Mr. Davenport, I put a -- this is just for demonstrative purposes. Have you ever used something similar to this in terms of teaching people the signs and symptoms of shock?

A: Yes, sir. I have.

Q: Have you ever taught somebody that shock, it goes from a patient begin stable and then they just drop off the table?

A: That's ridiculous. The body doesn't function in that manner.

Q: Can you explain to The Court what happens if a patient who's stable starts to head toward shock?

A: Sure. So, you have a patient that is completely stable, meaning their blood pressure's within normal limits, their heart rate's within normal limits, their respiratory rate their breathing is within normal limits, their skin color, condition, and temperature are all within normal limits for that patient. And then as you begin losing blood, your body begins to compensate for that blood loss in one of several areas. I'll leave the chemistry part out of it. Just to say, you know, the first thing that happens is you go into

compensatory shock, patient gets anxious, your pulse rate begins to climb a little bit, the blood is shunted from your extremities, and so your extremities begin to get cold and clammy like a chilly sweat like you maybe get in the middle of the night when you have like a flu or a stomach bug kind of thing. If the problem isn't remedied it will sometimes continue, not all the time but some of the times continue through compensatory into decompensatory or progressive shock. And then you end up in irreversible shock and die. But the idea that you go from being completely fine one minute to your heart stops the next, if that happens it wasn't a shock problem it's a cardiac issue. But that's not caused by blood loss, it's due to another factor.

Q: If you're treating a patient, and there's a concern about shock and their blood pressure starts to drop, is that the first indication you're going to see that that patient's going into shock?

A: Absolutely not. Your blood pressure dropping -- well, let me say your body's going to compensate to a certain point and maintain a

normally high blood pressure, or within normal limits. And then as your body gets to the point where it's lost so much blood and it can no longer compensate, then the heart rate will start to drop and the blood pressure will start to drop with it. If you're waiting until the blood pressure starts to drop, you're way behind the eight ball. But that isn't a reason to just, you know, stack eight balls on top of each other to try to get in front of it. There's plenty of other things that you can do for a patient that has nothing to do with trying to treat shock.

Q: Okay. Is installing just a IV port or I think a hepwell is what we talked about, is that a way to prevent shock?

A: Absolutely not. There's plenty of literature speaking of -- you asked earlier about what we do to maintain currency or move medicine forward. On of the other things is we're as SF Medics, we're required to do a research topic once a year on a topic that is assigned by like say Dr. DeAngelo our group or battalion surgeon. So it's not -- we don't get to choose based on what we want to write about. We

choose based on what those that are trying to teach us think we need to learn based on where our short comings are individually through counseling soldiers and being around them, through training exercises. So with that there's a lot of literature that talks about how bad it is for penetrating trauma patients to have IV fluid in the pre-hospital setting. And survival rates are better when the patient doesn't have IV fluid in the pre-hospital setting than it is if they get IV fluids in the pre-hospital setting. The body doesn't bleed saline, it bleeds blood. And by feeding -- the misnomer is well I can put saline in and just fill the container up, but all you're doing is diluting the red blood cells that are currently in the container. I'm trying not to talk in too great of detail chemistry wise. But there's a litany of problems with just putting fluid in people for, a, the sake of putting fluid in them and raising their blood pressure, and b, it's diluting the red blood cells which are carrying the oxygen. They're also what's carrying the clotting factors in your blood. So if you get the clotting factors to the site

of the bleed and they start to work and the blood pressure's dropping a little bit, that's not necessarily a bad sign. That can be better for the patient than just letting them maintain a, you know -- then just pumping their body back full of saline. I mean that's the simple approach to it. But the idea that when a patient starts to compensate you immediately have to fill them fluid is just ridiculous. It isn't founded in medicine. Trauma surgeons will tell you that that's not the way they operate in that OR. If you bring a patient to the OR, they may hang blood on that patient, but there's a huge difference between putting blood in somebody and putting saline. I mean, it's just been proven that it's not good for the body. And hospital stays -- I'm sorry.

Q: No, no. Go ahead.

A: I've gotten on a tangent. Not a tangent but on the topic. But hospital stays have been shown to be shorter with patients where IV fluids are restricted to the patient than when they get them in the pre-hospital setting because once you get into the hospital they have to fix all of the acid base balance issues that take place

in the body because once you start putting saline in and you displace blood with saline, now you're changing the body's PH level, and that causes all kind of problems.

Q: Now, I think there was a term used earlier or maybe late yesterday afternoon called an IV lifeline. Have you ever heard that term before?

A: Yesterday's the first time I heard that silliness.

Q: Okay. Is there such a thing as an IV lifeline?

A: No. There's not.

Q: Okay.

A: There's a surgeon lifeline but not an IV lifeline.

Q: In your experience in pre-hospital medicine, is our job in the field to install an IV that's going to be used at some point in the actual surgery itself?

A: No. As a matter of fact, most anesthesiologists that I've worked with and worked around, as soon as that patient gets to the ER or through the trauma bay going to the OR, those IV's get replaced because they're not trusted for a number of reasons. Aseptic

technique is one of the biggest ones. I mean you don't want anymore of an infection hazard than the patient already has. And that's one other route to get antibodies into the body.

Q: Okay. Let's talk about this stabbing call on March the 19th, 2016 when you were working at the Iva Rescue Squad. Tell me what you can recall about that particular day. Do you know how long you had been on duty at the time the call went out?

A: Yeah. I was working the backside of a 36 hour shift.

Q: Okay. And when the call came out, do you recall who was driving the ambulance on the way to the call?

A: I don't. I mean we changed that up. I mean, there's not one of us that drives anymore than the other one on the way to a call. It just, you know -- if I was closer to the truck and my partner's in the kitchen or out in the bay or something, you know, doing laundry, whatever the case may be, the first one in the truck usually starts the truck and is ready to go by the time the other person hops in the truck.

Q: How would you assess your driving ability

compared to Ms. Aiken's driving ability of the ambulance itself?

A: I'd say they're equal.

Q: Okay. Now when you got to the scene that night, what's the first thing you can recall. I mean, I know you've seen the video before. Tell me -- walk the Judge through what was going in your mind set as you first came up to assess that patient.

A: Well it was ---

Q: Was the patient awake at ---

A: Sorry. I was trying to figure out what to call him. The patient.

Q: The patient.

A: He was sitting in a semi-Fowler's position, kind of slouched down on the couch, awake and alert, talking to the law enforcement Officer. I was, you know, I mean it had just been recently that quite honestly James Kaiser had taken his own life very unannounced. I mean, Sheila talked about it earlier. And you know, we were still as friends dealing with helping her deal with her loss, which is not something that I took lightly.

Q: Do you know how long the patient had been

sitting on that couch before you all arrived?
A: The Officer said 20 minutes.
Q: Okay. And when you first got there, was the patient alert and oriented, or did he appear to be alert and oriented?
A: He appeared to be alert and oriented. He was speaking to the Officer. I walked in, stood there for a few seconds, watched the patient, watched the knife, made an unfortunate comment that, you know, everybody that's asked me, I've said I regret it. I mean, I don't know how much more I can get beat up over that. But, you know, I regret my choice of words, but ---
Q: How long did it take you to figure out that that patient was stable when you got onto the scene?
A: About 15 seconds.
Q: Okay. And how did you make that determination by observing the patient?
A: His skin was warm and dry, he had a strong pedal pulse, his respiratory rate was normal. He was awake and alert and answering questions.
Q: What did you decide to do -- I mean, did you notice any blood from the wound or much blood?
A: So the blood coming from the wound was dripping

straight down his body. I shouldn't say drip. I misspoke, but I mean it was pretty much dried on his abdomen. It looked like he maybe lost two to three CC's of blood, or milliliters.

Q: Did you see the photographs that came in during Ms. Aiken's testimony, the first witness?

A: I did.

Q: Have you ever seen those photographs before?

A: I have not.

Q: Based on looking at the photographs of the linoleum floor and the couch, can you estimate how much blood that patient lost?

A: Less than five milliliters.

Q: Okay. How much blood -- if I'm going to go down today to the Red-Cross and donate blood, how much blood is coming out of my body?

A: About 500 CC's.

Q: How did that compare to the amount of blood that you saw on the floor and on the couch?

A: I mean it's infinitesimal based on -- I mean, in the grand scheme of things. I mean the average guy cuts himself shaving probably as bad.

Q: I'm sure you've given blood before.

A: I have.

Q: But after you lose 500 CC's -- is it CC's?
A: 500 CC's.
Q: Do people start an IV on you to start saline after you've ---
A: Absolutely not.
Q: All right. So getting back to the scene. Had you had a previous, or have you had previous encounters with this particular gentleman?
A: Yes.
Q: Okay. And was he -- have you seen him out and about in the community?
A: Absolutely.
Q: Have you discussed this particular gentleman with other fellow members of the Rescue Squad at Iva?
A: Yes.
Q: Okay. And you'd been out to this gentleman's house, I think your earlier testimony was on one prior occasion?
A: One prior occasion, I was in the ambulance.
Q: Did you actually go into the house on that occasion?
A: No. The patient met us at the front door.
Q: Okay. Now when you said to the patient, did anybody ever tell you you're an idiot, what was

going through your mind when you made that comment?

A: Well a whole bunch of things. One, I was certainly still thinking about my friend Ms. Kaiser and that unfortunate circumstance. And then, I mean, there was a litany of other things that were running through my mind. Scene safety, you know, whether I thought that guy had the ability to get up off the couch and do harm to somebody with the Officer standing right next to him.

Q: Once you determined that the patient seemed to be stable, what was your next most important thing to do?

A: Stabilizing the object in his abdomen.

Q: How did you go about stabilizing the object in his abdomen?

A: Used a couple pieces of tape and horseshoe around the object itself so that that object, the handle couldn't tilt forward or backward, then put bulky dressing around it and tape that down.

Q: Okay. Prior to you taping that down, did you observe the handle, the knife handle or did you watch the knife handle as the patient was

breathing and sitting there on the couch?

A: Yeah. So, there was some testimony earlier in the week about that knife handle. The handle was perpendicular to the body's surface, well mostly perpendicular. He was kind of a -- had a round belly. But the knife handle was sticking straight out of the body, not at an angle. If it had been either in the diaphragm, which is the muscle that helps you breath, drops down is helping you inhale air, relaxes pushes air back out of your lungs. Had the knife penetrated the diaphragm, every time the patient breathed the knife handle would move, regardless of whether it was still suck in the diaphragm, it's irregardless to it moving. If it was in the path of the diaphragm the handle would have moved every time the patient breathed, all right? The knife doesn't, you know -- if the knife penetrated the diaphragm, as it's dropping, when it relaxes and comes up and pulls away from the knife, when it goes back down it's going to touch the knife blade again and cause the handle to move. The knife doesn't magically displace itself when it's done in the diaphragm. If it was in the aorta,

which it can't get to due to the placement of the aorta vice the trajectory of the blade and the handle, there would be a ticking motion every time the heart beat there would be a tick of that handle. And the reason I know both of those things is 'cause I've treated patients with impaled objects in their diaphragm, impaled objects in their aorta, pieces sticking completely through both of those items. It's not hard to tell when once of those items is injured. It's just hard to associate it when you haven't seen it.

Q: Okay. I think you were talking about you put horseshoe tape around the handle. What else did you do to secure the knife in place?

A: Took a couple rolls, not rolls but a couple pieces of what we call AB pads, or like five by nine inch pads. I rolled them up, laid them adjacent to the blade of the knife, taped those down in place to provide some bulky dressing around the handle so that it was less apt to be moved.

Q: Okay. Did you believe that you brought into that scene all the equipment that you were going to need to treat that patient based on

what the call was reported to be?

A: Absolutely.

Q: Have you ever taken all of the equipment off of the truck and brought it into a house at a scene?

A: I know that's what the protocol says, but that's a virtual impossibility. I mean it would take -- by the time I got all the equipment off of the truck and into the house for any given emergency, because you don't know what you have, so just because dispatch says you have one thing doesn't mean you'll always have that. Dispatch could say a patient's complaining of a headache and go in there and the patient's in cardiac arrest. Or the patient has a broke toe and you go in there and the patient's lying in between the toilet and the tub with a broke neck. It's somewhat of a crap shoot. But the point is, there comes a point where you have to go in, assess the patient, decide what you need, and then bring those extra supplies to the patient. You know, trying to take a stretcher, a stair chair, a spine board, a scoop stretcher, all the equipment out of the truck, which includes a

drug bag, a heart monitor, a suction unit, oxicaddy, I mean does all the equipment include all the equipment cabinets too? I mean all the four by fours, all the extra oxygen cylinders. I mean it's a bit ---

Q: If you brought all that stuff into the house, you can't just leave it in the house, right?

A: No.

Q: What would you have to do?

A: Well eventually you'll have to take it and put it back in the truck.

Q: Would that affect your scene time and your ability to get the patient to where he needs to go?

A: Absolutely.

Q: Now after you got the knife stabilized in place, what was your next major concern with this patient?

A: How we were going to move him.

Q: Okay. Did that present any particular challenges to you?

A: Yeah, several. One, you have a person that has an object impaled in them. Then you have the structure of the house itself, doorway sizes, how the door swings, if there's a railing on

the steps, how secure the steps are, whether the steps are secure, but they're not on a firm foundation if you will. Then there's the move from the house to the truck. Is it over gravel, is it over sand, is it mud, grass. I mean there's a litany of things that have to be considered when you're moving a patient. The most important one is the patient themselves.

Q: How quickly did you decide the best way to get that patient out of the house was to try and gingerly stand him up and walk him to down the stairs?

A: How quickly?

Q: Yes.

A: It was a thought process from the time I started stabilizing the object in his abdomen.

Q: Okay. Did you have any doubt in your mind that walking that patient out of the house at that time was the best way to get him out under the circumstances?

A: Absolutely not.

Q: Okay. Did you give any consideration to the protocols that say don't ambulate the patient to the ambulance?

A: You mean should not?

Q: Should not. I'm sorry, should not.
A: Well you shouldn't just blow off the protocols, but there's no chance that those pieces of paper can take into account every instance that you could possibly come across. I mean they just can't.
Q: Could you get that stretcher into the house, the stretcher from the ambulance into the house up the stairs?
A: I wouldn't not even attempt that.
Q: Okay. How heavy is the stretcher?
A: About 130 pounds.
Q: Okay. And I think some of the medical records said that patient was about 160 pounds?
A: Yeah, that's a little light for him, but ...
Q: Okay. So with his weight and the stretcher's weight, that's about what, close to 300 pounds?
A: Yes, sir.
Q: Okay. And do you often go to calls where it's just you and your partner on the truck?
A: We do.
Q: Okay. Is it feasible for two people, you and Ms. Aiken to carry a 300 pound stretcher out of the house and down a set of stairs?
A: No. Not the two of us.

Q: Okay. What about with four other people, like Police Officers or other first responders on the scene? Does that increase or decrease the danger in moving a patient having more people helping?

A: Anytime you have more moving pieces, there's more complexity to it. And there's a chance that something is going to go wrong the more pieces you add. I mean I know that there's a call for help, but just because you're getting more people doesn't necessarily mean you're getting more help or better help for that matter. So ...

Q: If you have say four people carrying that stretcher, and the patient down those stairs, somebody's got to be going backwards down the stairs. Is that right?

A: You'd either have to be going backwards -- I mean if it's two of you, somebody's going to have to go backwards and hopefully somebody would be standing at the bottom trying to spot you. But dropping that patient was the greater concern of anything else that was going on at that time.

Q: How quickly did it take you to stand that

patient up, gingerly walk him down the stairs, and get him to the ambulance if you had to estimate that to the nearest three seconds?

A: I'd say about 45 seconds.

Q: Okay. How long would it have taken you to go back to the rig, get the stair chair, bring the stair chair into the house, and get that patient back to the ambulance. I don't remember the stair chair being on that truck. For some reason I remembered that that truck had just returned from service and there was an issue with it, and so it was off the truck. Regardless of it being on the truck, I still wouldn't have used it. The type that we have does not have tracks on the back of it. It's a set of wheels that would require you to load the patient on it, strap him down, and then try to either walk him supporting his entire body weight with him in a upright position hoping that he doesn't feel like off balance and reach for something and throw us off balance, or you have to kind of roll the wheels off a step and let it fall down on the next step which is not an option. I mean that is worse for the patient than everything except for just

dropping him right on the knife.

Q: Once you get him down, if you got him down the stairs, out of the house and down the stairs, what was the ground like between the bottom of the stairs, and the back of the ambulance?

A: It's grass.

Q: Okay. How would you get the patient, if you used the stair chair, from the bottom of the stairs to the back of the ambulance?

A: You could either transfer the, if you were going to use a stair chair, you could either transfer the patient directly to the stretcher there, or continue to carry slash roll the stair chair to the back of the ambulance, and then you would transfer to the back of the ambulance.

Q: Now when you decided to stand the patient up, did you mean, or did you deliberately try to cause him the maximum amount of pain in moving him?

A: I know that's been a discussion. If I wanted to cause him the maximum amount of pain, I would have done a crappy job of stabilizing the knife. That way, it provided the most opportunity for that thing to move. That's not

what I did. I might have been short with patient, given some issues that a friend of mine was in her resent past, and made some inappropriate comments, but that guy has done nothing to me, despite me being upset at his, what I considered, his silliness of attempting suicide. I mean I have had people laterally shoot me, not shoot at me, but put holes in me, and me end up treating them afterwards, because it's the humane thing to do. I mean, if anybody I was going to let die, or cause pain to, it would be somebody that just tried to kill me. But, back to that patient, no I did not. If you'll see the video, when we stood him, we lifted him, I didn't tell him to stand on his own. I mean I could have said, hey man, get up of the couch, we're going to walk you outside, and just let him try to stand on his own, alright. An Officer was on one side, I was on the other, I grabbed him by the wrist, and underneath the arm, and lifted as much of his body weight off of him as possible to get him in an upright position. There is absolutely nothing wrong with that move. I understand that paramedics are cautious about

it, but that's because they don't have, and I hope this doesn't, at the risk of sounding arrogant, they don't have the experience moving patients by foot that I do, or with impaled objects in them.

Q: Now, when you were lifting that patient up, what were you doing, or where were you looking or where were you focused when that patient started to move?

A: That knife blade, or the knife handle.

Q: And as the patient got up and walked what, about 3 or 4 steps to the door --

A: Yep.

Q: Did you just leave him and walk down th steps?

A: No, when we opened the door, I turned with my back to the steps, and walked down the steps side by side, sideways holding him, in the event that he lost his footing, I would be there to catch him, but he's a pretty sure footed individual from what I've seen.

Q: I noticed you went out the steps first, and kind of hoped down the steps. Can you tell the court why you had to hop down the steps?

A: I can't take pain meds when I work, so I experience a fair amount of pain from my combat

injuries, on a daily basis.
Q: So, you went down first, pivoted around, and did you watch the patient come down the steps?
A: Yes.
Q: Okay. What was your -- Why did you go down first instead of letting the cop go down first?
A: Because if he fell, I wanted to be there to catch him.
Q: Okay.
A: Or support him.
Q: Did you have any trouble getting the patient down the steps?
A: Nope.
Q: Okay.
A: We -- if I may.
Q: Yeah, go ahead.
A: So, I mean Leo hit on this a little bit yesterday, Mr. Deason. Patients know what hurts them, you know. Us moving a patient, we can't feel what that patient feels. Anytime we're manipulating a patient that is in pain, we risk the chance of causing them more pain, because we are not feeling what they're feeling. If we allow them to manipulate themselves, there's a lot less pain involved.

They can stop when they feel pain, alright, or discomfort. One of the best examples of that is for years we put a C collar, if I may use an example, we put a C collar on a patient's neck in a car accident. We sit there and hold their head, in an effort to keep their neck from moving. Put a collar on them, and then we put this, either what's called Kendrick Extrication Device, KED, around them to prevent movement, and then turn them and lay them down. What the National Association of Athletic Trainers has found, through a bunch of research that's available online, is that if you let the patient get out of the car themselves, there's a lot less movement of their C spine, because they can stabilize themselves in their position of comfort, instead of us trying to put them in the position that we think their comfortable.

Q: Now before you got out of the house, there was, I think, some testimony earlier about after you made the comment, I think it was, does anybody ever tell you you're an idiot.

A: Yes.

Q: Did the patient stop interacting with you after you made that comment?

A: No, he did not.
Q: Okay. Now There was also a comment about I think some discussions between you and the Police Officer, and the patient about you know, why he did what he did or what he was trying to accomplish, and he indicated he was hoping to bleed out, he wanted to stab himself in the heart, and hoped to bleed out. And you made a comment to the affect of, man that's not where your heart is. What was your intention in making that comment?
A: To relieve any anxiety he had over where he put the knife. I mean, if he thought that his heart was there, and he was going to die, and that's why he called 9-1-1, I wanted him to know that he wasn't even near where his heart was, and he would be ok. I mean, I'll agree that just like the first comment I made to him, I was rough about it. And, I mean, I'm happy to talk about that later, but it wasn't a comment that was meant to suggest that he was an idiot and didn't do it right.
Q: Were you trying to coach him how to do it next time in the right way?
A: I don't even know that that deserves an answer.

Q: Okay. You also told the patient at one point, or sort of asked him, why he did it, and he said he's got it so bad, his nerves are shot, his wife's got an oxygen or depressed or whatever, and you made a comment to the affect, man I don't want to hear that. I stepped on a IED in Afghanistan and blew my nuts off. What was your thought process or your intentions in conveying that information to the stabbing patient?

A: SO, I believe I testified, that or I'm going crazy, while Mr. Wicevic was questioning me earlier in the week, that when I was healing from my injuries, I worked as part of the Force Preservation Director down at Seven Special Forces Group in Elgin Airforce Base where I was stationed, and a part of my duties was taking care of wounded soldiers, and these are Special Forces soldiers not unlike myself that were greatly injured, and a lot of them weren't doing nearly as well as I was. Multiple amputations, a bunch of dudes with their faces almost blown off, or shot off, and so, we had a rise in suicides. And, SF dudes don't talk about doing anything, they just do it. To be

honest with you, we're not the type to ask for help a lot of times. You know, we're kind of self sufficient in that area, or at least we think we are. Whether it's emotionally, physically, whatever the case may be, and so, what we found was there was not a lot of hinting around about guys who were going to commit suicide. And so, the courser that we took, was a, how to recognize it, and b, how to treat it in other guys, or other soldiers. And, you know, attacking is not the right word, but talking around the problem, sugar coating things, holding people's hands, and while I agree, certain people need their hand held if you will, not everybody's like that. And so, coddling people doesn't get you the results that you think it's going to get you, and like I said, we were taught to not sugar coat things, and talk right at them. Again I agree that I could have chosen better words, and maybe changed my tone a little bit, but I meant that man no harm.

Q: And you recall in the video, and you were there, you saw the Officer Boucher say something to the affect of, don't make me be

bad guy.

A: Condescending?

Q: Yeah, is it appropriate to talk to a patient with baby talk? I mean does that show compassion and care when you talk to someone with baby talk?

A: No, it does not.

Q: Okay. Now, as you were performing these procedures, and stabilizing, did you tell the patient what you were going to do for him?

A: No, I --

Q: Did you tell him you were going to tape the knife into place when you taped the knife into place?

A: I don't recall.

Q: Okay. Do you recall telling him that he's going to have to go to the Operating Room to have the knife --

A: Yes, yes.

Q: Why did you tell him he was going to have to go to the Operating Room?

A: Because I wanted to prepare him for what was about to happen to him, so that it wasn't a surprise. He had previous encounters, with EMS crews, had noted that he changed en route to

the hospital, and decided he didn't want to go, so he was going to put up a fight. I would rather it had started there while I had plenty of help, rather than him being in the ambulance, and I say, or Km says something to the affect of you're going to have to go the OR, and then he not have that in mind, and start fighting someone in the back of the truck.

Q: Okay. There was some interaction, again this is after the idiot comment was made, right? I mean this was a couple minutes after. There's a comment about, you mean I got to go to the hospital to get that taken out, you can't take that knife out. And what was your response to that?

A: I said, I could, but I'd lose my job.

Q: And what did you mean that you would lose your job if you tried to take that knife out?

A: Well, it's out of a paramedic's scope of practice.

Q: If that patient had the same knife wound in Afghanistan, could you have taken the knife out and fixed him?

A: Absolutely.

Q: Okay, but if you try to do that in Iva of South Carolina, that's way out here beyond the scope of practice of a civilian paramedic, you agree with that?

A: Yeah, I completely agree. That's why I didn't take it out right there. That and it not being sterile.

Q: Alright, so you get the patient out the back of the truck and I do remember when he stood up, he kind of grimaced with a little bit of pain. Was that normal to experience pain as you stand up with an impaled object in your stomach?

A: Yes, anywhere in your body it's going to hurt. I mean it could be in your foot, and you could put pressure on it it's going to hurt.

Q: Did you disregard that complaint of pain, or is that something you expected to see as you lifted ---

A: It was an expectation.

Q: And when you got the patient in the back of the truck and helped him, you said put your butt right there, were you being mean to the patient when you told him where to put his rear end?

A: No, I just wanted him to put his butt, where I told I wanted him to put his butt.

Q: Okay. He put his butt there, and he got sort of turned up on to the gurney, and he expressed a little bit more pain, right?

A: Yes.

Q: Is that something you would expect to see again, as you're manipulating that patient into that position? For those stomach muscles to tense up and for him to experience some pain?

A: So, sense you brought up stomach muscles. Anytime you move your core, your stomach muscles, your core has to be engaged to make that motion, so whether he moved himself, or I moved him, his body is still going to tense, because he's going to think it's going to hurt, and try to anticipate the pain that might be coming. So the idea that you could move somebody with an injury of any type, and never cause no pain, is just not so. I mean, sometimes you have to cause people a little pain to help them, you know. Setting bones, I mean, if you go to the hospital for sutures, the doctor, or PA or nurse practitioner, or SF medic, if you're around an Army base, that's going to suture you has to stick a needle in you to numb the area where he's going to suture

you. So, the mere fact that the patient hurt a little, isn't indicative of someone trying to hurt him. It's just a fact of trying to care for him.

Q: Okay. Then the patient got on, and he looked like he was a little too far toward the head of the stretcher, and he had to kind of get moved down to the back. How did you go about moving the patient down a little bit?

A: I grabbed his belt, below the site of the wound, and drug him down slightly, so he didn't have to move himself.

Q: Okay, and I think when that happened, he said ouch ouch. Did you do that internally or deliberately to hurt him?

A: No.

Q: Okay. What was your purpose in moving him down the stretcher?

A: Because his head was, I believe, about to hang off the top of the stretcher, or it was at the top of the stretcher.

Q: Now, I think at some point the -- I think it was Kim's husband said, hey man, you want to sit up some or something. Do you remember that?

A: Yes I do.
Q: Okay. Was it -- is it your understanding he's an EMT basic?
A: That's correct.
Q: Was it his place to tell you how to carry that patient into the hospital?
A: No.
Q: Okay. Why did you lay the patient down flat on the stretcher?
A: So when the patient was in the house, if you see from the video, when the patient's in the house, and he's kind of in that slouched down position. His heads craned forward a little bit, and he's constantly looking at that knife. It's like dangling something in front of a kid's face. He won't, you know -- it caught his attention, and he kept reaching for it. The Officer of course told him several times to leave it alone. It was my intention that if he's laying down flat, and looking at the ceiling, to see the knife, he'd have to lift his head and then reach for it, as opposed -- I mean, somebody with an object in their stomach just is not going to wave at they're abdomen and hope that they get it. I mean that

would be causing a bunch of pain to himself. But, anyway, my intention that laying him flat, which is the same position they put him in the ER, and it was the position he was going to be in the OR with the knife being removed. That he would look up at the ceiling, or look at Kim sitting over beside, or me sitting on one side, whoever was going to end up in the back with him, and be less apt to just reach for the knife. And by doing that, not end up having to try to wrestle him down to restrain him for causing himself more harm.

Q: And there was some talk about restraints. Did you give some consideration to physically restraining that person's arms or legs to the stretcher?

A: About a nanosecond.

Q: Okay, and what are the risks involved in trying to forcibly restrain a patient, especially one with a knife in the belly?

A: So, with any patient you're going to restrain, much less one with a knife in his belly, especially a psych patient who we end up restraining most of the time, unless it be somebody that's inebriated, that's wanting to

fight with you. But, you often times end up in a scuffle. The patient with a knife sticking out of his belly is not the guy I want to scuffle with in the back of the truck, or in his house for that matter. So, the longer we could go without that problem presenting itself, the better off he was, and by virtue of that, the better off Kim and I would be.

Q: After the patient gets into the back of the truck, I know there was a comment about I think one of the cops asked you, hey man you doing ok, and you said, you kind of expressed some frustration, you said, F'ing stupid people.

A: Yes.

Q: Was the door to ambulance almost, or on the way to being closed at that point?

A: Yes.

Q: Okay. Did you curse at that patient at anytime during your encounter with him?

A: No, I did not curse at him, I cursed in his presence.

Q: And what did the Police Officer say when you said that, what was his reaction?

A: Oh he said he was -- Kim made a comment about going to check on the wife who has significant

medical history as well, and they, the rescue squad had been out there numerous times for her as well. That she needed to be checked on, I think she was making a motion for Eric to go do it afterwards, her husband, but TJ Boucher the Officer in the case, said he was 1086, which is crazy in ten codes.

Q: And the Judge can look at the video, but I think that actually happened before you made the comment about F'ing stupid people.

A: I don't remember.

Q: Okay, but do you remember Boucher laughing and saying, man I couldn't agree with you more.

A: Yes.

Q: Okay. In your experience in emergency medicine, and interacting with firefighters and paramedics, and Police Officers, is that a fairly stressful environment?

A: It is.

Q: Okay. Is sort of a little comradery between the first responders and police, you're the guy, you see pretty tough situations from time to time, isn't that right?

A: Well, public safety has a dark sense of humor to begin with. I you know, all of us blow off

steam -- I shouldn't say all of us. That's a gross generalization, but the vast majority that I have come across, public safety, law enforcement, fire, police, have a dark sense of humor, and often times we blow off steam in the same way. It's no different than doing it in th OR, and it happens in the OR too. You know surgeons fixing people that have done stuff to themselves, get called all kinds of stuff while their asleep. But, I'm not excusing it, I'm just saying that it does happen, and it's a way of you know -- I mean it's a very stressful jobs, and it's the way guys bond, and the way people relieve stress.

Q: And I know, when you look at the video, I sure you've seen it hundreds of times, I mean if it was that -- first of all were you aware that, or did you pay attention to whether the Police Officer was running a body cam at the time of the call?

A: No, I didn't notice.

Q: Okay.

A: Wasn't paying any attention, the patient was my focus.

Q: And I know you've expressed regret several

times about how you sort lost, not lost your cool, but you had sort of a short tolerance with this particular patient.

A: Yes.

Q: Did that affect in any way, the level of care that you provided to this patient?

A: Absolutely not.

Q: And did you ever do anything malicious to try intentionally or deliberately and harm that patient?

A: No.

Q: Okay.

A: I mean, on that note, I mean if you watch the video as we were loading him in the truck he sat up, like he tried to sit his head up as we started to push the stretcher into the ambulance. I mean I gently put my hand on his forehand and said, whoa, and just gently guided his head back to the stretcher. There were plenty of opportunities I had to hurt that guy if I wanted to hurt him. Making him stand on his own would have been one. Walking him unassisted in any means. Making him move himself on the stretcher. I mean there's a litany of other means and ways I could have

harmed that patient if I had wanted to do him harm. That wasn't my goal. Like you said, I admit that I was short with him. Given, like I said, the recent history that we had had in Anderson with another paramedic. I was short with him.

Q: Have you ever heard the term BS meter?

A: Oh yeah, yeah.

Q: How was your BS meter reading about that time?

A: It was pegged.

Q: Okay.

A: I mean, you know, it just ...

Q: Did that have any impact at all on the level of care that you provided for this patient?

A: No more than it affected any of the guys I treated in combat that tried to do me harm.

Q: Now Deek told a story yesterday about a guy jumping off of a -- I think y'all were chasing and he jumped off like a three story building and landed on a pavement. What happened to that patient?

A: We went on a mission to capture Abrahim Al Badgadi who's the progenitor of ISIS who just got killed. But the guy that started ISIS. We were after his number two man in Iraq. And we

had gotten into a short firefight. He ran out of ammo and took off up the stairs and ended up trying to jump between roofs but didn't quite get there. His Spiderman skills weren't quite as good as Spiderman. He jumped and ended up falling, you know, three stories, landed on both feet, well landed on one foot and one tibia 'cause he rolled his ankle, inverted his ankle, like when you roll your ankle and fractured his ankle and the bone protruded out the end and into the asphalt.

Q: Was that a pretty gruesome injury?

A: It was painful. I don't know that I'd call it gruesome, but I'm sure he did.

Q: I mean this is a guy from Al Qadea that was shooting at you until he ran of ammunition?

A: Yes. Al Qadea in Iraq.

Q: Did you render medical care or medical attention to that person?

A: I did. I was on the second floor of the building. I was finishing what we call tactical interrogation, and I got a call over the radio that there was a downed bad guy. So I came back outside and he was thrashing around on the ground. The guys were standing around

him, you know, kicking him as he did it. Not our guys, the Iraqi SF guys. Ran them off, stabilized the fracture.

Q: Give any pain medicines?

A: Oh yeah. I did a regional nerve block and killed all the pain from his knee down on that side. Took him back to my clinic, put him in the OR, set the bone, cast him, and then we kept him in the holding area for about a week, and then I released him to the Iraqis once I was sure that infection was not going to be an issue in that leg.

Q: Did that patient's race or religion or the fact that he had been shooting at you affect the level of care that you provided for that patient?

A: No, sir.

Q: Okay. Did the stabbing patient in Iva, South Carolina, did any of those socio-economic conditions race, religion, color, any discrimination factor play any part of your treatment to that patient?

A: No.

Q: Okay. When you hear somebody like Dr. Alier say that that was a concern of theirs, how does

that make you feel?

A: Well, like I said, when I was interrogated the first time -- I'd hardly call that an investigation or fact finding mission, but I told them then that I can't make an excuse or a reason, I have no excuse for the way I talked to the patient. He needed to be talked to directly. The words I chose were poor. I had a bad day. Everybody has a, you know? But the patient's alive, which is a lot more than I can say for paramedics who suck at their skills and can't seem to intubate people. But I just have no -- I apologize. I don't know how many more times I can apologize for being short with him. But my medical care was not affected by -- or the care I provided him was in no way affected by what I thought of him at the time.

Q: Now after you get the patient in the back of the compartment, there's some discussion on the video that you have with Ms. Aiken about who's going to ride the call in. Do you recall that?

A: I do.

Q: Okay. Did you ever tell Ms. Aiken, this call is your call to ride in?

A: No. I did not.

Q: Okay. What was the language you actually used with Ms. Aiken?

A: So, a little back story. Ms. Aiken had had her backside chewed into by Mr. Stoller on a couple of occasions and she was hesitant sometimes to ride calls because she just didn't want that to happen again. It had nothing to do with patient care or her ability to care for somebody. She's just not a very strong personality. I mean she'll admit that herself, said so in her deposition. And she just tries to avoid conflict at all cost, and that really bothered her when Scott lit into her. I was trying to assure her that it was not going to be an issue moving forward that if it was I would talk to Scott and everything would be okay.

Q: When I was questioning Ms. Aiken I think it was my paraphrasing, when I said, it's your call. And the Judge has the video in evidence. But were you basically conveying to Ms. Aiken that it was up to her to let you know whether she was comfortable enough to ride the call in?

A: It's always up to the EMT whether they want to ride a call or not. I mean, I've said this to

more than one partner on more than one occasion. Regardless of whether it's a toenail that's torn off or a fracture, regardless of how insignificant the injury might be. If she doesn't or he doesn't feel like they are comfortable riding it -- but they have to speak up. Like I don't read soft language well, and I gave her plenty of opportunities to say, I do not feel comfortable riding this call, and she never said that. She just worried that she was going to get in trouble.

Q: Okay.

A: Which obviously has not happened.

Q: Compared to the other basic partners that you've had at the Iva Rescue Squad, would you describe Ms. Aiken as a real go getter?

A: Define go getter.

Q: I mean is she chomping a the bit to increase or learn her skills?

A: No. She's a little hesitant sometimes.

Q: Okay. As the senior medic on the team, the partners you get assigned -- this wasn't your partner all the time, right?

A: No. I worked there part-time.

Q: Okay. When you're assigned with an EMT basic,

do you view part of your role as to try and help educate the other EMT's on the rescue squad about how to do things or why you did certain things?

A: Absolutely. Every call is a teachable moment. If I'm not learning something myself, I'm trying -- and or trying to teach my partner something that I may have learned a long time ago or something changed that I've relearned or readdressed in training. Every shift, the ride back from the hospital with every partner I have is a discussion about patient care in some form or fashion. Why I did something, why I didn't do something, why you should do something, why you shouldn't do something. I mean if you're not trying to pass on your knowledge, then you're missing opportunities to -- especially at my age. I'm 45 years old, and as busted up as I am, I don't have a lot of career left in the field. And it's my responsibility, just like it was on the SF team to train my junior medic. It's also my responsibility to ensure that the people that come up behind me don't just have book knowledge to run off of because that's bad

medicine.

Q: Did you or Ms. Aiken ever just abandon that patient at the scene of the stabbing?

A: No. I've heard that said several times, abandon or, there was another word, discontinued care. That's no more discontinuing care than if a doctor comes in your hospital room, assesses you and he walks back out of the hospital room, goes down the hallway, and sits down to look up your labs or your x-rays or anything else. He has left where you currently are but that doesn't mean he's discontinued care. If that patient had had any issues whatsoever, that or any other patient. I won't even get into the silliness of that patient crashing. But you could have a patient in the back with a broken ankle on the way to the hospital, and that patient could go into cardiac arrest. You just pull over switch places. Now I agree that it's not optimal, but had I thought for a second that that patient was going to need anything more than what he currently had, Kim wouldn't have been in the back of that ambulance with that patient.

Q: Okay. The video shows Officer Burns inside the rig taking the still photographs. I guess Officer Boucher standing in the doorway 'cause he's got the camera on, right?

A: Well he stepped up inside the ambulance and turned so you could see, from his view you see the back of the ambulance. You see Burns, you see the bench on the left, you see the stretcher and the cabinets on the right. And then the back doors obviously. Burns is standing right beside the patient stretcher taking photos down. I mean, could he have fit two more people in the back of the ambulance? Absolutely. But that patient has an issue with authority as it is, now you're going to put four authority figures in a confined space with him? That's a receipt for disaster.

Q: Was the side door of the ambulance open ---

A: Yes, it was.

Q: --- at Officer Boucher's back?

A: Yes, sir. It was open.

Q: Were you and Kim doing anything at that time?

A: We were having a conversation outside the ambulance.

Q: Okay. And what were y'all talking about? I

know the video doesn't pick it up that well, but what can you recall talking about?

A: That's when I told her that it's up to her. She had made some comment about the wife, and I said, well we need to get on the road. Are you sure that you're comfortable with this. And she said, I'll be fine.

Q: About the tenth time I listened to the video I hear the phrase BLS call about that time when Officer Burns is finishing up his photographs. Have you ever heard that?

A: Basic life support.

Q: Okay. I mean do you recognize -- did you hear that on the video as well?

A: Yes.

Q: Okay. Who's voice was that that said BLS call?

A: I don't remember.

Q: Okay. So Ms. Aiken gets in the back of the truck, y'all go to the hospital. Did you view this as such an emergency that you went blaring down the highway lights and sirens?

A: No.

Q: Okay. Why did you decide not to do that?

A: Because that wasn't critical. It wasn't a critical injury, one. And two, the risk to

benefit of getting there two minutes faster running lights and sirens, it wasn't worth the risk to the patient, risk to the crew, risk to the system having an ambulance out if we'd had an accident on the way to the hospital. I mean we could have had an accident anyway, but anytime you turn the red lights and siren on, the likelihood that you're going to be in an accident increases dramatically.

Q: Is it disconcerting to the patient to hear the lights and sirens going off on the way to the hospital?

A: Well yeah, they think that the situation is far worse than what it really needs to be. The patient was completely stable. There was no impending issue with that patient despite, you know, he had a knife in his belly. Mr. Deason mentioned yesterday about a thumb tack, and I'm not equating a thumb tack to a knife in the belly. But both of those are penetrating trauma to the belly. Just because you have something in the abdomen does not make it critical.

Q: Did the exact length of that knife blade inside that man's belly matter to you in determining

whether the patient was stable or not?

A: No. Not in it's exactivness. The length of the knife blade has no bearing on his stability.

Q: So whether the knife blade was two and a half inches long or seven inches long, would that have affected your assessment of this patient in terms of whether he was stable or not?

A: No. Seven inches long it still can't get to his aorta.

Q: And is Ms. Aiken trained on how to monitor the vital signs of the patient on the way to the hospital?

A: Yes, she is. That diagram of the signs of shock is taught from EMT basic all the way through paramedic. I mean the renin and all that stuff, all the chemistry part of it, all that stuff is not taught at the basic level I don't think because it does them no good to know it. You're taught from the time you start EMT school how to recognize shock. Starting IV's on people doesn't fix shock. It doesn't fix blood loss. If the patient's bleeding internally the worst thing for that patient is more fluid. So as long as that patient's

sitting upright talking to me, he's still not getting fluids. Ms. Aiken, we've had several discussions about the presentation of shock and the most reliable signs of picking up on it. I mentioned earlier that skin color, condition, and temperature, the pulse rate, and the patient's alertness or anxiety level are the three best indicators of a patient that is going into shock. That doesn't mean that they will ever be in shock. That just means that they lost blood. So ...

Q: How did you find out that you were being suspended from Anderson County or at least having your medical controls suspended?

A: Scott Stoller walked into my office on Tuesday morning and handed me a piece of paper, told me to get my stuff, and that Sheila Kaiser would take me home, and she would be retrieving my keys, radio, and all of my County equipment.

Q: Let me show you Respondent's Exhibit 4. Do you recognize that document?

A: That would be what Mr. Stoller gave me.

Q: Okay. Did Mr. Stoller tell you what specific calls you were being investigated for?

A: He did not.

Q: Did Mr. Stoller tell you anything? I mean what was his demeanor like toward you when he said, you're being suspended?

A: He was pretty rude.

Q: Did he tell you to take any personal belongings out of your office?

A: Yeah. He told me that I could take all my military awards that were hanging on the wall and memorabilia with me. That I might not be coming back.

Q: What's the next interaction you had about this investigation that Mr. Stoller and Dr. Kickham were supposedly conducting?

A: He contacted me to set up a time for us to meet. And then we met on the 25th, Friday morning about 10:30 maybe.

Q: Let me show you Respondent's Exhibit 12.

MR. ROTHSTEIN: And, Your Honor, I'm going to move 4 into evidence.

MR. WICEVIC: And, Your Honor, the same relevance objection about this one.

THE COURT: Okay. It's admitted.

(Respondent's Exhibit Number 4 was admitted into evidence.)

Q: Okay. Do you recognize Exhibit 12?

A: Yeah. That's a list of text messages between Kim and I the afternoon after I was suspended.

Q: Okay. After you were suspended, how did you get home that day?

A: Sheila drove me home I my County issued vehicle, and then I gave her my keys, my badge, and all of my medical gear that wasn't in the vehicle. And then she drove it back to Scott.

Q: Okay. Did you contact Ms. Aiken about your suspension?

A: I did. I tried to call her first. So as I was leaving the building I ran into somebody that told me what it was about. And I want to say it was Taylor Jones' secretary at the time who worked for the Sheriff's Office.

Q: What did she tell you?

A: That it was about a stabbing patient.

Q: Okay. And does this set of text messages, Exhibit 12 accurately reflect the text communication you had with Ms. Aiken over whether or not she filed a complaint in the stabbing call?

A: That's the text messages. I drove down to Iva and we met that next day I want to say. Yeah, I want to say it was the next day I drove down

to Iva to get copies of that run report. Had no idea what the other two were about for it seems like a day or so. I don't remember how I learned about the other two, but it wasn't directly from Scott.

Q: At some point in your discussions over then next couple days after you were suspended, did you come to find out how the complaint was sort of generated about the stabbing call?

A: I confronted Scott the morning of the 25th at the meeting, and he said a complaint -- well he told me initially that a complaint was filed anonymously and that he couldn't get into the details. Of course I told him that I had a right to face my accuser and he told me in certain words not to worry about it. That it wasn't germane to the investigation.

MR. ROTHSTEIN: Your Honor, I move Exhibit 12 into evidence.

MR. WICEVIC: Your Honor, the same objections, relevance.

THE COURT: Thank you. It's admitted.

(Respondent's Exhibit Number 12 was admitted into evidence.)

Q: James, hang on to that. Can you look at page

2 of Exhibit 12?

A: Absolutely.

Q: At some point did you have some concerns about whether the Iva Police Department was actually the source of the complaint against you?

A: Yes.

Q: And can I clarify one thing. On that document, are the green bubbles your communications or Ms. Aiken's communications?

A: The green is me, the white is Ms. Aiken, or grey.

Q: And halfway down the second page of the text messages, what did she mean by the PD can't do anything can they? I mean they don't do PT care. What does that mean?

A: So, we had talked about, on the way out of the building when ---

Q: Taylor Jones' secretary?

A: Yeah. The secretary, I stopped back by her office while Sheila was collecting up her things so that she could take me home. And she said that she heard that it was somebody from the Iva PD. And that's why the comments about the PD.

Q: And what was your response to Ms. Aiken's

comment about whether the PD could do anything?

A: Say that again.

Q: How did you respond to Ms. Aiken's text about the PD can't do anything can they. I mean they don't do patient care.

A: Well I guess she thought that the PD wouldn't have filed the complaint 'cause they wouldn't have had a reason to. But that's when I said the supposedly called Scott with concerns according to Scott.

Q: Okay. And what was Ms. Aiken's response to that?

A: She obviously wanted to know if her report got pulled. I mean she said that she was fine riding it, the patient was stable the whole ride. And then she said she called Tim who is the Captain at the Iva Police Department. And he said he didn't now anything about it.

Q: What report was Ms. Aiken referring to with, did he pull my report? Was that the patient care report?

A: Patient care report I assume.

Q: Okay. What does soft abdomen mean?

A: That he didn't have a rigid abdomen. That he wasn't bleeding into his abdomen and there was

no abdominal contents that were spilling into the abdomen. If a patient's bleeding into their abdomen, the body doesn't like blood outside the vasculature. Especially inside the abdominal cavity and so it'll get rigid. The same thing will happen if you penetrate an organ in the abdomen or the hollow organs in the abdomen and spill bowel or abdominal contents into the peritoneal cavity. It get's really irritated, will get rigid, and you'll be able to feel it. Aside from that, it get's very painful.

Q: Are EMT basics trained on how to recognize the signs of a rigid abdomen?

A: Absolutely.

Q: Okay.

A: Again, it's part of the national curriculum.

Q: Okay. The next sentence on her text says -- did you interpret that to mean stable the whole time?

A: Yeah. Stable.

Q: Okay. All right, so you get the notice from Mr. Stoller that you're being suspended on Tuesday. What happened on Friday?

A: I sat down with Dr. Kickham. We had a meeting.

I ---

Q: Who was in that meeting?

A: Scott -- Mr. Stoller, Dr. Kickham, and myself.

Q: Okay. And what can you recall about the meeting?

A: It wasn't very long. They had some questions about the first two non-trauma related calls.

Q: When were those in relation to the stabbing call, when were the other two calls run?

A: More than a month earlier.

Q: Okay.

A: So I explained myself about them. Dr. Kickham kind of, you know, was basically like whatever. And then there was no protocols in front of him. Like we didn't go through the protocols, and he go, James this is what you did, this is what you should have done. It was more of a discussion about it says this is what you did on the report, can you explain to me why you did it, you know, justification. And I justified my actions, and for all three calls. He had some concerns over the elderly gentleman with the low blood pressure. But once I explained the history behind that all, he said that makes perfect sense. The patient was in

the ER for about an hour and then returned to the nursing home where he started. There was, you now, nothing to that one. I really didn't know why those two were, you know, pulled at all. And then we got to talking about the stabbing patient. We talked about my clinical decision making, why I made the decisions I did, the basis for the decisions I made. We left that meeting and it was my understanding that Dr. Kickham, while he -- I don't even know how to word it. We left the meeting and he's like, okay we'll be in touch in a little bit. And there was not, this is what you did, this is what you should have done. This is what the policy says, this is what you should do. So ...

Q: Let me show you Respondent's Exhibit 5. You recognize Exhibit 5?

A: Yes.

Q: What is Exhibit 5?

A: Exhibit 5 is Dr. Kickham returning me to duty after the investigation if that's the right word, and Scott stating that Dr. Kickham wanted me to take a protocol test and the PEPL class.

Q: Okay. Did you in fact take the protocol test?

A: I did. Well ... Yes, I took it.
Q: Okay. Did you go down to talk to Mark Henderson about scheduling a protocol test?
A: I called Mark on the phone the afternoon after I got this. He said he would be out of town for a few days. And so it took me about I think right at a week. It would have been the next Friday I believe that I took the protocol test. Passed it as always, and he passed the results to Scott, or Mr. Stoller.
Q: And, James, there's a date of March 22nd on the top of that letter. When did you actually receive that letter?
A: It should say the 25th. I believe there's an email between Mr. Stoller and the administration at Iva Rescue Squad where Scott states in the email that despite it saying the 22nd, it was a typo. He just erased the irrelevant portions of the email, and just used the email from the 22nd that we had a few minutes ago as the basis for this one. So he forgot to change the date.
Q: After you got this letter, did you submit anything in writing or email to Dr. Kickham or Mr. Stoller asking for more detailed

explanation of why they think you had done something improper?

A: So after I got this, Scott and I had a conversation on the phone, and I was trying to figure out why I need to take a protocol test when I had just taken one seven months earlier. And I basically got a bunch of words from Scott that were not expressed by Dr. Kickham in the meeting. So I sent Scott an email trying to clarify what he had said, you know, in hopes that I would get a return in email or in writing according to the policy. I felt that I had explained myself, and Scott kind of conflated things to the point where -- Scott made some inaccurate statements, so I was asking for clarification.

Q: If you turn in the white notebook to the last exhibit in the white notebook ...

A: 14?

Q: That's right.

MR. ROTHSTEIN: And, Your Honor, I move Exhibit 5 into evidence, by the way.

MR. WICEVIC: Same objection, Your Honor.

THE COURT: Same objection, okay. It's admitted.

(Respondent's Exhibit Number 5 was admitted into

evidence.)

MR. ROTHSTEIN: Is 14 already in evidence? DHEC 14?

MR. WICEVIC: I believe it is.

MR. ROTHSTEIN: Okay.

Q: James, do you recognize Exhibit 14 as the email you sent to Mr. Stoller asking for some additional explanation?

A: Say that one more time. Sorry. State the question again, David. I'm sorry.

Q: Yeah. Do you recognize Exhibit 14 as the email you sent to Mr. Stoller on March the 30th asking for some additional explanation for what policies you violated or how you violated County protocols?

A: Yes.

Q: Did you ever receive a response to the March 30th email, Exhibit 14?

A: I never received anything.

Q: Okay. Did Mr. Stoller after that point schedule you for any shifts on the QRV?

A: I want to say it was Saturday. I may have worked the QRV, but I think that was scheduled before the email was sent. I want to say I think that shift was scheduled before I took the protocol test pending me passing the test.

But this was sent the Wednesday two days prior to taking the protocol test.

Q: Did you run any shifts on an Iva County Rescue Squad ambulance after your Medical Control was restored by Dr. Kickham?

A: I have not.

Q: To this date, has Dr. Kickham told you that your Medical Control has been suspended again?

A: No. He has not.

Q: Okay. Now after this occurred did you sort of put that stabbing call out of your mind?

A: Yeah. I thought it was done.

Q: What was the next interaction you had with anybody about the stabbing call?

A: I received a phone call from either Sandy Sutherland or Tommy Miller from the Iva Rescue Squad letting me know that Mr. Naugler was trying to contact me. I don't remember which one it was that contacted me. They passed me Mr. Naugler's cell phone number I believe. And I proceeded to call Mr. Naugler.

Q: Okay. What did Mr. Naugler tell you when you called him back?

A: He said they were finishing up just a systematic chart review. I don't remember the

exact word. But he wanted to know if I would be willing to come down and answer a couple questions so they could close the case and put it behind them or something to that effect.

Q: Did Mr. Naugler identify himself as a DHEC inspector?

A: I don't remember him using the word inspector. I remember him saying -- he represented himself as Richard Naugler from DHEC. But I don't remember him saying that he was an inspector. I'm not saying he did not. I just don't recall him saying he was.

Q: Did he tell you that a formal complaint had been filed against you at DHEC?

A: No. He did not.

Q: Did he ever tell you he was investigating a complaint of potential misconduct by you for DHEC?

A: No. He did not.

Q: Did he ever indicate to you that the purpose of the interview with you was to determine whether or not to revoke your paramedic certificate?

A: Absolutely not.

Q: Okay. Did you cooperate with Mr. Naugler's request to come down to Columbia for an

interview?

A: Yes, sir. To the best of my recollection it was like maybe a day later, two days at the most it seems. I had something on my schedule. I cleared it to go.

Q: And you heard the snippets at the end of it. Obviously you remember that interview. What was your demeanor like or what were your expectations when you first got to the meeting about what they were going to do?

A: I thought it was just answer, you know -- like he said, chitchat. And, you know, ask some questions about a few things and that was it. I didn't think much about it.

Q: Going into that meeting, were you aware that the body cam video footage had been forwarded to DHEC?

A: No, I was not.

Q: Okay. Did Mr. Naugler explain to you on the phone when he first called you and asked you to come down there, that they saw something on the body cam video that they wanted you to explain?

A: He did not.

Q: When you got to the meeting in Columbia, did they tell you this was sort of a routine chart

review?
A: Something to that effect, yes.
Q: Okay. And that they had gotten a statement or they were forwarded a statement from your partner on one of the calls ---
A: That came out some point in the discussion. It wasn't up front.
Q: Okay. And they said to complete their file or close their they wanted to get your side of the case, is that right?
A: That's correct.
Q: Did you cooperate with them during that meeting?
A: Yes, sir.
Q: Okay. How many calls were discussed? Was it more than just the stabbing call that was discussed during the meeting?
A: No. That was the last one we discussed.
Q: Okay. Which ones did they discuss before they got to the stabbing call?
A: The pediatric seizure and the older gentleman with low blood pressure.
Q: Okay. At the time of that interview, did they have the Anderson County protocols in front of them?

A: No.
Q: Okay. Did they disclose to you that there was a chart review done by Keith Eudy?
A: I didn't see that until we did discovery.
Q: Okay. Did they say anything about your care other than O2, IV, and monitor on all three patients?
A: No. Not much.
Q: Okay. And about half way through that meeting, did the tone of the meeting change?
A: Yes.
Q: Okay. What happened?
A: I thought the meeting was over. Everybody had made comments. I'd pushed my chair back from the table a little bit, was getting ready when I thought we were going to adjourn. And then Mr. Wronski made some comment about from time to time they get forwarded information or they try to collect as much information as possible when they're making decisions, and then put the video on.
Q: Okay. And how did the room change or the attitude in the room toward you change at that point?
A: They became adversarial.

Q: Okay. Did you feel like you were being ambushed?
A: Yeah. I don't appreciate that a whole lot.
Q: Okay. Have you ever been ambushed as a Special Forces person?
A: Yes.
Q: Is that a good feeling?
A: No.
Q: Okay. Was your level of cooperation and friendliness, did it continue after they started to attack you?
A: No.
Q: Okay. At some point did they start to discuss with you whether or not they wanted to go after your paramedic credentials?
A: Yes.
Q: Okay. And at some point did they offer you a consent order? Not necessarily in the meeting.
A: Yeah. We discussed what it was I believe. But there wasn't -- they told me what a consent order was vice an administrative order, and that they try to solve them through consent orders as much as possible, but it was my choice. Made some comment about public record or the video being seen or something

derogatorily trying to force my hand into -- I felt like they were trying to coerce me into signing whatever it was that they put in front of me.

Q: Okay. At that point did you seek legal representation?

A: I did.

Q: Okay. If you knew what the meeting was -- before you went into that meeting, if you knew what was going to happen, would you have brought an attorney with you to the meeting?

A: Absolutely.

Q: Okay. Let me show you Respondent's Exhibit 2. I'm about finished. You recognize Respondent's Exhibit 2?

A: Yeah. That would be the grievance that I filed with the County Administrator against Mr. Stoller. Or against his actions.

Q: And I know that grievance was filed after the meeting you had at DHEC. But had you raised the issues that are set forth in that grievance with Mr. Stoller prior to the stabbing call on March the 19th?

A: Mr. Stoller and I had what I would have considered to be a friendship up to a certain

level prior to that. He offered me a job when I returned from -- while I was healing from surgeries. So I worked in the office a large part of the time because I was still healing from continuous surgeries. I've had 79 since October 2012, and so I would work for a period of time while I was healing between surgeries, and I'd go have surgery, come back home. And in those times I would work on various projects that Scott had going on, or that he wanted me to work on. A policy manual, changing dispatch policy and protocol, the mass casualty plan for the entire County to name a few of what I worked on. And then as our relationship developed he ended up relying on my more as an Operations Officer for the organization. I made a lot of day to day operational decisions even as a part-time paramedic. And in that capacity, I gained a lot more knowledge about some things that were going on in the organization that I couldn't turn a blind eye to.

Q: Did you confront Mr. Stoller about those items?

A: Oh yes. On several occasions we had discussions about -- almost everything in this

grievance we talked about at one time or another. Several of them on multiple occasions and when he couldn't get me to agree to certain things he would go to other people and try to get their agreement. Sheila for one, a couple of the other more senior paramedics in the organization.

Q: At some point in the early 20' or mid 2016 time frame, was Anderson County EMS planned to have a consultant come in and sort of do an evaluation of the EMS system?

A: I believe that started near the end of '15. They were collecting all the data from dispatch and I facilitated most of the data that they asked for. And then that consultant was supposed to show up, I want to say about May time frame it seems like, to do interviews with certain individuals, all the rescue squad Chiefs, the Dispatch Coordinator, 9-1-1 Coordinator, County Fire Chief, Sheriff, I mean a bunch of people.

Q: Were you supposed to be one of the ones that was going to be interviewed?

A: Yes.

Q: Okay. How many times had you been offered a

consent order in this case to turn in your paramedic credentials?

A: Twice.

Q: Have they ever offered you anything that didn't include turning in your paramedic credentials?

A: No.

Q: Okay. Why have you chosen to file this request for contested case hearing?

A: Because I feel that the way I was treated when I showed up to DHEC was wrong. It robbed me of my due process rights. And if as squeaky a wheel as I am, if they'll do it to me, there's no telling how many other people they've pushed into one over fear of them not having a job. Fact of the matter is I do this because I want to. I make a fairly good living on my military disability and retirement. So I don't have to be a paramedic. But I have a set of skills in a community that could certainly utilize those skills. And it seemed to me to be a waste to just sit at home and not use them. But I was not going to tolerate people telling me that the medicine that I provided that gentleman because their knowledge of the body or up to date medicine, they can't keep up with it, is

bad medicine because it saved hundreds of lives overseas. And it's founded on science and evidence, not on old time and not wanting to change and being stuck in old ways. It was a direct attack on my credentials or on my credibility and on my integrity. And that's not one of those things that I'm accustomed to turning a blind eye to.

Q: About a year ago there was a tragic shooting in Anderson County, a little town called Townville I think it was. I'm sure you're familiar with that.

A: Yes, sir.

Q: Okay. The little boy, Jacob, that lost his life when a bullet went through his femoral artery, have you seen that kind of injury before in your experience as an SF Medic?

A: Yeah. I suffered nearly the same injury, or pretty close to the same injury.

Q: Given your training as an SF Medic, do you believe that if you were on the scene providing primary care to that patient, that you could have saved that boy's life?

A: Absolutely.

Q: Okay. Would you have gotten out the protocol

book to put that patient on a spine board first?

A: Absolutely not.

Q: Would you have gotten the protocol book out and started an IV on that patient?

A: Absolutely not.

Q: But that's what the protocol says you're supposed to do.

A: Well the protocols, especially with the IV portion says assess patient for indications. Until you get bleeding stopped there's not an indication for an IV. Saline doesn't save lives. There's no lifeline to a bag of saline. If it was then when we give transfusions, we'd get transfused with saline, not blood. While it's a volume expander, meaning it can be used in the short term to replace a little bit, that little boy needed a surgeon. The wound should have been packed ---

Q: Is that ---

A: --- appropriately.

Q: --- how you were saved in Afghanistan?

A: Yes.

Q: Okay. And who saved you in Afghanistan?

A: My team Sergeant.

Q: How did they know how to do that in Afghanistan?

A: Over training that I provided.

Q: Could your team mates in Afghanistan have saved that boy's life in Townville?

A: Yes.

Q: If you had trouble stopping the bleeding at Townville with trying to pack the wound, could you have done that surgically?

A: Yes, I could have.

MR. WICEVIC: Your Honor, this is going on very far. I just don't understand the relevance.

MR. ROTHSTEIN: Well, Your Honor, part of this case is DHEC has this obligation to protect the public. And that's what we're here about today. And Mr. Davenport's skills as a medical technician have been attacked. And I'm just trying to show that the interest of the public is served by him having a paramedic license and being allowed to get in the field, rather than having his paramedic license revoked permanently and voided.

THE COURT: And I've got that, but I don't think we need to proceed on down the subject.

Q: Thank you, James.

MR. ROTHSTEIN: And, Your Honor, that rests our case.

THE COURT: Okay.

MR. WICEVIC: Your Honor, can I take a quick break. I really gotta use the restroom?

THE COURT: Okay. We'll do a ten here.

MR. ROTHSTEIN: And I think he's already, I mean he took his cross-examination first. I don't think he gets another bite at the apple.

THE COURT: Well ...

MR. WICEVIC: It won't take long. I promise you that.

THE COURT: Okay. Well we'll take a ten minute break before.

(Off the record from 3:46 p.m. until 4:01 p.m.)

THE COURT: If everyone's ready I'll reconvene the hearing. And, Mr. Wicevic, Mr. Rothstein is correct that you did do your cross initially. But I am going to allow you to do a short ...

MR. WICEVIC: Yes, Your Honor.

THE COURT: Yeah. Recross. But just make sure you keep it short and narrowly tailored.

MR. WICEVIC: Yes, Your Honor.

MR. DAVENPORT - RECROSS-EXAMINATION BY MR. WICEVIC.

Q: Mr. Davenport, you refused to take that

Principles of Ethics and -- PEPL leadership course, isn't that correct?

A: That's not true. I never refused to take it.

Q: Didn't you say in the interview, I won't be coming to that class?

A: Yeah, in June.

Q: Okay. So you were going to take it later?

A: Yes.

Q: And have you?

A: No. Because this thing hasn't been settled yet.

Q: Well you understand that you're still authorized to practice?

A: No. I did not.

Q: Mr. Rothstein didn't ---

A: No, no. I ---

MR. ROTHSTEIN: Your Honor, I'm going to object to anything that I discussed with Mr. Davenport. That's clearly ---

THE COURT: Right.

MR. ROTHSTEIN: --- attorney client privilege.

THE COURT: Right. It is.

MR. ROTHSTEIN: That's clearly an improper question.

Q: All right. Well let me ask you this. Do you understand that the PEPL class is aimed at

improving communication skills?

A: I'm sorry.

Q: The PEPL class is ---

MR. ROTHSTEIN: Your Honor, the PEPL class has nothing to do with why we're here today. The PEPL class was never imposed as a condition by DHEC. This was a condition that Dr. Kickham at Anderson imposed. The class wouldn't have been scheduled till two months down the road. So, I mean, this has nothing to do with the hearing.

THE COURT: I mean I think he's already testified that he didn't refuse to take the PEPL class.

MR. WICEVIC: Right. He also testified about his communication skills, and I think the PEPL class is specifically aimed at improving those communication skills people skills.

THE COURT: But he stated that he did not refuse to take it.

MR. WICEVIC: Right. Well I was asking him if he was aware of the aims of that class.

THE COURT: Okay. I'm going to allow you to ask your question.

MR. WICEVIC: I'll move on

THE COURT: Okay.

Q: Okay. There was some discussion in your direct testimony or I guess it's cross about organs being suspended by ligaments, is that correct?
A: Yes.
Q: But you do understand that when you do move, whether it's standing up, walking, sitting down, that those organs are moving?
A: Yes.
Q: Is that correct?
A: Yes. To a degree. I mean your liver can't end up in your pelvis.
Q: Right. And they're not going to come through your throat?
A: Yes. I mean the amount that each organ moves is completely dependant upon that organ itself.
Q: Right.
A: And where it's attached inside the body. There's not a uniform degree to which each organ moves inside the body. Everything is a little different.
Q: But the principle that as you move your organs move, you'd say that's correct?
A: Yes.
Q: Okay. Let's talk about blood pressure not being an early sign on shock. Is that what

you're testimony was?
A: I said it is not the most reliable indicator of a patient going into shock.
Q: But in your diagram here, that's the first thing listed as an early sign of shock, correct?
A: What are you talking about?
Q: The ten milliliters of mercury from baseline?
A: You see where it says map?
Q: Yes, sir.
A: You know what that means? That's mean arterial pressure. Do you now how that's calculated?
Q: I'm not testifying. You can explain for the record.
A: But you can't measure that in the field.
Q: Okay. But does that mean blood pressure's going down?
A: Just because the map changes doesn't mean the systolic blood pressure changes.
Q: Does that mean the blood pressure's going down?
A: No.
Q: Okay.
A: Again, just because the map changes doesn't mean the systolic blood pressure necessarily changes.

Q: Okay. You also testified about 500 CC's of blood being I guess lost for this particular patient?

MR. ROTHSTEIN: That's not what he ---

A: No. We were making an analogy about giving blood.

THE COURT: No. I remember the testimony. That's not what he testified.

MR. WICEVIC: Okay. I must have been mistaken.

THE COURT: I believe his testimony was that when you donate blood, that's generally the amount of blood that's removed.

Q: Well let me ask you this, do you know how much blood this patient lost?

A: Do I have an estimate, a total estimate? Yeah. Probably somewhere in the neighborhood of -- I mean are you talking about operatively or are you talking about in the field?

Q: I'm talking about in the field when you rode him.

A: I have an estimation of what was visible, yes.

Q: Okay. And what was that estimation?

A: About 5 CC's.

Q: 5 CC's. I'm sorry. Do you acknowledge that, you know, there was a discussion about bringing

the required equipment to the scene?
A: Uh-huh.
Q: And you're not going to carry the whole truck. That's common sense. There are two EMT's on the truck, correct?
A: Yes.
Q: And y'all both can take equipment. You can take the equipment bag, correct?
A: Yes.
Q: Ms. Aiken could take the carrying device, correct?
A: Depends on what carrying device is needed. You don't know that until you get to the patient. You can take a carrying device and then have to go back and get a different one 'cause the one you brought is the wrong one. So why not just cut that right out, assess what you have, and begin treating.
Q: Fair enough.
A: Can't treat it until you assess it.
Q: Okay. So this patient is sure footed. You know he's surefooted with a knife in his stomach?
A: I watched him ambulate.
Q: When did you watch him ambulate?

A: When he was ambulating.
Q: When you were assisting him?
A: Yes.
Q: Okay. Stomach muscles are engaged whenever you move?
A: Yes.
Q: So when you're walking, the logical following would be those muscles and your abs are moving then too.
A: That's correct. They're also engaged when you're being moved.
Q: And when you're sitting or standing still, or laying down?
A: They're always moving. They're always engaged. Unless you're completely relaxed.
Q: If you're in a static position?
A: Not necessarily. Just because you're -- I mean you're in a static position right now.
Q: Okay. What I'm getting at is when you're seated, there's less of a chance of those muscles moving, correct?
A: That's all dependant on the patient.
Q: Okay.
A: It isn't a they are or aren't. It's situationally dependent.

Q: Would you say this particular patient had issues with getting along with Officer Boucher?
A: That' patient -- so first of all he has an extensive psycho-social history. Who he gets along with is dependent on the day of the week.
Q: From your observation at this particular scene?
A: Yes. He seemed to get along with Officer Boucher fine.
Q: Officer Boucher's in a position of authority, correct?
A: Yes.
Q: Okay. And you agree there's a difference between sugar coating something and treating somebody with respect, correct?
A: I would not categorize the way Officer Boucher talked to that patient anymore respectful than I did.
Q: Well I wasn't asking that. I was asking if you consider a distinction between sugar coating and treating somebody respectfully?
A: Yes.
Q: Okay. The consent orders that were offered by the Department, they weren't offered on a take it or leave it basis.
A: It said do your suspension or I could appeal.

Q: After that?
A: Then it was a year or I could appeal. But after that there wasn't ---
Q: Well if there was a subsequent offer it wasn't a take it or leave it basis, correct?
A: What do you mean subsequent offer?
Q: There's two consent orders?
A: Yes. The first one after we met, and then the one after the IRC.
Q: Right. And I just want to be clear that the proposed consent orders were not to revoke your certificate.
A: If I'm not practicing, it may as well be. It's just a difference in time.
Q: Right. So the suspension. Those were ---
A: Still can't practice.
Q: Correct.
A: So it's a matter of semantics at that point.
Q: Okay. And am I correct that you haven't practiced as a paramedic since this incident?
A: I have not practiced on an ambulance since this incident in South Carolina.
Q: I think that's all I have for you. Thank you, Mr. Davenport.
THE COURT: Mr. Wicevic, let me correct myself. He

did not testify about the 5 CC's. He said 500 CC's was the amount that's normally extracted during blood donation. I think that's all we've got. Mr. Davenport, thank you.

MR. DAVENPORT: Thank you, Your Honor.

THE COURT: Mr. Rothstein, that's your last witness?

MR. ROTHSTEIN: Yes, Your Honor. We rest.

THE COURT: Okay. Thank you. Do you have anything in this ---

MR. WICEVIC: No, Your Honor.

THE COURT: Okay. Good. Okay. I think we're ready for closing. It's been a long week.

MR. ROTHSTEIN: I do have just a housekeeping matter. I think there was some confusion about exhibits. I think the court reporter said that 14 was in, but he was looking at the Department's 14 and not my ---

THE COURT: Not the Respondent's 14.

COURT REPORTER: Were you asking about yours or ---

MR. WICEVIC: I think you were asking about DHEC's.

MR. ROTHSTEIN: I want to make sure DHEC 14 ---

THE COURT: Yeah. I thought we ---

COURT REPORTER: Right. That one is in. I don't have it checked.

MR. ROTHSTEIN: Yeah. I guess it was DHEC 14 that I

wanted to make sure was in.

THE COURT: Okay.

MR. ROTHSTEIN: And then I also want to make sure Respondent's exhibit 2 is formally moved into evidence. That was the grievance complaint.

MR. WICEVIC: Your Honor, the same objection that we continuously logged.

THE COURT: What's the purpose of the, what relevance does the grievance complaint, since it was filed after ---

MR. ROTHSTEIN: Well I think he testified that it reflects things that he had brought up before. I don't need the document in. I mean I'm happy to withdraw if that'll make it easier.

THE COURT: Okay. I'm not inclined to ---

MR. ROTHSTEIN: Thank you, Your Honor.

THE COURT: --- admit that. Okay. Does that -- all the evidentiary issues are dealt with?

MR. ROTHSTEIN: Yes, ma'am.

THE COURT: Okay. Good. Now we're ready to move onto closing statements. And let's keep the closing statement's brief because y'all presented a lot. So we've got a lot to consider in this case.

MR. WICEVIC: Yes, Your Honor.

CLOSING STATEMENT BY MR. WICEVIC:

MR. WICEVIC: Your honor, it's a touch decision to revoke a certificate or license. It's probably the harshest sanction the Department has. It often includes somebody's likelihood, often includes their passion. And I know Your Honor doesn't take it lightly. I know our staff doesn't take it lightly. However, we considered the facts of this case, previous endorsements that we've taken, and we took the recommendation of the IRC, and determined that revokation was the most appropriate action here. The Department's charged with protecting the public health, and without any kid of assurance from Mr. Davenport regarding this incident, we have some significant concerns. We have a serious fear that something will happen again. And while this case didn't result in any adverse outcome's, our fear is that the next one will. Mr. Rothstein mentioned during his motion for directed verdict that the Department doesn't understand what a de novo hearing is. I suggest that we do. And we fully understand that Your Honor acts as the fact finder. That's correct. The

Court does not owe deference to our factual findings. Instead the Department's charged with producing the evidence to support our allegations. And I think we have produced enough evidence in this matter to support the findings of misconduct and unacceptable medical treatment. Beginning with the first one, disregarding an appropriate order by a physician concerning emergency treatment. There's a preponderance of evidence in the record that supports finding that Mr. Davenport failed to comply with the orders prescribed by the Anderson County Standards of Care Treatment protocols. We had Dr. Deschamps and Mr. Wronski testify about the distinctions between orders and protocols. Protocols guide decisions, criteria for diagnosis, and management of patients. Standing order on the other hand is a specific policy that prescribes a definitive action taken in a particular condition or situation. I think an additional guiding principle is interpreting the Anderson County Standards of Care through the mind of an EMT. This Court knows by now EMT's receive specialized education by where they learn

technical terms, and they use those technical terms in their industry. They learn and understand pre-hospital care terminology, and there is significant decision making in the practice of EMS. There's a lot of going back and forth between standards of care and protocols. That's how the practice works. It's not cookbook medicine, it's not monkey medicine. I suggest to you Mr. Davenport's reading of this completely removes orders from the Anderson County Standards of Care protocols. And that's absurd. It's one of many fallacies in his case. Mr. Davenport is accustomed to the practice of a Special Forces Medic, and he has apparent problems with taking orders from his Med. Control Physician, considers himself on par with these physicians, and PA's, and surgeons. And while he may have specialized form of training and education, and that's more than an ordinary South Caroline, he's still constrained by the same practice as any other South Carolina paramedic. So these are the final orders that we determined that he, Mr. Davenport violated. GP-18, demonstrate professionalism and courtesy. The body cam

speaks volumes. Mr. Davenport's characterization, his words and behaviors, and being terse and matter of fact I think just shows a general disconnect from the truth. GP-16, patient should not ambulate to the ambulance or transport. All patients need an appropriate carrying device. Again, the body cam testimony showed this improper transfer. He failed to use a carrying device. Trauma protocols, the patient's injury was critical trauma that any EMT using rational judgement would now triggers the trauma protocols. T-2 specifically lists penetrating abdominal injuries as traumatic in juries. Circumstances of this case, not knowing the length of the knife blade would lead a prudent paramedic to precaution proceeding with this injury and acting as if it were a multiple trauma injury. Further, the characteristics of this injury would also lead a prudent paramedic to proceed with the thought that shock was a substantial possibility. Mr. Davenport failed to recognize these concepts. Furthermore, because of the serious traumatic injury, the patient needed IV therapy. There's multiple protocols and orders

within Exhibit 1 that require IV therapy. T-3 requires initiate IV access in route to ED. Also says initiate IV access protocol. T-1 says that all IV lines will be established en route. Finally GP-3, intravenous protocol directs IV access and normal saline solution are appropriate for these types of trauma patients. Mr. Davenport points out some absurd examples of trauma injuries, a broken toe or broken pinky. I think a little common sense tells you that those injuries don't require IV's. This goes back to the basic principle, using some reasonable pre-hospital educated judgement in this case. Dr. Deschamps, Mr. Douglas, and Mr. Wronski all testified about this approach. Because of this injury, the patient also require oxygen therapy. Mr. Davenport failed to provide that. The protocol specifically orders trauma mechanism of injury and or severe trauma specifically listed in G-3, specifically ordered. It's not a trauma patient with respiratory distress and a trauma patient. It's not a certain pulse oximetry level. Simply to say, it's trauma. Again, EMT'S are expected to use their education and

training in reading these various protocols and orders. Finally, last thing, patient required cardiac monitor as specified in T-3. Specifically directs paramedics to initiate cardiac monitor lead two. Now whether an EMT agrees with Medical Control Physician's protocols is not significant. Whether the Physician's protocols and orders are based on the latest needs based medicine is not significant either. The EMT's operating under that Med. Control Physician's license and is therefore bound to that direction. It's just the nature of being a civilian EMT here in South Carolina. Mr. Davenport signed up for it, signed the Medical Control Agreement, he attested in the Anderson County Standards of Care and Treatment protocols are medically acceptable as testified by Dr. Deschamps, if you don't exceed the State protocol ceilings. Therefore Mr. Davenport needs to comply with them and he failed to do so. Second misconduct, after initiating care, he discontinued such care without the patient's consent without providing further administration of care by an equal or higher

medical authority. Similarly, there's some evidence in the record finding that he did this. He transferred care to Ms. Aiken, a lower level provider without the patient's consent. Despite Mr. Davenport's independent determination to the contrary, this patient required advanced life support, notably the establishment of IV access, supported by the protocols, supported by emergency medical standards. Mr. Davenport knew this patient was going to surgery. A trauma alert was called by the hospital nearly the same time that he arrived. Against all odds, he still maintained with basic life support. Notably Mr. Davenport's action of transferring this care to Ms. Aiken also violated Anderson County's policies regarding management of care. She wasn't reasonably -- she wasn't qualified to meet the patients reasonably perceived needs. The patient himself was ineligible because of his injuries, required ALS intervention, there was a possibility of multiple trauma, and because Ms. Aiken expressed apparent discomfort whether it's not verbal, with riding the call. The patient was ineligible for transfer. Mr.