THE STATE OF SOUTH CAROLINA
In The Court of Appeals

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

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SC Court of Appeals

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

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

v.

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

RECORD ON APPEAL
VOLUME 1 OF 4

Ashley C. Biggers, Esquire
Vito M. Wicevic, Esquire
South Carolina Department of Health
and Environmental Control
2600 Bull Street
Columbia, SC 29201
(803)898-3350
Attorneys for Appellant/Respondent
South Carolina Department of Health
and Environmental Control

David E. Rothstein, Esquire
Rothstein Law Firm, PA
1312 Augusta Street
Greenville, SC 29605
(864)232-5870
Attorney for Respondent/Appellant
James W. Davenport

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STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

South Carolina Department of Health and Environmental Control,	)	Docket No.: 17-ALJ-07-0003-CC
Petitioner,	)	
	)	**FINAL DECISION AND ORDER**
vs.	)	
James W. Davenport,	)	
Respondent.	)	

APPEARANCES: For the Petitioner: Vito Wicevic, Esquire
Ashley C. Biggers, Esquire

For the Respondent: David Rothstein, Esquire

STATEMENT OF THE CASE

This matter is before the South Carolina Administrative Law Court ("the ALC" or "the Court") pursuant to a Request for Contested Case Hearing filed by James W. Davenport ("Respondent"). Respondent is challenging the South Carolina Department of Health and Environmental Control's ("DHEC" or "the Department") Administrative Order revoking his South Carolina Emergency Medical Technician-Paramedic Certification based upon DHEC's findings that Respondent failed to provide emergency medical treatment of a quality deemed acceptable by DHEC and that Respondent was guilty of misconduct. DHEC issued the Administrative Order on October 21, 2016, and Respondent filed a Request for Final Review with the South Carolina Board of Health and Environmental Control ("the Board") on November 7, 2016. Respondent was notified on December 7, 2016 that the Final Review request was denied. On January 7, 2016, Respondent filed a Request for Contested Hearing with the ALC.

A hearing on the merits of the case was held before the undersigned on July 24, 2017 through July 28, 2017, at the ALC in Columbia, South Carolina.

FINDINGS OF FACT

Having observed the witnesses and exhibits presented at the hearing and closely passing upon their credibility, and taking into consideration the burden of persuasion by the parties, the

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Court makes the following findings of fact as shown by a preponderance of the evidence:

1. Respondent is the holder of an EMT-Paramedic certification issued by DHEC that expires on March 15, 2020. On the evening of March 19, 2016, while working with the Iva Rescue Squad, Respondent's ambulance responded to a 911 call for a patient who reportedly stabbed himself in the stomach in an apparent suicide attempt. Kimberley Aiken, who is certified as an EMT-basic, rode the call with Respondent. Because the patient had a history of psychosocial issues, the patient was well-known among members of the Iva Rescue Squad. The patient's history included multiple attempted suicides involving overdoses on prescription medications and a self-inflicted gunshot wound. When Respondent and EMT Aiken arrived at the patient's residence, officers from the Iva Police Department were already at the scene. One of the officers, T. J. Busha, activated his body-camera when he arrived at the scene, and the body-cam footage was admitted into evidence during the contested hearing.[1]

2. Respondent's initial appearance on the body-cam footage shows him entering the patient's residence with an equipment bag where the patient is sitting on a sofa with a knife embedded in his abdomen and talking with the police officers. After momentarily observing the patient, Respondent made the following statement: "You ever been told you're an idiot. You're being told it right now." The patient continued talking to the officers and eventually stated "it hurts", to which Respondent responded "Yea, well that's what the f**k happens when you stab yourself in the belly with a knife." While Respondent bandaged the wound and stabilized the knife, one of the officers explained that the patient stabbed himself approximately twenty minutes prior to the officers' arrival. When the officer explained that the patient stated he hoped to bleed out, Respondent responded by telling the patient "You stabbed yourself in the wrong spot. That's not where your heart is." The patient responded that he did not know where his heart is but maybe he will know the next time. When Respondent asked the patient why he was trying to kill himself, the patient stated he was trying to kill himself because of his nerves. Respondent made the following statement in response, "I don't want to hear that. I stepped on a goddamn IED and blew my nuts off."

3. After Respondent informed the patient he would have to be transported to a hospital with an operating room for the knife to be removed, the patient inquired about the operation and

[1] The Court recognizes that everything was not captured in Officer Busha's body camera video, as the body camera was worn in the front and only displays the area Officer Busha is facing at any given moment.

made a reference to stabbing himself in a different place the next time, to which Respondent responded, "Let's just don't be stupid." Officer Busha and Respondent assisted the patient as he walked out of the residence where he was placed on a stretcher and loaded into the back of the ambulance. As Respondent was closing the ambulance door, Officer Busha inquired if everything was good, to which Respondent responded, "yeah man, f**king stupid people." Prior to leaving the patient's home, Respondent can be heard while speaking with EMT Aiken, stating, "I'm not doing anything for him." A short time later, Respondent and EMT Aiken left the residence to transport the patient to AnMed Medical Center. Respondent drove the ambulance and EMT Aiken rode in the back with the patient.

4. On March 22, 2016, Scott Stoller, Director and Chief Paramedic for Anderson County EMS served Respondent with an official notice informing him that three of his calls were being investigated, and Respondent was immediately suspended. The March 19, 2016 call was among the calls being investigated. Subsequently, in a notice dated March 22, 2016,[2] Mr. Stoller informed Respondent that the investigation was complete, and Respondent needed to comply with three requirements before he could return to work as a full status paramedic. The three requirements were: (1) a protocol test administered by Mark Henderson at MedShore Ambulance Service; (2) successful[ly] complete the NAEMT Principles of Ethics and Personal Leadership ("PEPL") class offered by SC DHEC EMS; and (3) maintain a 100 percent on his QA/QI review for ninety (90) days. At the time of the hearing, Respondent had fulfilled two of the requirements, but had not completed the PEPL class.

5. On March 25, 2016, Dr. Arnold Alier, Director of EMS at the SC DHEC Bureau of EMS, received Respondent's QA review from Mr. Stoller. The QA review addressed the three calls involving Respondent that were investigated by Anderson County. Dr. Alier took no further action believing the issue was properly handled through Anderson County's QA process. However, on April 13, 2016, Mr. Stoller forwarded a google drive to Dr. Alier that contained the body-cam video footage of the March 19, 2016 call. After viewing the video footage, Dr. Alier shared the footage with other Department personnel, and an investigation of Respondent was initiated on April 14, 2016.

6. On April 19, 2016, Respondent met with several individuals from DHEC, including

[2] Although the notice is dated March 22, 2016, Respondent testified that the notice was incorrectly dated and should be dated for March 25, 2016, which is the date he was served with the notice.

Robert Wronski, Bureau Chief of DHEC's Bureau of EMS and Trauma, and Richard Naugler, the investigator assigned to Respondent's case. During the meeting, Respondent was questioned about the three calls investigated by Anderson County that were addressed in the QA review provided by Mr. Stoller. Respondent was also shown the video footage of the March 19, 2016 call. Following the interview, the Department determined two of the calls were appropriately dealt with at the local level and no further actions were needed. However, the Department identified several acts related to the March 19, 2016 call that were deemed as violations by Respondent. Approximately two weeks after the meeting with Respondent, the Department contacted Respondent and offered him a consent order to resolve the matter. Under the proposals in the consent order, Respondent's EMT-Paramedic Certification would be suspended for two years. Respondent refused to sign the proposed consent order and retained an attorney.

7. An Investigative Review Committee ("IRC") was convened on June 23, 2016 to review the information gathered as part of the Department's investigation and to make recommendations on the matter. Respondent and his attorney were present for the IRC meeting, although Respondent's participation was limited. Ultimately, the IRC recommended the suspension of Respondent's EMT-Paramedic Certification for a period of one year; that Respondent undergo a comprehensive psychiatric evaluation by a licensed physician and complete any treatment ordered; and that Respondent complete two training courses. The IRC also recommended that the Department revoke Respondent's EMT-Paramedic Certification if Respondent refused to sign a consent order agreeing to comply with the IRC's recommendations.

8. The Department proposed and Respondent refused to sign the consent order containing the IRC's recommendations. On October 21, 2016, the Department issued an administrative order revoking Respondent's EMT-Paramedic Certification because of Respondent's alleged misconduct on March 19, 2016. Specifically, the Department found that Respondent disregarded appropriate treatment orders, discontinued care of a patient without providing for further administration of care by an equal or higher medical authority, and created a substantial possibility that death or serious physical harm could result from his actions or inactions. On November 7, 2016, Respondent filed a Request for Final Review with the Board challenging the Department's administrative order. On December 7, 2016, the Board mailed Respondent notice of its decision declining to conduct a final review conference. Respondent filed a request for a contested hearing with the ALC on January 6, 2017.

9. Dr. Edgar DesChamps serves as the State Medical Control Physician and was chairman of the IRC that reviewed Respondent's case. During the contested hearing, Dr. DesChamps testified for the Department and was qualified as an expert in emergency and internal medicine. He testified that Anderson County's Standards and Protocols were in line with protocols recommended by the Department, and were appropriate in terms of generally accepted emergency medicine standards. Dr. DesChamps also testified that the patient suffered a critically traumatic injury that required advanced life support care, and that Respondent disregarded several of Anderson County's standards and protocols while caring for the patient. In addition, Dr. DesChamps opined that Respondent's actions and inactions, including Respondent's ambulation of the patient, failure to ride in the compartment with the patient while the patient was being transported to AmMed, and failure to establish an IV, created a substantial possibility of death and serious physical harm to the patient.

10. Harry Dean Douglas, a paramedic and prehospital care instructor, testified on the Department's behalf and was qualified as an expert in prehospital medical care and education. Mr. Douglas testified that the patient's injury was a critical trauma, and Respondent violated several generally accepted standards of prehospital care while caring for the patient. Specifically, Mr. Douglas testified that Respondent's posture was inappropriate, and ambulating the patient from the home to the ambulance posed a substantial risk of further injuring the patient. Finally, Mr. Douglas opined that generally accepted prehospital standards of care required IV access, and required an advanced EMT or EMT-paramedic ride in the patient care compartment while the patient was being transported.

11. Dr. Thomas Kickham, who was Anderson County's medical control physician at the time of the incident, testified about specific County standards and protocols Respondent is alleged to have violated while responding to the March 19, 2016 call. Dr. Kickham testified that the call involved a trauma patient who required advanced life support ("ALS") care and Respondent violated County protocols by providing basic life support ("BLS") care. Specifically, Dr. Kickham testified Respondent did no assessment of the patient's airway and did not establish an intravenous (IV) access. He additionally testified protocols were violated when Respondent entered the patient's residence without all his equipment and when he failed to document the patient's vital signs. Dr. Kickham also testified that while he might view the patient as a trauma patient, someone else might view the situation differently because the patient was talking with the

knife in his abdomen. A bee sting, stubbed toe and hang nail were examples given by Dr. Kickham of injuries that are also viewed as traumas. He further stated that in certain situations a paramedic must depend on his or her own judgment of what treatment is needed.

12. Respondent testified that he did a visual assessment of the patient when he initially entered the residence, and took the patient's dorsal pulse. Following the assessment, Respondent stated he determined this was not a trauma situation. According to Respondent, he was aware of the patient's mental status and made subjective judgement calls while weighing the patient's pain with scene safety. Respondent testified he analyzed how to remove the patient from the home while he was stabilizing the knife, and because his biggest concern was dropping the patient, determined it was best to have the patient walk from the residence, with assistance, to the stretcher. When the patient expressed discomfort when instructed to lay down on the stretcher, Respondent stated it was his judgement that the patient would be less inclined to pull the knife out while in transport if the knife was not visible. Respondent testified he believes he handled the patient appropriately, however he expressed regret for his choice of words, and if he should have done anything differently, it would have been using different words while speaking to the patient and moving at a slower pace at times while assisting the patient from his home to the stretcher.

13. Dr. Frank J. DeAngelo, a trauma surgeon at the Atlantic City Regional Medical Center, Atlantic City, New Jersey, testified on Respondent's behalf. Dr. DeAngelo was qualified as an expert in diagnosing and treating trauma patients, and also testified that he previously treated patients with abdominal knife wounds. In his testimony, Dr. DeAngelo stated the patient didn't require supplemental oxygen or an IV, and no medicine was needed while the patient was being transported. He also testified that allowing the patient to walk slowly with assistance was not problematic because the patient looked relaxed in the supine position while on the stretcher, and he noted that patients usually cross their legs when in pain. Dr. DeAngelo additionally testified that by observing how the knife was positioned in the body and the stability of the patient, Respondent could have formulated some idea of the knife's path and whether any vital organs were wounded. He also noted that based on Respondent's prior interactions with this particular patient, there is a possibility that Respondent's demeanor could have been calming. Dr. DeAngelo concluded by stating that it is his professional opinion that Respondent's actions were based on sound judgement and were appropriate.

14. Leo Deason, Emergency Medical Services Department Chair and Instructor at

Herzing University, Trussville, Alabama, also testified on Respondent's behalf. Mr. Deason was qualified as an expert in emergency medical education and standards of care for nationally certified paramedics. According to Mr. Deason, when a wound is abdominal, unless a major organ is severed or punctured, an EMT's primary concern is the possibility of an infection, which cannot be corrected in the field. He testified that a patient's expression of pain while moving or ambulating is the best way of accessing the patient's pain level. In addition, he stated that any decision on how to best move a patient is based on the situation at the scene since moving a patient with an impaled object is always risky. Under the circumstances involved in this case, Mr. Deason stated that Respondent's decision to ambulate the patient from the sofa to the ambulance was proper. He also stated the patient did not need an IV and using one in this instance would not have been beneficial because there was no indication of shock in the patient. Mr. Deason testified that the Department's contention that professional standards require an IV, oxygen and monitoring for all trauma patients is incorrect as this method has been obsolete since 2010. It was his professional opinion that Respondent met the generally accepted standards of care in treating the patient; however, Respondent was rude to the patient.

CONCLUSIONS OF LAW

Based upon the foregoing Findings of Fact, the Court concludes the following as a matter of law:

1. The Court has jurisdiction over this contested case pursuant to S.C. Code Ann. § 1-23-310 to -390 (Supp. 2016); S.C. Code Ann. § 1-23-600(A) (Supp. 2016); S.C. Code Ann. § 44-1-60(F) (Supp. 2016); and S.C. Code Ann. § 44-61-70(A) (Supp. 2016); and 3 S.C. Code Ann. Regs. 61-7 § 3-4(H) (2011).

2. DHEC is responsible for administering the Emergency Medical Services Act of South Carolina. S.C. Code Ann. § 44-61-30(A) (Supp. 2016). Included in DHEC's administrative responsibilities is the training and certification of emergency service personnel. S.C. Code Ann. § 44-61-30(B)(4) (Supp. 2016).

3. DHEC is charged with developing standards and regulations for the improvement of emergency medical services in this State. S.C. Code Ann. § 44-61-30(A) (Supp. 2006). Pursuant to its authority, DHEC promulgated Regulation 61-7, Emergency Medical Services.

4. All ambulance attendants must obtain a valid EMT certificate from DHEC. S.C. Code Ann. § 44-61-80(A) (Supp. 2016). An EMT is statutorily defined as an individual possessing

a valid EMT, advanced EMT, or paramedic certificate issued by the Department pursuant to the provisions of this article. S.C. Code Ann. § 44-61-20(12) (Supp. 2016). A "certificate" is an "official acknowledgement by DHEC that an individual has successfully completed one of the appropriate EMT training courses and requisite examinations, which entitles that individual to perform the functions and duties as delineated by the classification for which the certificate was issued." S.C. Code Ann. § 44-61-20(6) (Supp. 2016).

5. DHEC may take enforcement action against the holder of an EMT certificate "any time it is determined that the holder no longer meets the prescribed qualifications set forth by [DHEC] or has failed to provide to patients emergency medical treatment of quality deemed acceptable by [DHEC] or is guilty of misconduct." S.C. Code Ann. § 44-61-80(F) (Supp. 2016).

6. Misconduct under the EMS Act means, among other definitions, that the certificate holder:

> ...
>
> (6) disregarded an appropriate order by a physician concerning emergency treatment or transportation;
>
> (8) after initiating care of a patient at the scene of an accident or illness, discontinued care or abandoned the patient without the patient's consent or without providing for further administration of care by an equal or higher medical authority;
>
> (14) by his actions or inactions, created a substantial possibility that death or serious physical harm could result;
>
> ...

S.C. Code Ann. § 44- 61-80(F)(6), (8), and (14) (Supp. 2016).

7. Additionally, pursuant to Regulation 61-7 § 1000(A) (2011),

> "During the transportation of patients, there shall be an EMT, EMT-I, AEMT or Paramedic in the patient compartment at all times. The crew member with the highest level of certification shall determine which crew member will attend the patient during transport. If advanced life support procedures are in use, the responsible EMT-I, AEMT or Paramedic shall attend the patient in the patient compartment during transport."

8. When DHEC decides to take enforcement action against the holder of an EMT certificate, it may either suspend or revoke the holder's certification. See generally S.C. Code Ann. § 44-61-80 (Supp. 2016).

9. "Suspension" means that DHEC has temporarily voided a license, permit, or certificate and the holder may not perform the function associated with the license, permit, or

certificate until the holder has complied with the statutory requirements and other conditions imposed by DHEC. S.C. Code Ann. § 44-61-20(31) (Supp. 2016).

10. "Revocation" means that the Department has permanently voided a certificate and the holder no longer may perform the function associated with the certificate. Additionally, the Department will not reissue the certificate for a period of four years, and at the end of the four-year period, the certificate holder may petition for reinstatement. S.C. Code Ann. § 44-61-20(28) (Supp. 2016).

11. Where an expert's testimony is based upon facts sufficient to form the basis for an opinion, the trier of fact determines its probative weight. See Berkeley Elec. Coop. v. South Carolina Pub. Serv. Comm'n., 304 S.C. 15, 402 S.E.2d 674 (1991). A trier of fact is not compelled to accept an expert's testimony, but may give it the weight and credibility he determines it deserves. See Florence County Dep't. of Social Services v. Ward, 310 S.C. 69, 425 S.E.2d 61 (1992). When several expert witnesses testify regarding a matter in controversy, it is incumbent on the trial court to carefully weigh and consider the evidence presented by each.

DISCUSSION

The Department alleges Respondent violated S.C. Code Ann. § 44-61-80(F)(6) and 3 S.C. Code Ann. Regs. 61-7 § 1100(B)(6) by disregarding appropriate physician orders concerning emergency treatment or transportation of a patient. It is the Department's contention that the physician orders Respondent violated were a part of Anderson County's EMS standards and protocols. The Department's expert Dr. DesChamps testified that various orders contained in the County's standards and protocols are compliant with general practice and principles of emergency medicine and are in accordance with the scopes of practice of the different certification levels of EMTs. However, Dr. Kickham, who wrote Anderson County's standards and protocols that were being used at the time, testified that he is not aware of any direct physician order that Respondent might have violated while caring for this patient.

In addition, the Department contends Respondent violated S.C. Code Ann. § 44-61-80(F)(8) and 3 S.C. Code Ann. Regs. 61-7 § 1100(B)(8) by discontinuing care of the patient without the patient's consent and without providing for further administration of care by an EMT – paramedic of higher medical authority. Again, the Department presented extensive testimony about applicable provisions of the County's standards and protocols the Respondent violated. The main dereliction the Department alleges is Respondent allowing his partner, Ms. Aiken, to ride in

the compartment with the patient while he drove the ambulance to AmMed's Emergency Department. However, by all accounts, the patient was stable throughout the call. The patient's vital signs were within normal limits; the patient's distress level was listed as "mild"; and the patient's pain level was reported as a 4 out of 10. Both Respondent and Ms. Aiken testified that no IV was initiated, no medication was administered, and no heart monitor was hooked up. In sum, the Department hasn't established that skills higher than those possessed by Ms. Aiken, an EMT-Basic, was necessary for this patient. The Department speculates that it was possible for the patient's condition to deteriorate, however Respondent was readily available to resume care of the patient if anything changed en-route to the hospital, which is authorized by Anderson County's EMS policies.

Finally, the Department contends Respondent violated S.C. Code Ann. § 44-61-80(F)(14) and 3 S.C. Code Ann. Regs. 61-7 § 1100(B)(14) by creating a substantial possibility of death or serious physical harm in his treatment of the patient. Specifically, the Department asserts the violations occurred when Respondent directed the patient to walk out of the house to the ambulance, and to lay flat on the stretcher. It is the Department's contention that Respondent should have used a carrying device like a stair chair or long-spine board to remove the patient from the house, and that he should have allowed the patient to remain in a propped-up position instead of laying the patient flat on the stretcher. There was considerable debate during the hearing about Respondent's decision to have the patient slowly walk out of the house, with assistance, after the knife was secured in place and stabilized to minimize movement. The Department pointed to a provision in Anderson County's patient safety protocol, GP-16, which states "[p]atients should not ambulate to the ambulance", and further states "[t]ransport all patients via an appropriate carrying device." In fact, one of the Department's expert suggested that if a standard carrying device couldn't be used, Respondent could have improvised and used a kitchen chair to move the patient instead of having the patient ambulate.

There was no dispute that the patient had to be moved from the house in an expeditious manner and that any method of moving the patient involved some degree of risk because of the knife impaled in the patient's abdomen. Although witnesses for the Department offered various criticisms of Respondent's decision to walk the patient from the house, the suggested alternative methods also had apparent risks that were equal to or greater than the method chosen by Respondent. However, none of the witnesses testified that Respondent's decision was objectively

unreasonable or that no reasonable paramedic in the same circumstances would have chosen to walk the patient out of the house in the same manner as Respondent.

Respondent also explained in his testimony that his decision to lay the patient in a supine position on the stretcher was intended to prevent the patient from looking at the knife sticking out of his belly so he would be less inclined to mess with it. Again, the Department's witnesses were critical of Respondent's decision, however there was no credible evidence that laying the patient flat created a substantial possibility of death or serious physical harm. Respondent's explanation of his decision was both sensible and reasonable, and as stated by the Department's paramedic expert, Mr. Douglas, there are times when an EMT paramedic has to deviate from a protocol, and without the benefit of being at the scene it's difficult to say what Respondent's judgement calls were based on.

With regards to the profane language used by Respondent when communicating with the patient, Respondent acknowledges he was wrong in addressing a patient in this manner. Other than the improper language used by Respondent during the March 19, 2016 call, his conduct was reviewed and investigated by Mr. Stoller and Dr. Kickham prior to the Department's involvement. The curative conditions imposed by the County to be met by Respondent before full restoration of his EMT paramedic duties appears to have been appropriate, and the Department appears to have thought so initially since no investigation was started. The only issue not addressed by the County during the QA review was Respondent's improper language during the March 19, 2016 call, and I find that this issue can be addressed by Respondent's completion of the PEPL course.

Based upon the evidence presented during the contested hearing, I find there is insufficient evidence that Respondent committed misconduct, as defined by S.C. Code Ann. § 44-61-80(F)(6), (8) and (14) (Supp. 2016), and 3 S.C. Code Ann. Regs. § 1100(B)(6), (8) and (14) (Supp. 2011) such that revocation of his South Carolina EMT certification is warranted. However, Respondent by his own admission used extremely inappropriate language when speaking to the patient in question. The Department contends this conduct was a violation of Anderson County EMS's patient abuse policy, and I agree. It is apparent that the County recognized this and addressed it as part of the QA review by requiring Respondent to complete the PEPL class. Because this requirement appropriately addresses the violation, this Court will not impose additional punitive

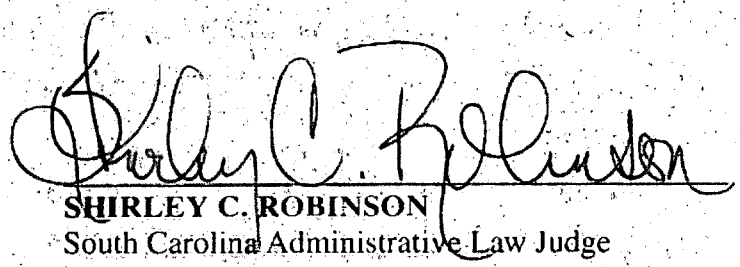
restrictions on Respondent's certification, but will mandate Respondent's completion of the PEPL class within a reasonable time period following entry of this order.[3]

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law, **IT IS HEREBY ORDERED** that DHEC's Administrative Order is **vacated**.

IT IF FURTHER ORDERED that Respondent must successfully complete the NAEMT Principles of Ethics and Personal Leadership ("PEPL") class offered by SC DHEC EMS within nine (9) months of receipt of this Order.

AND IT IS SO ORDERED.



SHIRLEY C. ROBINSON
South Carolina Administrative Law Judge

March 20th, 2018
Columbia, South Carolina

CERTIFICATE OF SERVICE
This is to certify that the undersigned has this date served this order in the above entitled action upon all parties to this cause by depositing a copy hereof, in the United States mail, postage paid, or in the Interagency Mail Service addressed to the party(ies) or their attorney(s).
This 20 day of March, 2018
By: _____
Judicial Law Clerk

[3] There was testimony that except for the NAEMT Principles of Ethics and Personal Leadership ("PEPL") class offered by the Department, Respondent has completed the conditions imposed by Anderson County following the QA review. If the Respondent successfully completed the PEPL class subsequent to the hearing, he will have met this Court's requirement.

STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

South Carolina Department of Health and Environmental Control, Petitioner, vs. James W. Davenport, Respondent.	)	Docket No. 17-ALJ-07-0003-CC **RESPONDENT'S PETITION FOR ATTORNEYS' FEES AND COURT COSTS**

Respondent, James W. Davenport, by and through his undersigned counsel, hereby submits this Petition for Attorney's Fees and Court Costs, pursuant to S.C. Code Ann. § 15-77-300 et seq. and Rule 54, SCRCP. Respondent requests that the Court order Petitioner, South Carolina Department of Health and Environmental Control, to pay the reasonable and necessary attorney's fees and costs that Respondent incurred in connection with this Contested Case, which involved extensive discovery and a one-week non-jury trial in Columbia, SC, from July 24-28, 2017. Pursuant to S.C. Code Ann. § 15-77-310, this Petition is supported by the Affidavit of Petitioner's Counsel, David E. Rothstein, which is attached hereto as Exhibit A.

Section 15-77-300(A) of the South Carolina Code provides as follows:

> In any civil action brought by the State, any political subdivision of the State, or any party who is contesting state action, unless the prevailing party is the State or any political subdivision of the State, the court may allow the prevailing party to recover attorney's fees to be taxed as court costs against the appropriate agency if:
> (1) the court finds that the agency acted without substantial justification in pressing its case against the party; and
> (2) the court finds that there are no special circumstances that would make the award of attorney's fees unjust.

S.C. Code Ann. § 15-77-300(A).

An award of attorney's fees under Section 15-77-300 lies within the sound discretion of the trial court. Heath v. County of Aiken, 302 S.C. 178, 182, 394 S.E.2d 709, 711 (1990) ("[T]he award of attorney's fees in this case will not be disturbed unless appellants demonstrate that the trial judge abused his discretion in his consideration of the applicable factors."). As the South Carolina Supreme Court has recognized, "There are three prerequisites that must be established prior to the recovery of attorney's fees and costs by a party contesting state action. First, the contesting party must be the 'prevailing party;' second, the court must find that the agency acted without substantial justification in pressing its claim against the party; and third, the court must find that there are no special circumstances that would make an award of attorney's fees unjust." City of Charleston v. Masi, 362 S.C. 505, 510, 609 S.E.2d 301, 304 (2005) (internal citations omitted).

In determining whether a party is the "prevailing party," the court must evaluate "the degree of success obtained." Heath, 302 S.C. at 183, 394 S.E.2d at 711. "[A] party need not be successful as to all issues in order to be found to be a prevailing party." Id. at 182, 394 S.E.2d at 711. Here, there can be little doubt that Respondent was the prevailing party. The Court vacated DHEC's administrative order and found that there were no grounds to support a finding of misconduct under the EMS Statute and Regulations.

Next, the phrase "without substantial justification" means that challenged action did not have any "'reasonable basis in law and fact.'" McNaughton v. Charleston Charter School for Math & Sciences, Inc., 411 S.C. 249, 267, 768 S.E.2d 389, 399 (2015). The South Carolina Supreme Court has held that "a court need not go so far as to brand a claim 'frivolous' in order for it to be found to be without substantial justification." Heath, 302 S.C. at 183, 394 S.E.2d at 712. Here, the Court found that DHEC presented "no credible evidence" to support the assertion that Respondent's

actions created a substantial possibility of death or serious physical harm; that "by all accounts, the patient [in question] was stable throughout the call," despite the Department's "speculat[ion]" that it was possible for the patient's condition to deteriorate; and that "none of [the Department's] witnesses testified that Respondent's decision was objectively unreasonable or that no reasonable paramedic in the same circumstances" would have treated the patient in the same manner as Respondent. Accordingly, Respondent respectfully submits that DHEC's prosecution of this matter was "without substantial justification," because it lacked any reasonable basis in fact and law.

Third, there are no special circumstances in favor of the Department that would make an award of attorney's fees unjust in this case. Respondent is a disabled veteran of relatively modest means, who should not have to bear the burden of defending himself from an unwarranted attack on his livelihood and professional standing.

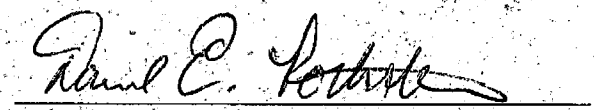
Although Section 15-77-300(C) contains an exception to the fee-shifting provisions for certain cases, including "disciplinary actions by state licensing boards," S.C. Code Ann. § 15-77-300(C), this case plainly falls outside of the statutory exception. The record in this case is very clear that this Contested Case did not involve a "disciplinary action," but rather an "enforcement action," and that paramedics do not hold "licenses" from DHEC, but rather hold "certificates" or "certifications." This is not an appeal from one of the many licensing boards administered by the South Carolina Department of Labor, Licensing and Regulation. The term "license" is expressly defined in the SC Emergency Medical Services Act to mean "an authorization to a person, firm, corporation, or governmental division or agency to provide emergency medical services in the State." S.C. Code Ann. § 44-61-20(19). As EMS Bureau Chief Wronski testified during the trial of this matter, the only "licenses" actually issued by DHEC are for the ambulance

services and agencies, not the individual EMTs and paramedics who work for those services or agencies. Compare also S.C. Code Ann. § 44-61-40 (required licenses and permits for EMS Services) with S.C. Code Ann. § 44-61-80 (EMT certificates). Because the General Assembly used the term "license" as a term of art in the EMS Act, the Court must presume that the legislature meant what it said. See, e.g., Beaufort County v. Jasper County, 220 S.C. 469, 479, 68 S.E.2d 421, 426 (1951) ("The primary rule of construction, as to which all other rules for statutory construction is subservient, is that one which requires that the legislative intent must prevail if it can reasonably be discovered in the language used . . . .").

In determining what is a reasonable attorney's fees, the Court must examine the factors set forth in S.C. Code Ann. § 15-77-300(B): "(1) the nature, extent, and difficulty of the case; (2) the time devoted; (3) the professional standing of counsel; (4) the beneficial results obtained; and (5) the customary legal fees for similar services." S.C. Code Ann. § 15-77-300(B). These factors are addressed in the attached Affidavit of Respondent's Attorney, David E. Rothstein. As the Court observed, this case was a complicated, week-long trial before the Administrative Law Court, which involved numerous lay witnesses and expert witnesses and which was aggressively prosecuted by DHEC. The case involved over 360 hours of attorney time through discovery, including half a dozen depositions, and trial. The undersigned's professional standing is addressed in detail in the attached Affidavit, which includes almost 25 years of practice, primarily in individual employment litigation matters. The results of this case were very favorable, as the Court vacated Petitioner's Administrative Order revoking his paramedic certificate. Finally, the undersigned's requested hourly rate of $300.00 per hour is reasonable and customary for experienced employment lawyers in South Carolina, especially certified specialists in employment and labor law.

In conclusion, for all of the foregoing reasons, Respondent requests an award of attorney's fees in the amount of $109,350.00 pursuant to S.C. Code Ann. § 15-77-300, plus taxable costs under Rule 54, SCRCP.

Respectfully submitted,



David E. Rothstein
ROTHSTEIN LAW FIRM, PA
1312 Augusta Street
Greenville, SC 29605
(864) 232-5870 (office)
(864) 241-1386 (facsimile)
drothstein@rothsteinlawfirm.com

Attorney for Respondent, James W. Davenport

March 21, 2018

Greenville, South Carolina.

Exhibit A

STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

South Carolina Department of Health and Environmental Control, Petitioner, vs. James W. Davenport, Respondent.	)	Docket No. 17-ALJ-07-0003-CC **AFFIDAVIT OF RESPONDENT'S COUNSEL, DAVID E. ROTHSTEIN**

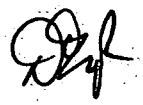
STATE OF SOUTH CAROLINA)
)
COUNTY OF GREENVILLE)

PERSONALLY appeared before me David E. Rothstein, who, after being duly sworn, deposes and states the following:

1. My name is David E. Rothstein. I am older than eighteen years of age. The statements in this Affidavit are based upon my own personal knowledge.

2. I am counsel for Respondent, James W. Davenport, in the above-captioned case.

3. I am an attorney in good standing and have been licensed to practice law by the State of South Carolina since November 15, 1993, and by the State of North Carolina since April 11, 2008. I am also admitted to practice before the United States District Court for the District of South Carolina, the United States District Court for the Western District of North Carolina, the United States District Court for the Middle District of North Carolina, the United States District Court for the Eastern District of North Carolina, the United States Court of Appeals for the Fourth Circuit, and



the United States Supreme Court.

4. I graduated cum laude from the University of South Carolina School of Law on May 14, 1993, where I was Editor in Chief of the South Carolina Law Review, a member of the Order of the Coif, and a member of the Order of the Wig and Robe.

5. Upon graduation from law school, I served as a judicial law clerk to the Hon. Joseph F. Anderson, Jr., United States District Court Judge for the District of South Carolina, from August 1993 to August 1995. Thereafter, I served as a judicial law clerk to the Hon. Robert F. Chapman, then Senior United States Circuit Court Judge for the Fourth Circuit Court of Appeals, from August 1995 to October 1996.

6. I worked as an associate attorney at the law firm of Nexsen Pruet Jacobs & Pollard, LLP, in Columbia, South Carolina, from October 1996 to January 1999, where the majority of my practice involved employment law. While employed at the Nexsen Pruet firm, I represented both employers and employees in employment litigation and appeals.

7. I worked as an associate attorney at the law firm of Gergel Nickles & Solomon, P.A., in Columbia, South Carolina, from January 1999 to June 30, 2005, where the majority of my practice involved employment law.

8. I was a shareholder in the law firm of Burnette & Rothstein, P.A. from July 1, 2005 until July 31, 2010, when I moved to Greenville, SC and formed Rothstein Law Firm, PA, which is currently a solo practice law firm. Almost all of my law firm's current practice involves employment law and litigation.

9. I have been a Certified Specialist in Employment and Labor Law since February 2006. Although I primarily represent individual employees (and classes of employees) in

employment-related matters, my firm also represents several small employers in employment-related matters.

10. I previously served as an associate member of the South Carolina Board of Law Examiners, which position I held from January 2007 through January 2016.

11. I have had extensive experience in employment litigation, both as an attorney and as a judicial law clerk to two federal judges. In addition, I have written several articles and made numerous CLE presentations on employment law and related topics. I am a member of the Employment Law Sections of the South Carolina Bar, the South Carolina Association for Justice, and the National Employment Lawyers Association. I am a past Chair of the Employment and Labor Law Section Council of the South Carolina Bar (2011), and previously served as a member of the Specialization Advisory Board for Employment and Labor Law through the South Carolina Supreme Court Commission on CLE and Specialization (2011-17).

12. The above-captioned case involved substantial investigation and discovery, as well as substantial legal research and drafting, culminating in a week-long trial in July 2017 in the Administrative Law Court.

13. I have reviewed my contemporaneous time entries relating to this case from April 21, 2016, through the date of this Affidavit, which have been recorded on a computerized law-office management program called Clio. As reflected in the attached Invoice I generated with Clio, I have spent 364.5 hours of time in connection with this case during the approximately 23-month period I have been representing Mr. Davenport. I anticipate spending another 5-8 hours of time in connection with this Petition for Attorney's Fees. I believe that all of the time recorded in Clio is reasonable and was necessary in the representation of Mr. Davenport.

14. The expenses or out-of-pocket costs that my firm has expended in connection with this case is also tracked in Clio. To date, my firm has expended over $6,500.00 in connection with this case. I have been very careful to keep the expenses in this case as low as possible. I believe that the expenses are reasonable and were necessary in the representation of Mr. Davenport.

15. At the time of the trial in this matter, my regular hourly rate in employment cases was $300.00 per hour. Effective January 1, 2018, I increased my regular hourly rate to $350.00 for employment cases, the first increase in my hourly rate since July 1, 2010. I believe that my hourly rates are consistent with those of employment lawyers in South Carolina with similar experience and expertise.

FURTHER AFFIANT SAYETH NOT.

David E. Rothstein

SWORN to and subscribed before me,

this 21st day of March, 2018

H. LORRAINE MILLER
NOTARY PUBLIC
State of South Carolina
My Commission Expires Mar. 28, 2027

(L.S.)
Notary Public for South Carolina

My commission expires: 3/28/27

Invoice # 677
Date: 03/21/2018
Due Upon Receipt

ROTHSTEIN LAW FIRM, PA
1312 Augusta Street ◆ Greenville, SC 29605

James W. Davenport
108 Burberry Drive
Williamston, SC 29697

16-042

James W. Davenport adv. SCDHEC 17-ALJ-07-0003-CC

Services

Attorney	Date	Description	Quantity	Rate	Total
DER	04/21/2016	Initial consultation with Mr. and Mrs. Davenport	2.00	$300.00	$600.00
DER	04/24/2016	Email from Mr. Davenport with draft of grievance letter (0.2); email from Davenport re: return to practice (0.1)	0.30	$300.00	$90.00
DER	10/31/2016	Meeting with clients regarding appeal.	2.00	$300.00	$600.00
DER	11/06/2016	Review file (2.0); prepare draft of request for final review (2.6); email draft of RFR to Mr. Davenport (0.1)	4.70	$300.00	$1,410.00
DER	11/07/2016	Email from Mr. Davenport (0.1); email from Mr. Davenport (0.2); revise draft of RFR (0.6); email revisions to Davenport (0.1); TC to Mr. Davenport (0.2); prepare cover letter from RFR (0.1); email to Wicevic at DHEC (0.1); TC to DHEC to pay filing fee by credit card (0.1); email from Davenport (0.1)	1.60	$300.00	$480.00
DER	11/09/2016	Email from DHEC clerk acknowledging receipt of RFR (0.1)	0.10	$300.00	$30.00
DER	11/29/2016	Receive and review staff response to RFR (1.5)	1.50	$300.00	$450.00
DER	11/30/2016	Email to Mr. Davenport about response (0.1); email to Wicevic about rebuttal (0.1)	0.20	$300.00	$60.00
DER	12/01/2016	Email from Mr. Wicevic to Lisa Lucas at DHEC (0.1); email from Mr. Lucas about no provision for rebuttal (0.1)	0.20	$300.00	$60.00
DER	12/07/2016	Message from Davenport (0.1)	0.10	$300.00	$30.00
DER	12/10/2016	Receive and review DHEC board declination (0.2); email to Mr. Davenport (0.1)	0.30	$300.00	$90.00

DER	12/13/2016	Message from Mr. Davenport (0.1)	0.10	$300.00	$30.00
DER	12/15/2016	Message from Davenport (0.1)	0.10	$300.00	$30.00
DER	12/30/2016	E-mail from Mr. Davenport (0.1); research re: ALC rules (0.6); e-mail to Mr. Davenport (0.2)	0.90	$300.00	$270.00
DER	12/30/2016	Email from Davenport (0.1); research re: contested case hearing (0.4); email to Davenport (0.2)	0.70	$300.00	$210.00
DER	01/05/2017	Prepare request for contested case hearing and assemble exhibits (0.8); research re: ALC proceeding (2.5)	3.30	$300.00	$990.00
DER	01/06/2017	Prepare filing letter to ALC for request for contested case hearing (0.1)	0.10	$300.00	$30.00
DER	01/08/2017	Emails from and to Davenport (0.2); TC to Mr. Davenport to discuss case (0.5)	0.70	$300.00	$210.00
DER	01/12/2017	Email from Davenport confirming meeting (0.1); email to Davenport (0.1)	0.20	$300.00	$60.00
DER	01/13/2017	Meeting with Mr. and Mrs. Davenport to discuss case (2.0)	2.00	$300.00	$600.00
DER	01/17/2017	Receive and review notice of assignment from SCALC (0.1)	0.10	$300.00	$30.00
DER	01/22/2017	Email to Davenport about case assignment (0.1); research about Judge Robinson (0.2); TC to Mr. Shissias about Judge Robinson (0.2)	0.50	$300.00	$150.00
DER	01/25/2017	Email from Ms. Davenport about scheduling meeting (0.1); email to Ms. Davenport (0.1)	0.20	$300.00	$60.00
DER	01/26/2017	Emails from and to Davenports to schedule meeting (0.1)	0.10	$300.00	$30.00
DER	01/27/2017	Receive and review DHEC Agency Information Sheet and Notice of Appearance (0.4)	0.40	$300.00	$120.00
DER	02/03/2017	Meeting with Mr. Davenport to discuss case (1.8); email from Ms. Davenport (0.1); receive and review order for pre-hearing statements (0.3)	2.20	$300.00	$660.00
DER	02/09/2017	Email from Ms. Davenport about EEO (0.1)	0.10	$300.00	$30.00
DER	02/20/2017	Work on pre-hearing statement (2.5); email to Davenport about pre-hearing statements (0.1); TC to Mr. Davenport (0.4); draft discovery for ALC (1.2); email to Davenport about discovery (0.1); prepare subpoenas for Anderson County and Anderson County EMS (0.5)	4.80	$300.00	$1,440.00
DER	02/21/2017	Email from Davenport about discovery (0.1); email from Davenport about draft of pre-hearing statement (0.3); email from Ms. Davenport (0.1); revise pre-hearing statement (0.4); email from Ms. Davenport about scheduling (0.1); email from Davenport about camera in Sheila Kaiser's office (0.1); cover letter to court with pre-hearing statement (0.1); receive and review email from DHEC with pre-hearing statement (0.1); email to Davenport re: DHEC's prehearing statement (0.1); review pre-hearing statement (0.4)	1.80	$300.00	$540.00
DER	02/23/2017	Prepare subpoenas for Iva Police Department, Iva Rescue Squad, and Dr. Kickham (0.5); prepare cover letters for subpoenas (0.2); prepare first set of discovery to DHEC (1.1); prepare service letter to DHEC (0.1)	1.90	$300.00	$570.00
DER	02/24/2017	Email from lawclerk re: scheduling contested case hearing (0.1); email to Mr. and Mrs. Davenport about scheduling (0.1); email to court about schedule for hearing (0.1)	0.30	$300.00	$90.00
DER	02/27/2017	Email from Wicevic about hearing date (0.1); TC to Mr. Wicevic about scheduling order (0.2)	0.30	$300.00	$90.00

DER	02/28/2017	Email from lawclerk (0.1); email from Wicevic (0.1); email from Ms. Henderson (0.1); email from Davenport about records (0.1)	0.40	$300.00	$120.00
DER	03/01/2017	Receive certified mail receipts for subpoenas (0.1)	0.10	$300.00	$30.00
DER	03/02/2017	Email from Mr. Wicevic about scheduling order (0.1)	0.10	$300.00	$30.00
DER	03/06/2017	Email from Craig Lawless about subpoena (0.1); email to Davenport about Lawless email (0.1); email from Davenport (0.1)	0.30	$300.00	$90.00
DER	03/07/2017	Email from Mr. Wicevic (0.1); emails from Mrs. Davenport (0.1); email to Mrs. Davenport (0.1); emails from Mr. Davenport (0.2); email from Mr. Wicevic (0.1); TC with Mr. Wicevic (0.2)	0.80	$300.00	$240.00
DER	03/08/2017	Email to Mr. Lawless about subpoena (0.1); TC to Mr. Davenport to discuss case (0.3)	0.40	$300.00	$120.00
DER	03/10/2017	Email from Mr. Wicevic with proposed scheduling order (0.1); email to Davenport with proposed order (0.1); TC from Mr. Davenport (0.1)	0.30	$300.00	$90.00
DER	03/13/2017	Email from Ms. Davenport about scheduling conflicts (0.1); email from Mr. Wicevic (0.1); review proposed scheduling order (0.1); email to Mr. Wicevic (0.1)	0.40	$300.00	$120.00
DER	03/14/2017	Email from Mr. Wicevic with revised proposed order (0.1); email to Davenports (0.1); email to Wicevic with signed consent order (0.1); emails from Wicevic re: proposed order (0.1)	0.40	$300.00	$120.00
DER	03/15/2017	Email from Ms. Campbell to Mr. Wicevic (0.1)	0.10	$300.00	$30.00
DER	03/16/2017	Email from Judge Robinson's staff attorney (0.1); email to Davenport about hearing date (0.1); email from Ms. Davenport (0.1)	0.30	$300.00	$90.00
DER	03/17/2017	Email from Mr. Davenport (0.1)	0.10	$300.00	$30.00
DER	03/20/2017	Email from Mr. Wicevic (0.1); email from Wicevic to Ms. Campbell (0.1)	0.20	$300.00	$60.00
DER	03/23/2017	TC from Ms. McCormac re: subpoena to Iva PD (0.2)	0.20	$300.00	$60.00
DER	03/24/2017	Receive subpoena responses from Anderson County (0.2); receive DHEC's answers to RFA (0.1); email to Davenport about DHEC responses (0.1)	0.40	$300.00	$120.00
DER	03/27/2017	Email from Davenport about Anderson County subpoena responses (0.3); email from DHEC re: discovery responses (0.2); email to Davenport about discovery responses (0.1); email from Davenport (0.1)	0.70	$300.00	$210.00
DER	03/29/2017	Receive scheduling order (0.1); receive discovery from DHEC (0.3); TC from Wicevic about coniidentiality order (0.2); email from Wicevic to court about confidentiality order (0.1)	0.70	$300.00	$210.00
DER	03/30/2017	Email from Ms. Campbell (0.1); email from Ms. McCormac about subpoena responses (0.1); email to Ms. McCormac (0.1); email from Ms. McCormac (0.1); emails from and to Ms. Hazel about conference call (0.2); email to Mr. Davenport (0.1); emails to and from Davenport about meeting to review discovery responses (0.1)	0.80	$300.00	$240.00
DER	03/31/2017	Conference call with Judge Robinson about confidentiality order (0.2)	0.20	$300.00	$60.00
DER	04/03/2017	Receive and review documents from Iva PD (0.2)	0.20	$300.00	$60.00
DER	04/04/2017	Email from Wicevic re: proposed order (0.1)	0.10	$300.00	$30.00
DER	04/05/2017	Meeting with Mr. Davenport to review and discuss discovery responses (2.2)	2.20	$300.00	$660.00

DER	04/10/2017	Email from Wicevic (0.1)	0.10	$300.00	$30.00
DER	04/12/2017	Email from Wronski re: Stoller investigation (0.1); email to Davenport (0.1); email from Davenport (0.1)	0.30	$300.00	$90.00
DER	04/17/2017	Email from Davenport (0.1); email from Ms. Davenport (0.1); email from Wicevic (0.1); email to Wicevic about proposed order (0.1); TC to Mr. Davenport (0.3)	0.70	$300.00	$210.00
DER	04/18/2017	Email from Wicevic (0.1); email from Wicevic to Ms. Campbell (0.1); email from Ms. Hazel about proposed order (0.1); email to Ms. Hazel (0.1)	0.40	$300.00	$120.00
DER	05/04/2017	Receive hearing notice (0.1)	0.10	$300.00	$30.00
DER	05/08/2017	Message from Davenport (0.1); TC to Mr. Davenport (0.2); receive DHEC's responses to RFPs (0.2)	0.50	$300.00	$150.00
DER	05/09/2017	Email from Davenport about deposition topics (0.6); email to Davenport (0.1)	0.70	$300.00	$210.00
DER	05/10/2017	Email from Davenport (0.1); meeting with Davenports to discuss depositions (1.5)	1.60	$300.00	$480.00
DER	05/11/2017	TC to Leon Harmon's paralegal about deposition schedule (0.2); email to Mr. Harmon about depositions (0.1); TC to Mr. Wicevic about depositions (0.2)	0.50	$300.00	$150.00
DER	05/12/2017	Receive and review subpoenas from DHEC for Iva PD, Anderson County, AnMed, and Iva Rescue Squad (0.2); email from Ms. Wilkes about depositions (0.1)	0.30	$300.00	$90.00
DER	05/16/2017	* TC with Mr. Davenport (1.0)	1.00	$300.00	$300.00
DER	05/18/2017	Email from Davenport with DeAngelo CV (0.1)	0.10	$300.00	$30.00
DER	05/19/2017	Email to Mr. Wicevic about discovery responses and depositions (0.1)	0.10	$300.00	$30.00
DER	05/21/2017	Email from Mr. Wicevic (0.1)	0.10	$300.00	$30.00
DER	05/22/2017	**Preparation of discovery responses (6.0).	6.00	$300.00	$1,800.00
DER	05/22/2017	Email from Mrs. Davenport about new witness (0.1); email from Ms. Wilkes about deposition schedule (0.1); email to Wicevic about deposition schedule (0.1); email from Wicevic (0.1); work on discovery responses (2.6); TC to Davenport about discovery responses (0.5); email discovery response to Wicevic (0.1); prepare service letter to DHEC (0.1)	3.70	$300.00	$1,110.00
DER	05/23/2017	Email from Wicevic about deposition schedule (0.1)	0.10	$300.00	$30.00
DER	05/24/2017	Email from Wicevic about Dr. Kickham deposition (0.1); email to Davenport (0.1); TC from Davenport (0.2)	0.40	$300.00	$120.00
DER	05/25/2017	TO to Mr. Davenport about deposition availability (0.2); email to Wicevic (0.1)	0.30	$300.00	$90.00
DER	05/26/2017	Email to Craig Lawless about deposition (0.1); prepare deposition notices and cover letters for Kickam, Kaiser, Stoller, and Lawless (0.3); email to Wicevic re: deposition notices (0.1)	0.50	$300.00	$150.00
DER	05/27/2017	Email from Davenport re: text messages with Kim Aiken (0.1)	0.10	$300.00	$30.00
DER	05/29/2017	Email from Wicevic re: deposition notice of Dr. Kickham (0.1)	0.10	$300.00	$30.00

DER	05/30/2017	Request Ms. Miller to schedule court reporter for deposition (0.1); email from Ms. Wilkes about subpoenas (0.1); email from Lawless about deposition (0.1); email to and from Lawless about deposition (0.1)	0.40	$300.00	$120.00
DER	05/31/2017	Prepare deposition subpoenas for Stoller and Kaiser (0.3); prepare cover letter to Leon Harmon (0.1); email to Mr. Harmon (0.1); email to Davenport (0.1); email from Davenport about Aiken text messages (0.1)	0.70	$300.00	$210.00
DER	06/01/2017	Email from Davenport about Dr. DeAngelo (0.1)	0.10	$300.00	$30.00
DER	06/05/2017	Email from Davenport about deposition prep (0.1); emails to and from Mr. Davenport about meeting to prepare for depositions (0.1); review file to begin preparing for depositions (2.4)	2.60	$300.00	$780.00
DER	06/06/2017	Work on deposition outlines (4.5); meeting with Mr. Davenport to prepare for depositions (1.8); email from Davenport (0.1); email from Wicevic about Davenport and Aiken depositions (0.1); email to Wicevic (0.1); TC to Ms. Wilkes about subpoenaed document (0.1); email from Ms. Wilkes (0.1)	6.80	$300.00	$2,040.00
DER	06/07/2017	Travel to and from Anderson for deposition of Dr. Kickham (1.5); attend deposition of Dr. Kickham (7.3); meeting with Davenport to discuss Kickham deposition (1.2)	10.00	$300.00	$3,000.00
DER	06/08/2017	Travel to Anderson for depositions of Lawless and Stoller (1.5); meeting with Davenport to discuss depositions (0.5); attend depositions of Lawless and Stoller (7.5); meeting with Davenport to debrief about depositions (1.5); email from Mr. Davenport about protocols (0.1); email from Ms. Davenport about medals (0.1)	11.20	$300.00	$3,360.00
DER	06/09/2017	Emails from Davenport re: articles about EMS issues (4) (0.6); email to Davenport about articles (0.1); TC from Mr. Davenport (0.8)	1.50	$300.00	$450.00
DER	06/10/2017	Email from Davenport about O2 article (0.2)	0.20	$300.00	$60.00
DER	06/11/2017	Email to Dr. DeAngelo (0.1)	0.10	$300.00	$30.00
DER	06/12/2017	Email from Davenport about IV article (0.3); emails from Ms. Davenport about Wronski DUI and judgments (0.4); email from Davenport to DeAngelo (0.3); email to Davenport about Wronski case (0.1); research re: Baumgardner case (0.6)	1.70	$300.00	$510.00
DER	06/13/2017	Email from Davenport with Leo Deason CV (0.2); email from DHEC with deposition notice for Davenport (0.1)	0.30	$300.00	$90.00
DER	06/14/2017	Receive deposition transcripts from EveryWord (0.2); receive documents from DHEC (0.2)	0.40	$300.00	$120.00
DER	06/15/2017	Email from Wicevic to Harmon with deposition notices for Kaiser and Aiken (0.1); email to Wicevic about court reporter (0.1); email from Wicevice about court reporter (0.1)	0.30	$300.00	$90.00
DER	06/16/2017	Email to Davenport about deposition notices (0.1)	0.10	$300.00	$30.00
DER	06/18/2017	Prepare for Kaiser and Aiken depositions (2.5); email deposition outlines to Mr. Davenport (0.1)	2.60	$300.00	$780.00
DER	06/18/2017	Prepare for depositions of Kaiser and Aiken (4.8); email deposition outlines to Davenport (0.1)	4.90	$300.00	$1,470.00
DER	06/19/2017	Travel to and from Anderson for depositions (1.5); meeting with Mr. Davenport to prepare for depositions (1.5); depositions of Sheila Kaiser and Kim Aiken (7.5); meeting with Mr. Davenport to discuss his deposition (1.0)	11.50	$300.00	$3,450.00

DER	06/19/2017	Travel to and from Anderson for depositions of Kaiser and Aiken (1.5); meeting with Davenport to discuss depositions (1.0); attend depositions of Kaiser and Aiken (5.5); meeting with Davenport to discuss depositions (1.5)	9.50	$300.00	$2,850.00
DER	06/20/2017	Email from EveryWord re: depositions (0.1); meeting with Davenport to prepare for deposition (0.8); defend Davenport deposition (6.5)	7.40	$300.00	$2,220.00
DER	07/05/2017	Review exhibit list and witness list from DHEC (0.2); TC to Mr. Wicevic about additional expert witness (0.2); email to Wicevic with CV for new expert witness (0.1); prepare draft of witness list for trial (0.2); TC to Mr. Davenport about witness list (0.2); email to Davenport with draft of witness list (0.1)	1.00	$300.00	$300.00
DER	07/06/2017	TC with Mr. Davenport and Leo Deason (0.8); email documents to Deason (0.1); finalize witness list and exhibit list (0.4); email to Davenport (0.1); prepare cover letter and email to Mr. Wicevic about witness list and exhibit list (0.1); confer with Ms. Miller about deposition transcripts (0.1); TC with Dr. DeAngelo (0.6); email documents to Dr. DeAngelo (0.1); email from Wicevic about evidence (0.1); email to Wicevic about objections (0.1)	2.50	$300.00	$750.00
DER	07/07/2017	Email from Mr. Wicevic (0.1); email from Wicevic to court about objections (0.1); email from Judge Robinson's law clerk (0.1)	0.30	$300.00	$90.00
DER	07/08/2017	Email from Davenport with notice about depositions (0.6); email from Davenport with military evaluations (0.1)	0.70	$300.00	$210.00
DER	07/09/2017	Email from Davenport about case and review revised notes about depositions (0.5); work on motions in limine (2.0); pull copies of exhibits (1.5)	4.00	$300.00	$1,200.00
DER	07/10/2017	Email from Wicevic to Ms. Hazel about extension (0.1); email from Wicevic about Naugler and Alier (0.1); upload trial exhibits to Dropbox folder (0.5); email to Wicevic about trial exhibits (0.1); receive and review trial subpoenas from DHEC (0.1); email from Wicevic about exhibits (0.1); email from Court re: exhibits (0.1); email from court reporter about deposition transcripts (0.1); TC to Leon Harmon's office about trial subpoenas (0.1); prepare draft of motions in limine and objections (1.8); email draft of motion to Mr. Davenport (0.1); TC to Davenport about motion (0.3); finalize motion in limine (0.4); email to Craig Lawless about hearing subpoena (0.1); email from Lawless (0.1); emails from Davenport about case (0.2)	4.30	$300.00	$1,290.00
DER	07/11/2017	Confirmation about FedEx delivery to court (0.1); email from Ms. Hazel about receipt of notebook (0.1); email from Davenport about Deason (0.1); add Deason to DropBox list (0.1); TC with Mr. Davenport and Mr. Deason (0.8); email from Deason about documents (0.1); review and summarize depositions (3.5)	4.80	$300.00	$1,440.00
DER	07/12/2017	Meeting with Davenport to review deposition and discuss trial (3.0); email from Davenport about 2010 evaluation (0.1); email documents to Deason (0.1); review and summarize depositions (4.2)	7.40	$300.00	$2,220.00
DER	07/13/2017	TC with Mr. Davenport regarding strategy and status (0.5); meeting with Mrs. Davenport regarding items needed/to-do (0.4); email from Wicevic about exhibits (0.1); email from Deason about hearing (0.1); email to Wicevic (0.1); email from Wicevic (0.1); emails from Ms. Davenport about Wronski (0.3); review PeopleMap report about Wronski and Eudy (0.5); receive and review DHEC's motion in limine (0.4); email to Davenport about deposition transcript (0.2); email to Davenport about DHEC's objections and motion in limine (0.1); trial prep (2.5)	5.30	$300.00	$1,590.00

DER	07/14/2017	Email from Davenport about DHEC motion (0.1); email to Wicevic about electronic version of JDAVENPORT.pdf file (0.1); email from Davenport about case and 2017 state-wide protocols (0.2); review 2017 state-wide protocols (1.5); emails from Ms. Davenport about Wronski judgments (0.2); email from Mr. Davenport about patient abandonment issue (0.2); review article about patient abandonment (0.3); prepare hearing subpoenas for Stoller and Kaiser (0.5); email subpoenas to Mr. Harmon (0.1); prepare hearing subpoena for Craig Lawless (0.1); email to Lawless (0.1); prepare hearing subpoena for Deason (0.1); email subpoena to Deason (0.1); research re: DHEC state-wide protocols (0.6); emails to Davenport about protocols (0.2); email subpoenas to Wicevic (0.1); emails to and from Wicevic about encrypted documents (0.1); emails form Davenport about case (0.2); email to Ms. Hazel about visiting courtroom (0.1); emails to and from Ms. Wilkes about David Vaughn documents (0.2); email from Mr. Deason (0.1); email from Davenport re: stair chair (0.1); trial prep (2.5)	7.80	$300.00	$2,340.00
DER	07/15/2017	Email from Davenport re: Stoller deposition notes (0.5); review and summarize Davenport deposition (4.0)	4.50	$300.00	$1,350.00
DER	07/16/2017	Review and analyze other paramedic enforcement actions (1.5); deposition review and trial prep (5.0)	6.50	$300.00	$1,950.00
DER	07/17/2017	Email from Wicevic about attachment (0.1); email from Ms. Hazel about hearing (0.1); email from Court about motion in limine hearing (0.1); email from Wicevic (0.1); TC to Mr. Davenport (0.1); meeting with Mr. Davenport do discuss deposition errata pages (2.8); email to court about hearing (0.1); email errata pages to court reporter (0.1); trial prep (3.6); email to Davenport about recusal of Alier (0.1); research re: gmail and HIPAA (0.4); emails to Davenport about case (0.3)	7.90	$300.00	$2,370.00
DER	07/18/2017	Email from Wicevic about hearing (0.1); email from Wicevic about motions (0.1); email from court reporter about errata pages (0.1); email from Wicevic about hearing (0.1); email from Ms. Hazel about hearing (0.1); TC with Wicevic about objections (0.4); email to Davenport (0.1); research re: DesChamps lawsuits (0.8); email to Davenport about DesChamps malpractice case (0.1); trial prep (3.5)	5.40	$300.00	$1,620.00
DER	07/19/2017	Email from Davenport about DesChamps case (0.1); emails from Davenport about EMS articles (0.3); TC to Mary McCormac about photographs from Iva P.D. (0.1); email from Ms. McCormac about photos (0.1); email from Lawless about deposition transcript (0.1); email deposition to Lawless (0.1); prepare for motions hearing (0.8); trial prep (4.0)	5.60	$300.00	$1,680.00
DER	07/20/2017	Prepare for motions hearing (1.5); travel to and from Columbia for pre-trial hearing on evidentiary motions (3.0); attend motions hearing before Judge Robinson at SCALC (1.4); research re: body-worn cameras (0.5); email to Davenport about BWC laws (0.1); email from Ms. McCormac about knife (0.1); email to McCormac requesting Iva BWC policy (0.1); receive and review records custodian affidavits from Mr. Wicevic (0.2); email from Davenport about evidence (0.1)	5.50	$300.00	$1,650.00
DER	07/21/2017	Trial prep (6.5); email from Davenport re: EMS articles (0.2); emails from Ms. McCormac re: evidence custodian affidavit from Iva PD and body-worn camera policy (0.4); receive and review photos of patient and scene from Ms. McCormac (0.2); receive and review summary of evidentiary rulings from Judge Robinson (0.2); email from Mr. Wicevic to Ms. Hazel about delaying start of trial (0.1); TC to Mr. Wicevic (0.2); conference call with Judge Robinson's law clerk about delaying start of trial (0.2); email to Ms. Hazel setting forth position (0.2); email from Mr. Wicevic (0.1); email from Ms. Hazel about Judge's decision to delay start of trial (0.1); emails to Davenport (0.2); TC to Mr. Davenport to discuss hearing (0.4)	9.00	$300.00	$2,700.00

DER	07/22/2017	Trial prep (8.5)	8.50	$300.00	$2,550.00
DER	07/23/2017	Prepare for trial (8.5), meeting with Mr. Davenport to discuss case and trial strategies (4.0)	12.50	$300.00	$3,750.00
DER	07/24/2017	Prepare for trial, meeting with Mr. Davenport to discuss case (4.0); travel to and from Columbia for trial before SCALC (3.0); attend trial (4.5); dinner meeting with Davenport to discuss trial strategy (1.5); trial prep for upcoming witnesses (3.5); email from and to Lawless about subpoena (0.1); TC to Rusty Harmon about Kaiser and Stoller subpoenas (0.1)	16.70	$300.00	$5,010.00
DER	07/25/2017	Travel to and from Columbia for trial before SCALC (3.0); attend trial (7.5); meeting with Davenport to discuss trial strategy (1.5); meeting with Dr. DeAngelo to prepare for expert testimony (1.5); prepare outline for DeAngelo testimony (2.0); emails from and to Mr. Lawless about subpoena (0.1)	15.60	$300.00	$4,680.00
DER	07/26/2017	Travel to and from Columbia for trial before SCALC (3.0); attend trial (9.0); meeting with Davenport, Deason, and Crews to prepare for witness examinations (1.5); review and annotate recording of DHEC interview with Davenport for Wronski cross exam (4.5); emails to and from Craig Lawless about subpoena (0.1); email to Leon Harmon about subpoena (0.1)	18.20	$300.00	$5,460.00
DER	07/27/2017	Travel to and from Columbia for trial before SCALC (3.0); attend trial (9.0); prepare for final witness examinations and closing arguments (2.5); review Stoller deposition to pull excerpts (2.5)	17.00	$300.00	$5,100.00
DER	07/28/2017	Travel to and from Columbia for trial before SCALC (4.0); attend trial (7.5); meeting with Davenport to discuss case strategy (1.0); debriefing with Mr. Davenport about trial (0.8); email to Mr. Wicevic requesting litigation hold notice (0.2)	13.00	$300.00	$3,900.00
DER	07/30/2017	Draft proposed order, research applicable law (5.2); email draft to Davenport (0.1); TC from Mr. Davenport to discuss proposed order (0.3); review and revise proposed order (1.2)	7.80	$300.00	$2,340.00
DER	07/31/2017	Finalize proposed order (0.8); email from Mr. Wicevic about litigation hold request (0.1); email to Court with proposed order (0.1)	1.00	$300.00	$300.00
DER	08/01/2017	Email from Ms. Hazel about receipt of proposed order (0.1); email to Ms. Hazel (0.1)	0.20	$300.00	$60.00
DER	08/04/2017	Email from Mr. Wicevic to Court about Stoller deposition excerpts for record (0.4)	0.40	$300.00	$120.00
DER	08/08/2017	TC from Mr. Davenport regarding paramedic at Spartanburg airport (0.2); email to Mr. Davenport (0.1); email to Wicevic about defamation incident (0.2); email from Ms. Davenport (0.1); email to Ms. Davenport about interference with employment (0.1); email from Mr. Wicevic (0.1); email from Mr. Davenport (0.1)	0.90	$300.00	$270.00
DER	08/10/2017	Emails from Ms. Davenport about Wronski judgments (3) (0.2)	0.20	$300.00	$60.00
DER	08/14/2017	TCs regarding Mr. Thompson [3] (0.8); review redacted recordings (1.5); email to Mr. Wicevic about redactions (0.1)	2.40	$300.00	$720.00
DER	08/16/2017	Email from Mr. Wicevic about recordings (0.1)	0.10	$300.00	$30.00
DER	08/28/2017	Receive and review proposed order from Mr. Wicevic (0.8); email to Mr. Davenport (0.1)	0.90	$300.00	$270.00
DER	08/29/2017	Email from Ms. Hazel confirming receipt of DHEC's proposed order (0.1)	0.10	$300.00	$30.00
DER	09/19/2017	Email to Mr. Wicevic about proposed order (0.1); email from Wicevic (0.1)	0.20	$300.00	$60.00

DER	10/05/2017	Email from Mr. Davenport re: Anderson County SOPs (0.2)	0.20	$300.00	$60.00
DER	10/18/2017	TC from Mr. Davenport about status of case (0.3); draft email to Judge Robinson's lawclerk (0.2); email to Mr. Davenport (0.1); email from Ms. Davenport (0.1)	0.70	$300.00	$210.00
DER	10/30/2017	Email to Judge Robinson's law clerk (0.1); email from Mr. Davenport (0.1)	0.20	$300.00	$60.00
DER	11/01/2017	Email from Ms. Hazel (0.1); email to Davenport (0.1); email from Ms. Davenport (0.1)	0.30	$300.00	$90.00
DER	03/09/2018	TC to Mr. Davenport to discuss case (0.4); message to Wicevic (0.1)	0.50	$300.00	$150.00
DER	03/15/2018	Email to Ms. Hazel about status of case (0.1); email to Mr. Davenport (0.1)	0.20	$300.00	$60.00
DER	03/16/2018	Email from Ms. Hazel (0.1); email to Mr. Davenport (0.1); email to Mr. Davenport (0.1); TC to Mr. Davenport (0.3)	0.60	$300.00	$180.00
DER	03/19/2018	Email to Mr. Davenport about appeal procedures (0.1)	0.10	$300.00	$30.00
DER	03/20/2018	Email from Ms. Hazel with copy of final order (0.1); email to Mr. Davenport (0.1); review order (0.8); TC to Mr. Davenport (0.3); text messages with Davenport about order (0.1); TC from Mr. and Mrs. Davenport to discuss case (0.7); email order to Mr. Harmon (0.2)	2.30	$300.00	$690.00
			Quantity Subtotal		**336.5**
			Services Subtotal		**$100,950.00**

Expenses

Date	Description	Quantity	Rate	Total
11/07/2016	SCDHEC filing fee for RFR	1.00	$100.00	$100.00
11/07/2016	Copies: 27 x .20	1.00	$5.40	$5.40
11/07/2016	Postage [Stamps.com]	1.00	$1.78	$1.78
01/05/2017	Copies: 56 x .20	1.00	$11.20	$11.20
01/06/2017	Filing fee (SC Administrative Law Court)	1.00	$200.00	$200.00
01/06/2017	Postage [Stamps.com]: 2 x $1.36	1.00	$2.72	$2.72
02/21/2017	Copies: 56 x .20	1.00	$11.20	$11.20
02/21/2017	Postage [Stamps.com]: $2.03 + (2 x $1.40)	1.00	$4.83	$4.83
02/23/2017	Copies: 22 x .20 = $4.40; 143 x .20 = $28.60	1.00	$33.00	$33.00
02/23/2017	Postage [Stamps.com]: 5 x $6.56 = $32.80; $1.19; 2 x $1.40 = $2.80	1.00	$36.79	$36.79
03/01/2017	WestLaw legal research charges - February 2017	1.00	$34.61	$34.61
03/16/2017	Copies: 4 x .20	1.00	$0.80	$0.80
03/16/2017	Postage [Stamps.com]	1.00	$0.46	$0.46
05/22/2017	Copies: 32 x .20	1.00	$6.40	$6.40
05/22/2017	Postage	1.00	$1.82	$1.82

05/26/2017	Copies: 12 x .20	1.00	$2.40	$2.40
05/31/2017	Copies: 6 x .20	1.00	$1.20	$1.20
05/31/2017	Postage [Stamps.com]	1.00	$0.46	$0.46
06/06/2017	Copies: 210 x .20	1.00	$42.00	$42.00
06/06/2017	Copies: 12 x .20	1.00	$2.40	$2.40
06/07/2017	Copies: 52 x .20	1.00	$10.40	$10.40
06/07/2017	Mileage to and from Anderson for Kickham deposition (66 mi. @ $0.535 per mi.)	1.00	$35.31	$35.31
06/07/2017	Lunch during depositions--J Peters	1.00	$35.62	$35.62
06/08/2017	Mileage to and from Anderson for Stoller and Lawless depositions (66 mi. @ $0.535 per mi.)	1.00	$35.31	$35.31
06/08/2017	Drinks after deposition--J Peters	1.00	$30.08	$30.08
06/08/2017	Lunch during depositions--Sullivan's Metropolitan Grill	1.00	$28.40	$28.40
06/08/2017	Meal expense - Sullivan's Metropolitan Grill	1.00	$28.40	$28.40
06/15/2017	Copies: 318 x .20	1.00	$63.60	$63.60
06/17/2017	Copies: 132 x .20	1.00	$26.40	$26.40
06/19/2017	Mileage to and from Anderson for Kaiser and Aiken depositions (66 mi. @ $0.535 per mi.)	1.00	$35.31	$35.31
06/19/2017	Lunch during depositions--J Peters	1.00	$38.50	$38.50
06/19/2017	Breakfast during depositions--Eggs Up Grill	1.00	$23.77	$23.77
06/19/2017	Dinner after deposition--J Peters	1.00	$41.88	$41.88
06/20/2017	Deposition of Dr. Kickham	1.00	$530.30	$530.30
06/20/2017	Lunch during deposition--Purple Int'l Bistro	1.00	$36.13	$36.13
06/22/2017	Depositions of Scott Stoller and Craig Lawless	1.00	$1,344.40	$1,344.40
07/06/2017	Copies: 15 x .20	1.00	$3.00	$3.00
07/06/2017	Postage [Stamps.com]	1.00	$0.67	$0.67
07/09/2017	Copies: 101 x .20	1.00	$20.20	$20.20
07/10/2017	Copies: 19 x .20	1.00	$3.80	$3.80
07/10/2017	Color Copies: 4 x .60 = $2.40; B&W Copies: 154 x .20 = $30.80; and Binders and Tabs: 4 x $10 = $40.	1.00	$73.20	$73.20
07/10/2017	Copies: 363 x .20 [depositions]	1.00	$72.60	$72.60
07/10/2017	FedEx to Judge Robinson	1.00	$26.67	$26.67
07/10/2017	Postage [stamp]	1.00	$0.49	$0.49
07/14/2017	Garber Reporting - Depo invoice #11075	1.00	$666.98	$666.98
07/14/2017	Garber Reporting - Depo invoice #11072	1.00	$770.01	$770.01
07/18/2017	Copies: 19 x .20	1.00	$3.80	$3.80

07/18/2017	Postage [Stamps.com]	1.00	$0.98	$0.98
07/20/2017	Mileage to and from Columbia for SCALC motions hearing (210 miles @ $0.535 per mi.)	1.00	$112.35	$112.35
07/20/2017	Parking for SCALC motions hearing	1.00	$1.50	$1.50
07/20/2017	Lunch after SCALC hearing--Villa Tronco	1.00	$48.70	$48.70
07/23/2017	Copies: 147 x .20	1.00	$29.40	$29.40
07/23/2017	Lunch during trial prep--Moe's	1.00	$22.53	$22.53
07/24/2017	Mileage to and from Columbia for SCALC trial (210 miles @ $0.535 per mi.)	1.00	$112.35	$112.35
07/24/2017	Parking for SCALC trial	1.00	$1.50	$1.50
07/24/2017	Dinner after trial--Al Amir Epicurean	1.00	$39.79	$39.79
07/24/2017	Lunch on way to court--Groucho's Deli Irmo	1.00	$23.90	$23.90
07/25/2017	Mileage to and from Columbia for SCALC trial (210 miles @ $0.535 per mi.)	1.00	$112.35	$112.35
07/25/2017	Parking for SCALC trial	1.00	$15.00	$15.00
07/25/2017	Breakfast during trial--Chick-fil-A Mauldin	1.00	$6.27	$6.27
07/26/2017	Mileage to and from Columbia for SCALC trial (210 miles @ $0.535 per mi.)	1.00	$112.35	$112.35
07/26/2017	Parking for SCALC trial	1.00	$15.00	$15.00
07/26/2017	Dinner with witnesses--Villa Tronco	1.00	$162.30	$162.30
07/27/2017	Mileage to and from Columbia for SCALC trial (210 miles @ $0.535 per mi.)	1.00	$112.35	$112.35
07/27/2017	Parking for SCALC trial	1.00	$15.00	$15.00
07/27/2017	Dinner with Davenport and Deek Crews after trial--Ruth's Chris	1.00	$216.20	$216.20
07/27/2017	Breakfast during trial--Chick-fil-A Mauldin	1.00	$18.80	$18.80
07/27/2017	Dinner - Ruth's Chris Steak House	1.00	$216.20	$216.20
07/28/2017	Mileage to and from Columbia for SCALC trial (210 miles @ $0.535 per mi.)	1.00	$112.35	$112.35
07/28/2017	Parking for SCALC trial	1.00	$15.00	$15.00
07/28/2017	Breakfast during trial--Dunkin Donuts Irmo	1.00	$12.91	$12.91
08/01/2017	WestLaw legal research charges - July 2017	1.00	$321.42	$321.42
			Expenses Subtotal	**$6,341.20**

Time Keeper	Quantity	Rate	Total
David Rothstein	336.5	$300.00	$100,950.00
		Quantity Total	**336.5**
		Subtotal	**$107,291.20**
		Total	**$107,291.20**

Detailed Statement of Account

Current Invoice

Invoice Number	Due On	Amount Due	Payments Received	Balance Due
677	03/21/2018	$107,291.20	$0.00	$107,291.20
			Outstanding Balance	**$107,291.20**
			Amount in Trust	**$0.00**
			Total Amount Outstanding	**$107,291.20**

Please make all amounts payable to: Rothstein Law Firm, PA

Payment is due upon receipt.

Invoice # 474
Date: 10/31/2016
Due Upon Receipt

ROTHSTEIN LAW FIRM, PA
1312 Augusta Street ◆ Greenville, SC 29605

James W. Davenport
108 Burberry Drive
Williamston, SC 29697

16-042

James W. Davenport adv. SCDHEC 17-ALJ-07-0003-CC

Services

Attorney	Date	Description	Quantity	Rate	Total
DER	04/25/2016	E-mail from Mr. Davenport re: grievance letter; e-mail from Davenport about return to practice; receive revised grievance letter from Ms. Davenport	0.50	$300.00	$150.00
DER	04/26/2016	E-mail from Davenport re: draft of extension request to Mr. Wronski	0.10	$300.00	$30.00
DER	04/27/2016	Review and revise draft of grievance letter; e-mail red-lines to Mr. Davenoport	2.20	$300.00	$660.00
DER	04/28/2016	E-mail from Mr. Davenport about grievance	0.10	$300.00	$30.00
DER	04/29/2016	Receive and review final draft of grievance letter; meeting with Mr. and Mrs. Davenport to discuss DHEC meeting	2.80	$300.00	$840.00
DER	05/01/2016	Prepare letters of representation to Rusty Burns and Robert Wronski; e-mail to Mr. Davenport; e-mails from Davenport about Stoller e-mails	0.50	$300.00	$150.00
DER	05/02/2016	E-mail from Mr. Davenport about drafts of letters and grievance letter (0.1); revise grievance letter (0.5); e-mail to Mr. Davenport (0.1); finalize letters to Burns and Wronski (0.2); e-mail letters of representation (0.1); e-mail from Mr. Wronski (0.1); e-mail to Wronski (0.1); receive final copy of grievance from Mr. Davenport (0.2); e-mail from Davenport (0.1)	1.50	$300.00	$450.00
DER	05/03/2016	TC to Dr. Kickham to discuss Mr. Davenport; e-mail to Dr. Kickham; receive DHEC file from Ms. Davenport; receive patient care reports from Ms. Davenport	0.80	$300.00	$240.00
DER	05/04/2016	E-mail from Dr. Kickham; e-mail to Dr. Kickham and Leon Harmon; e-mail to Mr. Davenport; e-mails from Mr. and Mrs. Davenport	0.50	$300.00	$150.00

DER	05/06/2016	E-mail from Mr. Wronski re: IRC meeting; e-mail to Mr. Wronski; e-mail from Mr. Wronski about confidentiality; e-mail to Mr. Wronski; e-mail from Wronski; letter from Leon Harmon; e-mails from Davenport (4).	0.80	$300.00	$240.00
DER	05/07/2016	E-mails to Mr. Davenport; e-mail to Wronski; e-mail to Harmon; e-mail from Davenport	0.40	$300.00	$120.00
DER	05/09/2016	TC from Mr. Harmon; e-mail to Mr. Davenport; e-mail from Davenport re: scheduling grievance hearing	0.30	$300.00	$90.00
DER	05/11/2016	E-mail from Vito Wicevic; TC to Mr. Wicevic	0.30	$300.00	$90.00
DER	05/13/2016	E-mail from Mr. Wronski re: notice of re-scheduled IRC meeting; e-mail to Mr. Davenport; e-mail from Davenport	0.30	$300.00	$90.00
DER	06/13/2016	E-mail from Mr. Davenport about status	0.10	$300.00	$30.00
DER	06/18/2016	E-mail to Mr. Davenport about preparing for IRC	0.10	$300.00	$30.00
DER	06/20/2016	E-mail from Mr. Davenport	0.10	$300.00	$30.00
DER	06/21/2016	E-mail from Ms. Davenport; e-mail from Wronski; e-mail to Mr. Wronski about IRC meeting	0.30	$300.00	$90.00
DER	06/22/2016	Meeting with Mr. and Mrs. Davenport to discuss IRC meeting (1.5); prepare direct and cross examinations for IRC meeting (1.0); prepare exhibits for IRC meeting (0.8); research re: paramedic statutes and regs. (1.4); TC to Mr. Wicevic about e-mail complaint from Stoller and IRC meeting (0.3); receive and review redacted documents from Wicevic (0.1); e-mail to Davenport (0.1); e-mail to Wronski about witnesses (0.1); e-mail from Wronski (0.1)	5.40	$300.00	$1,620.00
DER	06/23/2016	Travel to and from Columbia for IRC meeting (3.0); meeting with Mr. Davenport to discuss IRC meeting; attend IRC meeting (2.5)	5.50	$300.00	$1,650.00
DER	07/01/2016	TC to Mr. Wronski to follow up on IRC decision	0.10	$300.00	$30.00
DER	07/20/2016	E-mail from Mr. Davenport about IRC meeting	0.10	$300.00	$30.00
DER	07/29/2016	E-mail form Mr. Davenport about status of case	0.10	$300.00	$30.00
DER	08/08/2016	TC to Mr. Wicevic about case	0.20	$300.00	$60.00
DER	08/11/2016	TC Michael Owens to discuss potential position with Anderson County Sheriff's Dep't	0.30	$300.00	$90.00
DER	08/16/2016	E-mail from Mr. Wicevic with proposed consent order; (0.1) review proposed consent order (0.2)	0.30	$300.00	$90.00
DER	08/23/2016	E-mail to Mr. Davenport with proposed consent order (0.1); e-mail from Mr. Davenport (0.1); e-mail to Mr. Wicevic (0.1); e-mail from Mr. Wicevic (0.1); research re: EMS statute (0.5); e-mail to Mr. Wicevic(0.1); TC from Mr. Owens (0.5); TCs to Mr. Davenport (0.4)	1.90	$300.00	$570.00
DER	08/24/2016	E-mail from Mr. Wicevic about procedures for appea	0.10	$300.00	$30.00
DER	08/31/2016	E-mail from Mr. Wicevic re: IRC transcript (0.1); review transcript of IRC meeting (1.4); e-mail transcript to Mr. Davenport (0.1)	1.60	$300.00	$480.00
DER	10/24/2016	E-mail from Mr. Wicevic with copy of AO revoking Mr. Davenport's paramedic certificate (0.1); review order (0.3)	0.40	$300.00	$120.00
DER	10/26/2016	E-mail from Mrs. Davenport about order (0.1); e-mail to Mr. and Mrs. Davenport about order (0.1); e-mail from Mr. Davenport about order; e-mail to Mr. Davenport (0.1)	0.30	$300.00	$90.00

Quantity Subtotal	**28.0**
Services Subtotal	**$8,400.00**

Expenses

Date	Description	Quantity	Rate	Total
04/25/2016	Copies: 19 x .20	1.00	$3.80	$3.80
05/02/2016	Copies: 24 x .20	1.00	$4.80	$4.80
05/02/2016	Postage [Stamps.com]: 3 x .47	1.00	$1.41	$1.41
06/22/2016	Copies: 19 x .20	1.00	$3.80	$3.80
06/22/2016	Copies: 180 x .20	1.00	$36.00	$36.00
06/23/2016	Mileage to and from Columbia for IRC meeting at DHEC (210 miles @ $0.54 per mi.)	1.00	$113.40	$113.40
06/23/2016	Meals	1.00	$19.32	$19.32
08/31/2016	Notebook - $5 Copies: 36 x .20 = $7.20	1.00	$12.20	$12.20
10/31/2016	Copies: 34 x .20	1.00	$6.80	$6.80
			Expenses Subtotal	**$201.53**

Time Keeper	Quantity	Rate	Total
David Rothstein	28.0	$300.00	$8,400.00
		Quantity Total	**28.0**
		Subtotal	**$8,601.53**
		Total	**$8,601.53**

STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

South Carolina Department of Health and Environmental Control, Petitioner, vs. James W. Davenport, Respondent.	)	Docket No. 17-ALJ-07-0003-CC **SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL'S MEMORANDUM IN OPPOSITION TO JAMES W. DAVENPORT'S PETITION FOR ATTORNEY'S FEES AND COURT COSTS**

Petitioner South Carolina Department of Health and Environmental Control (the Department) submits this Memorandum in Opposition to Respondent James W. Davenport's Petition for Attorney's Fees and Court Costs for the below stated reasons.

Background

On April 19, 2016, the Department received body-cam footage of a March 19, 2016 call involving Respondent, a certified paramedic who was employed by Iva Rescue Squad. The Department initiated an investigation based upon the notification. As a result, the Department determined Respondent failed to provide acceptable emergency medical treatment and committed misconduct as defined by the *Emergency Medical Services Act of South Carolina* (the *EMS Act*), S.C. Code Ann. Sections 44-61-10, et seq., and *Emergency Medical Services* (the *EMS Regulation*), Regulation 61-7. Shortly thereafter, the Department proposed a consent order to Respondent which would suspend his paramedic certification for two years. Respondent declined the proposal.

The Department then convened the Investigative Review Committee (the IRC), a professional peer review committee composed of the State Medical Control Physician and various

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professionals in the EMS community, to review the Department's investigation and make recommendations. *See* S.C. Code Ann. § 44-61-20(16). On June 23, 2016, the IRC met to review the investigation. The Department presented information gathered during its investigation and Respondent, along with his counsel, provided statements and additional information regarding the March 19, 2016 incident. At the conclusion, the IRC provided its recommendations to the Department. The IRC recommended the Department propose a consent order suspending Respondent's paramedic certification for a period of one year, requiring Respondent to undergo a comprehensive psychiatric evaluation by a licensed physician and to complete any ordered treatment, and requiring completion of two training courses. If Respondent rejected that proposal, the IRC recommended the Department revoke Respondent's paramedic certification. The Department adopted the IRC's recommendations. The Department proposed the IRC-recommended consent order, and Respondent rejected it. Accordingly, on October 21, 2016, the Department issued the administrative order revoking Respondent's paramedic certification based upon the Department's conclusions that he failed to provide acceptable emergency medical treatment and committed misconduct.

On November 7, 2016, the Board of Health and Environmental Control (the DHEC Board) received Respondent's request for final review (RFR) challenging the administrative order. On December 7, 2016, the DHEC Board mailed notice of its decision to decline to conduct a final review conference. On January 6, 2017, Respondent filed a request for a contested case hearing with the Administrative Law Court (ALC or the Court).

Notice of a contested case hearing was given to the parties, and a hearing on the merits was held on July 24-28, 2017, at the ALC. Both parties appeared and presented testimony and evidence. On March 20, 2018, the Court issued its Final Decision and Order which vacated the

Department's administrative order revoking Respondent's certification, but ordered Respondent to successfully complete the NAEMT Principles of Ethics and Personal Leadership (PEPL) class. Respondent thereafter filed a Petition for Attorney's Fees and Court Costs in the amount of $109,350 pursuant to S.C. Code Ann. Section 15-77-300, plus taxable costs under Rule 54, SCRCP.

Arguments

I. Section 15-77-300 is not applicable because this is a contested case involving an enforcement action by the Department against a regulated professional.

S.C. Code Ann. Section 15-77-300(A) states, "In any ***civil action*** brought by the State . . . the court may allow the prevailing party to recover reasonable attorney's fees . . . against the appropriate agency . . . ." (Emphasis added). A contested case is not a "civil action" as used in Section 15-77-300(A). A "civil action" is commenced by filing a summons and complaint with the court. *See, e.g.*, Fed. R. Civ. P. 3, and S.C. R. Civ. P. Rule 3. In *McDowell v. S.C. Dep't of Soc. Servs.*, the South Carolina Supreme Court held an action in circuit for judicial review of an agency decision was a "civil action," but proceedings before DSS were not because the agency was functioning as an "administrative decision-maker." 304 S.C. 539, 543, 405 S.E.2d 830, 833 (1991). While the ALC is the "court of record," it is situated in the executive, not judicial branch. *See* S.C. Code Ann. § 1-23-500. Further, there has been at least one bill incorporating administrative proceedings into Section 15-77-300 that was not passed into law. *See* H.3383, 112th Leg., 1st Sess. (1997). This is evidence that Section 15-77-300 was not intended to include contested cases before the ALC. *See Vernon v. Harleysville Mut. Cas. Co.*, 244 S.C. 152, 157, 135 S.E.2d 841, 844 (1961) ("It will be presumed that the Legislature in adopting an amendment to a statute intended to make some change in the existing law.").

Even if a contested case is a "civil action," Section 15-77-300(C) provides, "The provisions of this section do not apply to civil actions relating to . . . disciplinary actions by state licensing boards . . . ." While the Department is a distinct agency from the Department of Labor, Licensing and Regulation (LLR) and its various Professional and Occupational Licensing (POL) Boards, the Department's regulation and certification of EMTs is substantially the same as the POL Boards' regulation and licensure of their respective licensed professionals. Accordingly, Section 15-7-300 should not apply to this enforcement action against a certificate holder by the regulating agency.

In this context, certificate and license have the same meaning. In fact, these two terms are synonyms. *Ballentine's Law Dictionary*, License (3rd ed. 2010). License is defined as, "the privilege conferred by a public body on a person for the doing of something which otherwise he would not have the right to do." *Id.; see also* 51 Am Jur 2d Licenses and Permits § 1. The *EMS Act* defines "certificate" as an:

> ***official acknowledgment*** by the department that an individual has completed successfully one of the appropriate emergency medical technician training courses referred to in this article in addition to completing successfully the requisite examinations, ***which entitles that individual to perform the functions and duties as delineated by the classification for which the certificate was issued.***

S.C. Code Ann. § 44-61-10(6) (2017) (emphasis added)[1]. Witnesses and counsel alike used the terms "certificate" and "license" interchangeably in this matter. (July 24th Trial Tr. 20:2; July 27th Trial Tr. 76:22 and 78:4-79:1; July 28th Trial Tr. 132:7 and 257:19). Discipline and enforcement, as used in this context, also have the same meanings. In fact, the EMS Act utilizes both terms. *See* S.C. Code Ann. §§ 44-61-20(30) (requiring the State Medical Control Physician

[1] The *EMS Act* defines "license" as "an authorization to a person, firm, corporation, or governmental division or agency to provide emergency medical services in the State." Licensees are ambulance and first responder agencies, such as Iva Rescue Squad, and certificate holders are EMTs, such as Respondent. Licenses and certificates are both privileges conferred by the Department to perform certain activities with licenses being issued to agencies (to perform as ambulance and first responder agencies) and certificates being issued to professionals (to practice as EMTs).

duties to include "provide recommendations for *disciplinary actions* in cases involving inappropriate patient care;") and 44-61-80(F) (providing "The department may take *enforcement action* against the holder of a certificate . . . ."). Both terms refer to administrative sanctions imposed by a regulatory body based upon some alleged noncompliance. Witnesses and counsel likewise used the terms "enforcement" and "discipline" interchangeably throughout this matter. (July 24th Trial Tr. 37:15; July 26th Trial Tr. 266:12-15 and 305:5-16; July 27th Trial Tr. 38:9-11, 80:23-81:1, 151:16-20, 205:24; Resp't prehearing statement at p. 3 and req. to produc. 3).

The POL Boards and the Department in the EMT context regulate professionals through licensure/certification schemes that are aimed at protecting the health, safety, and welfare of South Carolinians. These agencies exercise the same general quasi-legislative and quasi-judicial functions over their respective professionals. The quasi-legislative functions include promulgation of regulations. *See, e.g.*, State Board of Medical Examiners regulations, S.C. Code Ann. Regs. 81-1 *et seq.*; State Board of Nursing regulations, S.C. Code Ann. Regs. 91-1 *et seq.*; and *Emergency Medical Services*, 3 S.C. Code Ann. Regs. 61-7. The quasi-judicial functions include determinations of compliance and discipline or enforcement. *See, e.g.*, S.C. Code Ann. §§ 40-1-120(A) and provisions in practice acts for POL Board discipline authority; § 44-61-80(F) for Department enforcement authority. The POL Boards and the Department in the EMT context even follow the same general steps with regards to discipline or enforcement – (1) Receipt of initial complaint; (2) Investigation by staff; (3) Review of evidence by an IRC; (4) IRC recommendation; (5) Presentation of facts to the Board (POL Board or DHEC Board); and (6) final decision. *See* Melina Mann, Holly G. Pisarik, and Benjamin P. Mustian, *Professional and Occupational Licenses*, in South Carolina Administrative Practice and Procedure 6, 276-277 (Randolph R. Lowell 3rd ed. 2013). The lone distinction is that contested cases for POL Boards disciplinary

actions are conducted before the respective Board or a delegated hearing panel or officer. By contrast, contested cases for the Department Bureau of EMS enforcement actions are conducted before the ALC. Both contested case hearings involve discovery, are subject to the rules of evidence, and have a preponderance of the evidence standard of proof. The policy rationale behind Section 15-77-300(C) of not hindering or obstructing action against professionals by regulatory bodies exercising their lawful police powers is present with both the POL Board disciplinary actions and the Department enforcement actions against EMTs. Based upon these similarities, it is reasonable and in accordance with legislative intent to hold that the Department's EMT enforcement actions are not subject to attorney's fees in accordance with Section 15-77-300(C).

For the above reasons, this contested case involving the Department's enforcement authority against a regulated professional should not be subject to an award of attorney fees pursuant to S.C. Code Ann. Section 15-77-300.

II. If this matter is subject to attorney's fees, Respondent is not entitled to attorney's fees because the Court determined Respondent committed misconduct and/or unacceptable emergency medical treatment, the Department's action had a reasonable basis in law and fact, and special circumstances exist that make an award of attorney's fees unjust.

"There are three prerequisites that must be established prior to recover of attorney's fees and costs by a party contesting state action. First, the contesting party must be the 'prevailing party;' second, the court must find that the agency acted without substantial justification in pressing its claim against the party; and third, the court must find that there are no special circumstances that would make an award of attorney's fees unjust." *City of Charleston v. Masi*, 362 S.C. 505, 510, 609 S.E.2d 301, 304 (2005). The three prerequisites for awarding attorney's fees pursuant to Section 15-77-300 are not present in this matter.

A. While the Department's administrative order was vacated, Respondent was not the prevailing party regarding all alleged misconduct and unacceptable emergency medical treatment.

Respondent requested the Court dismiss the case "outright" and "without any disciplinary action." (July 28th Trial Tr. 289:6-8; Resp't prehearing statement at p. 3). The Court did not dismiss the case outright or without any discipline. Instead, the Court determined Respondent committed misconduct and/or unacceptable emergency medical treatment in particular based upon the patient abuse and ordered Respondent to complete the PEPL class. Declining to affirm the Department's discipline, the Court determined there "is insufficient evidence that Respondent committed misconduct . . . such that revocation is warranted." (Final Order at p. 11). Therefore, Respondent is not the prevailing party.

B. The process for reviewing and taking enforcement and the record demonstrate the Department had a reasonable basis in law and fact in issuing the administrative order.

The Department is charged with administering the EMS program, which includes the certification of EMS personnel. *See* S.C. Code Ann. § 44-61-30(A) and -(B)(4). Section 15-77-300(A) states, in part, "The agency is presumed to be substantially justified in pressing its claim against the party if the agency follows a statutory or constitutional mandate that has not been invalidated by a court of competent jurisdiction." Accordingly, Respondent bears the burden in proving the Department acted "without substantial justification" in pressing its claim. *See R.P. v. S.C. Dep't of Health and Human Servs.*, 06-ALJ-08-0605-AP (May 15, 2014) (holding that "unlike under federal law, the party seeking attorneys' fees pursuant to Section 15-77-300 has the burden of proving that the government agency acted without substantial justification."). Substantial justification for purposes of Section 15-77-300 does not mean "justified to a higher degree," but rather "justified to a degree that could satisfy a reasonable person." *Heath v. County of Aiken*, 302 S.C. 178, 183, 394 S.E.2d 709, 712 (1990) (*quoting Pierce v. Underwood*, 487 U.S. 552, 564, 108 S. Ct. 2541, 101 L. Ed. 2d 490 (1988)). The relevant inquiry

is whether the agency's position in litigating the case had a reasonable basis in law and in fact. *McDowell*, 304 S.C. at 542. In analyzing substantial justification, courts will consider "the substance and outcome of the matter eventually litigated." *Layman v. State*, 376 S.C. 434, 448, 630 S.E.2d 265, 327 (2008) (*citing Heath* at 302 S.C. at 184). The substance of the matter litigated involves an inquiry into the clarity of the governing law – i.e., whether the applicable law was clear and settled by precedent or ambiguous with no precedent. *See, e.g., McDowell*, 304 S.C. 539 (1991) (finding DSS acted without substantial justification when there was settled precedent contrary to its position), *Layman*, 376 S.C. 434 (2008) (finding the State acted without substantial justification when the State breached an unambiguous contract with certain TERI participants), *Heath*, 302 S.C. 178, 394 S.E.2d 709 (1990) (finding a county acted without substantial justification in violating an unambiguous statute); *see also* 32 Am Jur 2d Federal Courts §§ 254, 256, 260, and 261. The Department had a reasonable basis in law and fact in proceeding with enforcement.

This matter went through several administrative filters prior to reaching the ALC. In evaluating the investigation and potential enforcement, the Department consulted Dr. DesChamps, the State Medical Control Physician who is responsible with "provid[ing] recommendations for disciplinary actions in cases involving inappropriate patient care." S.C. Code Ann. § 44-61-20(30); (July 26th Trial Tr. at 232:7-233:16 and 293:25-294-24). The Department then convened the IRC, a professional peer review committee composed of experienced EMS professionals including the State Medical Control Physician, which reviewed information gathered during the Department's investigation, heard from Respondent, and issued recommendations. S.C. Code Ann. § 44-61-20(16). In fact, the Department adopted the recommendations of the IRC in proceeding with enforcement. (July 27th Trial Tr. at 42:13-44:21). Additionally, the DHEC Board

reviewed Respondent's RFR and the Department's administrative order and ultimately declined to conduct a final review conference. Although the administrative order was vacated, the Court agreed in part with the Department's administrative order holding Respondent committed patient abuse. Regardless of this Court's ultimate conclusion, the fact that the decision was formulated utilizing this process supports the reasonableness of the Department's enforcement.

Furthermore, unlike the various cases where courts have held the government acted without substantial justification, the law in this EMT discipline context is not clearly settled and unambiguous. With exception to one contested case, there is no case law on the subject matter of this case. *See S.C. Dep't of Health and Envtl. Control v. Platt*, 2006-ALJ-07-0477 (Aug. 28, 2007). The parties presented arguments regarding statutory and regulatory provisions that are arguably ambiguous. This contested case is in many regards a case of first impression. *See Cody v. Caterisano*, 631 F.3d 136, 142 (4th Cir. 2011) ("litigating cases of first impression is generally justifiable").

In his Petition, Respondent cites bits and pieces of the Court's Order then without any analysis concludes the Department's enforcement was not substantially justified. (Resp't Pet. at pp. 2-3). Respondent fails to meet this burden. The record, which consisted of five days of trial testimony and numerous exhibits, contains evidence reasonably supporting the Department's enforcement. In conclusion, the Department acted in good faith, utilized multiple levels of review, and based its decision upon reasonable facts. Therefore, the Department was substantially justified in issuing and defending its administrative order.

C. Awarding attorney's fees would be unjust because doing so would chill future enforcement actions.

Special circumstances exist which make an award of attorney's fees unjust. Though there are not any South Carolina cases regarding special circumstances, the South Carolina Supreme

Court has noted the similarity between Section 15-77-300 and the *Equal Access to Justice Act* (the EAJA)[2] and there are instructive federal cases addressing the EAJA special circumstances. *See, e.g., Heath*, 302 S.C. 178 (1991) and *McDowell*, 304 S.C. 539 (1991). The EAJA special circumstances exception was held to act as a safety valve and serves at least two purposes. *The Taylor Group, Inc. v. Johnson*, 919 F.Supp. 1545 (M.D. Ala 1996); *see also* 32 Am Jur 2d Federal Courts 263. First, the exception helps insure that the government is not deterred from advancing in good faith the novel, but credible extensions and interpretations of the law that often underlie vigorous enforcement efforts. *Id.* Second, it gives the court discretion to deny awards where equitable considerations dictate an award should not be made. *Id.*

The Department is the agency charged with the regulation and certification of EMTs. S.C. Code Ann. § 44-61-30(B)(4). Awarding attorney's fees against the Department when it had reasonable evidence supporting its allegations and a good faith and reasonable basis in law would deter future enforcement actions. This chilling effect is contrary to the General Assembly's granting of police powers to the Department. When reviewing cases where courts have awarded attorney's fees pursuant to Section 15-77-300, this case involving enforcement of professional standards is undoubtedly distinguishable. *Cf. with McNaughton v. Charleston Charter Sch. For Math & Sci., Inc.*, 411 S.C. 249, 768 S.E.2d 389 (2015) (awarding attorney's fees to a teacher in a breach of contract claim), *Heath*, 302 S.C. 178 (1990) (awarding attorney's fees when a county violated an unambiguous state statute), *Layman*, 376 S.C. 434 (2008) (awarding attorney's fees when the State and retirement system breached an unambiguous contract), and *McDowell*, 304

[2] 28 U.S.C. § 2412(d)(1) states, "Except as otherwise specifically provided by statute, a court shall award to a prevailing party other than the United States fees and other expenses, in addition to any costs awarded pursuant to subsection (a), incurred by that party in any civil action (other than cases sounding in tort), including proceedings for judicial review of agency action, brought by or against the United States in any court having jurisdiction of that action, unless the court finds that the position of the United States was substantially justified or that special circumstances make an award unjust."

S.C. 539 (1991) (awarding attorney's fees when DSS relied on an erroneous legal conclusion in denying food stamp benefits). Therefore, special circumstances exist that would make award of attorney's fees unjust and inequitable.

III. Should the Court grant attorney's fees, Respondent's requested fees are unreasonable and should be substantially reduced.

Respondent requests an award of attorney's fees and costs in the amount of $109,350 pursuant to S.C. Code Ann. Section 15-77-300, plus taxable costs under Rule 54, SCRCP. While the Department maintains attorney's fees should not be granted for the abovementioned reasons, the proposed amount is unreasonable and inconsistent with the fees allowed pursuant to Section 15-77-300.

First, Respondent inappropriately included time spent and expenses incurred prior to the contested case. Time spent and expenses incurred prior to the contested case are not recoverable under Section 15-77-300. In *McDowell*, the Supreme Court held that the plaintiff was not entitled to attorney's fees under Section 15-77-300 for the hearing before DSS because "at this point the agency was not 'pressing its claim' in litigation against [the plaintiff] but was merely functioning as an administrative decision-maker." *McDowell*, 304 S.C. at 543, 405 S.E.2d at 833; *see also Town of Arcadia Lakes, et al. v. S.C. Dep't of Health and Envtl. Control*, 09-ALC-07-0069-CC (June 14, 2017) (equating the DSS hearing in *McDowell* to a final review conference before the DHEC Board). Respondent included fees for time spent and expenses incurred during the IRC and DHEC Board review. These fees and expenses are not recoverable pursuant to Section 15-77-300.

Respondent also included various expenses, which are not recoverable against the Department pursuant to Section 15-77-300 and Rule 54(d), SCRCP. Rule 54(d) states, in part:

> Except when express provision therefor is made either in a statute or in these rules, costs shall be allowed as of course to the prevailing party unless the court otherwise

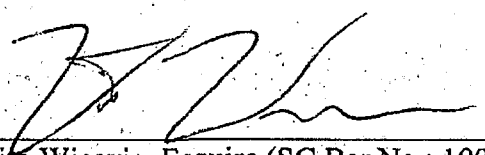
directs; but ***costs against the State, its officers, and agencies shall be imposed only to the extent permitted by law.*** . . . .

(Emphasis added). Respondent has cited no law allowing for recovery of costs or expenses against the Department in this matter. Section 15-77-300 references only "attorney's fees" and does not mandate reimbursement of incurred "expenses" or "costs." *Cf. with* EAJA (providing for recovery of "fees and other expenses"). Even if Section 15-77-300 allowed recovery of expenses, the various expenses included by Respondent, which include breakfast, lunch, and dinner bills from various restaurants[3], and mileage and parking expenses, are unreasonable and should not be recoverable.

Conclusion

For the abovementioned reasons, the Department respectfully requests the Court deny Respondent's Petition for Attorneys' Fees and Costs or, in the alternative, substantially reduce the sought after amount.

Respectfully Submitted,



Vito Wicevic, Esquire (SC Bar No.: 100265)
Ashley Biggers, Esquire (SC Bar No.: 17225)
South Carolina Department of Health and Environmental Control
2600 Bull Street
Columbia, SC 29078
P: (803) 898-3350
F: (803) 898-3367
E-mail: biggerac@dhec.sc.gov
E-mail: wicevivm@dhec.sc.gov

Columbia, South Carolina
April 5, 2018

[3] Restaurant bills include Ruth's Chris Steak House, Villa Tronco, J Peters, and other establishments. Note that it appears the Ruth's Chris bill is duplicated. There are two line items for dinner at Ruth's Chris on July 27, 2017, with each item being $216.20.

STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

South Carolina Department of Health and Environmental Control, Petitioner, vs. James W. Davenport, Respondent.	)	Docket No. 17-ALJ-07-0003-CC **RESPONDENT'S REPLY BRIEF IN SUPPORT OF PETITION FOR ATTORNEY'S FEES AND COSTS**

Respondent, James W. Davenport, by and through his undersigned counsel, hereby submits this Reply Brief in Support of Petition for Attorney's Fees and Court Costs. As explained in further detail below, Petitioner's brief contains a sanitized and misleading version of the procedural background and facts of the underlying contested case that is simply not supported by the record developed at trial. In addition, Petitioner's arguments would require the Court to disregard the plain language of the attorney's fees statute, S.C. Code Ann. § 15-77-300, as well as applicable provisions of the South Carolina Administrative Law Court Rules and the South Carolina Rules of Civil Procedure. Furthermore, Petitioner ignores the indisputable testimony of Petitioner's own witness, Robert Wronski, the Bureau Chief for EMS and Trauma at SC DHEC, who carefully explained the difference between a license and a certificate for EMTs and Paramedics, as well as the difference between the terms disciplinary action and enforcement.

As set forth in the Supplemental Affidavit of Respondent's Counsel attached hereto, Respondent seeks an additional 19.2 hours or $5,760.00 in attorney's fees and $4,343.85 in additional costs under the statute for obtaining the complete trial transcript and responding to Petitioner's brief.

As an initial matter, the "Background" section of Petitioner's brief fails to portray an accurate account of the procedural or factual background of the underlying matter. Petitioner completely disregards damaging testimony from Petitioner's own witnesses that Anderson County EMS Director, Scott Stoller, colluded with his former partner from the Greenville County EMS Department, Arnold Alier, who is now the DHEC EMS Director, for the purpose of harming Respondent's credibility in retaliation for Respondent's complaints about serious misconduct within the Anderson County EMS Department. The initial complaint about Respondent's treatment of the patients in question was initially dismissed as a "local problem" that did not warrant DHEC's involvement. After the body-camera video of one of the patient encounters was transmitted to DHEC in violation of DHEC's own protocols and the patient's privacy rights under HIPAA, DHEC initiated a sham "investigation" that was more interested in entrapping Respondent than in discovering the underlying facts. DHEC completely disregarded Respondent's due process rights, as well as fundamental principles of common decency, in trying to force Respondent to surrender his paramedic certification. Petitioner's Medical Director, Dr. Edgar Deschamps, was involved from the very earliest review of the body-camera video, to leading the Investigative Review Committee, to the final agency decision, and even to serving as a expert witness for DHEC at trial. This process was not an independent effort to gather all relevant facts, to deliberate fairly about the standard of care provided, and to improve the quality of pre-hospital care in the interests of public safety. Instead, it was a rushed, strategic effort to achieve the "ultimate objective" of forcing Mr. Davenport to surrender his paramedic certification. This attorney's fee petition is a necessary check on potential abuses of the substantial power that DHEC wields over men and women who devote their careers to public health as paramedics and EMTs in South Carolina.

Turning to the merits of Petitioner's brief, Petitioner first argues that Section 15-77-300 is not applicable here because the underlying contested case is not a "civil action" as that phrase is used in the statute. With all due respect, Petitioner's argument suggests an overly narrow reading of the statute. The term "civil action" is not defined by S.C. Code Ann. § 15-77-300. Black's Law Dictionary defines the term "civil action" as follows: "An action brought to enforce, redress, or protect private rights. In general, all types of actions other than criminal proceedings." Black's Law Dictionary at 245 (6th ed. 1990).

The underlying contested case before the Administrative Law Court is clearly a "civil action," not a criminal or quasi-criminal action. The standard of proof in a contested case before the ALC is generally by a preponderance of the evidence, not beyond a reasonable doubt. S.C. Code Ann. § 1-23-600(A)(5). Rule 68 of the South Carolina Administrative Law Court Rules actually incorporates the South Carolina Rules of Civil Procedure (not Criminal Procedure) to contested cases, to the extent that questions are not specifically addressed by the ALC Rules. SCALC Rule 68. Rule 1 of the South Carolina Rules of Civil Procedure similarly provides, "These rules govern the procedure in all South Carolina courts in all suits of a civil nature . . . ." Rule 1, SCRCP (emphasis added); see also Rule 81, SCRCP ("These rules, or any of them, shall apply to every trial court of civil jurisdiction within this state . . . ."). Furthermore, Rule 2 of the South Carolina Rules of Civil Procedure provides, "There shall be one form of action to be known as 'civil action.'" Rule 2, SCRCP. This provision reflects the modern practice of merging of actions at law with suits in equity and is not intended to exclude cases in the Administrative Law Courts. There can be no doubt that a contested case before the ALC is a civil action.

Petitioner also argues that this contested case is not a "civil action" because it was not

commenced by the filing of a summons and complaint. Petitioner is simply misreading Rule 3 of the South Carolina Rules of Civil Procedure. Rule 3 does not define what a "civil action" is; rather, Rule 3 merely defines when an case under the rules is deemed "commenced." Petitioner's argument was squarely rejected by the South Carolina Supreme Court in McDowell v. South Carolina Department of Social Services, 304 S.C. 539, 543, 405 S.E.2d 830, 833 (1991) ("DSS contends . . . this is not a 'civil action' since it is not commenced by service of a summons and complaint, *see* Rule 2 and 3(a), SCRCP, and § 15-77-300 by its terms applies only to 'civil action.' We reject DSS's argument."). Indeed, the McDowell case was commenced by the Appellant under the previous version of the APA, S.C. Code Ann. § 1-23-380, contesting the agency's decision to deny food stamps, not by filing a summons and complaint; yet, the SC Supreme Court concluded that the case was a civil action for purposes of the attorney's fees statute. 304 S.C. at 540, 405 S.E.2d at 832.

The fact that the ALC is situated in the executive branch and not the judicial branch of South Carolina government in not relevant. The 2004 amendment to Section 1-23-500 of the South Carolina Code expressly describes the SCALC as "a court of record." S.C. Code Ann. § 1-23-500.

Petitioner also asserts that an unsuccessful attempt in 1997 to amend Section 15-77-300 in an effort expressly to incorporate administrative proceedings into the statute suggests that the Section 15-77-300 was originally intended to exclude matters before the ALC. This argument is simply unavailing. Proposed legislation that was never enacted, especially a proposed bill that was rejected over twenty years ago, has no bearing on any statute. Petitioner's quotation from the case of Vernon v. Harleysville Mut. Cas. Co., 244 S.C. 152, 157, 135 S.E.2d 841, 844 (1964), is simply misplaced. The proposed bill from 1997 referenced by Petitioner was not adopted by the General Assembly.

The Vernon case actually contains language that is strongly supportive of Respondent's

position, not that of Petitioner. The South Carolina Supreme Court in Vernon stated, "Where the terms of statutes are positive and unambiguous, exceptions not made by the Legislature cannot be read into the Act by implication. Where there is an express exception in a statute, all other exceptions which are not expressly set forth are excluded. The inclusion of one exception amounts to an affirmation of the applicability of the statute's provision to all other cases which are not excepted." Id.

Petitioner next asserts that the case against Mr. Davenport is analogous to one of the listed exceptions in Section 15-77-300(C), which excludes "disciplinary actions by state licensing boards." S.C. Code Ann. § 15-77-300(C). According to Petitioner, DHEC should be considered by the Court to be the equivalent of a "state licensing board" because its regulation of EMTs and paramedics is "substantially the same" as the function performed by various Professional and Occupational Licensing Boards administered by the South Carolina Department of Labor, Licensing and Regulation. The terms "disciplinary action" and "state licensing boards" are not expressly defined by Section 15-77-300. It is clear that the General Assembly intended the phrase "state licensing boards" to refer to the Professional Licensing Boards administered by the South Carolina Department of Labor, Licensing, and Regulation. As Petitioner has conceded, DHEC is a separate governmental agency from LLR within the executive branch of government. S.C. Code Ann. §§ 1-30-10(A); 1-30-45 (DHEC); and 1-30-65 (LLR). Professional licensing boards are governed by an extensive statutory scheme found in Title 40 of the South Carolina Code, as well as by regulations promulgated by the respective governing boards of each of the over three dozen specific regulated professions. Section 40-1-20(3) defines the term "board" to mean "the group of individuals charged by law with the responsibility of licensing or otherwise regulating an occupation or profession within the State."

S.C. Code Ann. § 40-1-20(3). The phrase "disciplinary action proceedings" is also a defined term under S.C. Code Ann. §§ 40-1-90 and -120.

Paramedics and EMTs are not governed by Title 40. Instead, they are governed by the Emergency Medical Services Act of South Carolina, S.C. Code Ann. § 44-61-10 et seq., which is administered by DHEC, not by LLR. If the General Assembly had intended for DHEC matters to be included within the exception to Section 15-77-300(C), it would have done so expressly. See Vernon, 244 S.C. at 157, 135 S.E.2d at 844 ("Where there is an express exception in a statute, all other exceptions which are not expressly set forth are excluded.").

Petitioner asserts that during the trial, counsel and witnesses routinely used the terms "licence" and "certificate," as well as the terms "disciplinary action" and "enforcement action" interchangeably. This argument disregards the extensive testimony of Mr. Wronski, the EMS and Trauma Bureau Chief, who carefully distinguished between the two pairs of statutory terms:

> Q. And I think this is important because you keep using the term licensor.
>
> A. I'm sorry. Would you like me to clarify? It's another one of those interchangeable terms. EMT's and paramedics are not licensed. Only LLR licences. We issue credentials.
>
> * * * *
>
> Q. You do issue some licenses, but paramedics and EMT's receive certificates, right?
>
> A. Credential certificates. Yes, sir.
>
> Q. The only licenses you issue would be to somebody like Dr. Kickham, the Medical Control Physician, is that right?
>
> A. No, sir. We only issue licenses to the agencies.
>
> Q. Okay.

A. So the agency is licensed.

Q. Okay. I'm sorry. So Dr. Kickham's Anderson County EMS gets the licenses, right?

A. Yes.

Q. Okay. So when you issue licenses it's to agencies, not to paramedics and EMT's?

A. Correct. Yes, sir.

(Tr., Vol. 4, at 78, l.4 to 79, l.1) (emphasis added).

Mr. Wronski was also careful to point out the difference between the terms "disciplinary action" and "enforcement action":

Q. So under subsection F of this statute [(S.C. Code Ann. § 44-61-80(F))], the Department may take enforcement action, okay, against the holder of a certificate at any time it is determined that the holder no longer meets the prescribed qualifications set forth by the Department or has failed to provide to patients emergency medical treatment of a quality deem[ed] acceptable by the Department or is guilty of misconduct. You see that?

A. Yes, sir.

Q. Okay. So this is the statutory authority for you to take enforcement action against Mr. Davenport, right?

A. Against any paramedic or EMT. Yes, sir.

Q. And it's not disciplinary action. It's enforcement action?

A. It's enforcement. Yes, sir. We don't like to use that word.

(Tr., Vol. 4, at 80, l. 8 to 81, l. 1).

Petitioner completely ignores Mr. Wronski's testimony in this regard. Instead, Petitioner's counsel cherry-picks approximately a dozen instances in the over 1,300 pages of trial transcript

where witnesses or counsel alike allegedly used the terms "certificate" and "license" interchangeably or used the terms "enforcement" and "discipline" interchangeably. Petitioner's argument is unavailing for several reasons. First, one of the most basic aspects of every jury instruction is the admonition, "What the lawyers say is not evidence." See, e.g., Bennett v. Angelone, 92 F.3d 1336, 1347 (4th Cir. 1996). Next, in several of the passages cited by Petitioner, Respondent's counsel immediately corrected himself to use the proper term of art. See Tr., Vol. 3, at 266, ll. 12-14 ("Okay, but you at DHEC are not going to discipline that or take enforcement action against that paramedic who let the patient walk."); Tr., Vol. 4, at 151, ll. 16-20 ("And I think one of the other ground that you've mentioned for proposed disciplining – sorry, enforcement action against Mr. Davenport's paramedic certificate is patient abandonment. Is that right?"); Tr., Vol. 5, ll. 5-7 ("A little girl died in the fire, and you didn't take any action against the paramedic's license or certification, did you?") (emphases added). One of the passages cited by Petitioner is actually a question from Petitioner's counsel, which he certainly cannot use in his own favor. See Tr., Vol. 4, at 38, ll. 9-11. In any event, the relevant issue is what terms the General Assembly used in enacting the statute, not whether counsel or witnesses slipped up in their phraseology a handful of times during a 5-day trial.

Petitioner also argues that the underlying functions of the POL Boards (with licenced professionals) and DHEC (with paramedics and EMTs) is analogous, so the Court should overlook the actual language used in the respective statutes. Petitioner asserts that because both LLR and DHEC regulate professionals, the underlying policy of S.C. Code Ann. § 15-77-300(C) of not hindering or obstructing action against professionals by regulatory bodies is the same. Although this may be an argument DHEC should make to the General Assembly to amend Section 15-77-300(C), the plain language of the statute compels a different result.

Next, in Section II of its brief, Petitioner asserts that Respondent was not the "prevailing party" under the attorney's fee statute because the Court found that Respondent acted rudely in speaking with the patient in question, and because the Court ordered Respondent to take a continuing education class within nine months of receipt of the Court's order. As mentioned in the initial Petition for Attorney's Fees and Court Costs, the South Carolina Supreme Court has expressly stated that a party can be considered the "prevailing party" for purposes of Section 15-77-300 without prevailing on all issues. Heath v. County of Aiken, 302 S.C. 178, 182, 394 S.E.2d 709, 711 (1990) ("[A] party need not be successful as to all issues in order to be found to be a prevailing party."). Here, there can be no real dispute that Mr. Davenport was the prevailing party. DHEC's administrative order was vacated in its entirety. The PEPL class was never part of DHEC's administrative order; instead, this was only a requirement imposed internally by the Anderson County EMS Medical Control Physician. Respondent himself always acknowledged that his language with the patient in question was not appropriate.

Petitioner also asserts that Respondent cannot demonstrate that the state acted "without substantial justification" in pressing its case against Respondent. The appropriate inquiry here is whether the state's case had a "'reasonable basis in law and fact.'" McNaughton v. Charleston Charter School for Math & Sciences, Inc., 411 S.C. 249, 267, 768 S.E.2d 389, 399 (2015). The fact that this matter allegedly went through "several administrative filters" prior to reaching the ALC is not significant. With all due respect, none of the steps DHEC took prior to the final agency action had any degree of independent review: Deschamps, Wronski, and Alier were intimately involved in all administrative steps at DHEC. Wronski actually testified that he crafted a strategy immediately after viewing an unofficial copy of the body-worn camera video to achieve the "ultimate objective"

of forcing Respondent to relinquish his paramedic credentials. In fact, at no time during this process was Respondent ever presented with any proposed consent order that would have allowed him to retain his paramedic certification. No evaluation was made of any potential mitigating circumstances surrounding Mr. Davenport's comments, nor was any consideration given to the fact that no patient suffered any adverse outcome. Compared to other enforcement actions against paramedics and EMTs reported by DHEC within the past 10 years, the proposed actions against Respondent in this case were unusually harsh. See South Carolina Dep't of Health & Envt'l Control v. Stuart Platt, Docket No. 06-ALJ-07-0477-CC (Final Order and Decision, July 20, 2007), at p. 18 of 19 ("I find that revocation, the highest punishment, is not warranted in this case since this is Respondent's first violation.").

Petitioner's argument that an award of attorney's fees would "chill future enforcement actions" is not particularly persuasive. The language of the statute "without substantial justification" already ensures that legitimate enforcement efforts will not be implicated. Respondent suggests that actions taken against private citizens of modest means in an effort to deprive them of their ability to earn a livelihood in their chosen profession should be carefully scrutinized. DHEC must ensure that any enforcement action it takes against an EMT or paramedic has a reasonable basis in law and in fact. Petitioner's case against Mr. Davenport was simply not based on a novel theory or a good-faith effort to extend the law. DHEC's enforcement power should not have been used as a tool to do the bidding of the Anderson County EMS Director to retaliate against Mr. Davenport.

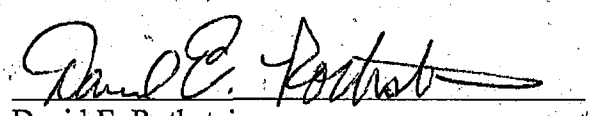
With respect to the amount of attorney's fees requested, Respondent agrees that under the holding of McDowell v. South Carolina Department of Social Services, 304 S.C. 539, 405 S.E.2d 830 (1991), the attorney's fee statute only applies after the final agency decision was rendered and

Respondent filed his request for a contested case hearing. Respondent agrees that only time entries on or after December 10, 2016, are properly compensable under Section 15-77-300. Accordingly, Respondent's attorney's fee request should be reduced by 40.7 hours or $12,210.00 for time entries prior to December 10, 2016. (Rothstein Supp. Aff., at 2-3, ¶ 8). On the other hand, since Respondent filed his fee petition on March 21, 2018, Respondent's counsel has devoted another 19.2 hours to the case in review Petitioner's brief and in preparing this Reply brief. (Id. at 2, ¶ 6). Accordingly, the fee petition should be increased by $5,760.00, for a net reduction of $6,450.00 from the original attorney's fee request.

Finally, with respect to the request for costs, Respondent concedes that one meal charge during the trial has been inadvertently duplicated in the amount of $216.20. Respondent's counsel apologizes for this oversight. Respondent has submitted an itemized listing of expenses, which the Court can easily line through items that are not properly recoverable under the statute. In the interest of keeping Respondent's expenses as low as possible, Respondent's counsel did not initially order a copy of the trial transcript. Unfortunately, because Petitioner cited to several portions of the trial transcript in its brief in opposition to the petition for attorney's fees and court costs and because Petitioner's counsel refused to provide an electronic copy of the transcript to Respondent's counsel, Respondent's counsel was reluctantly forced to purchase a copy of the trial transcript, which has added $3,938.20 to the recoverable costs in this matter. (Rothstein Supp Aff., at 1-2, ¶¶ 4, 5, and 7).

In conclusion, for all of the foregoing reasons and for the reasons stated in Respondent's original Petition, Respondent requests an award of attorney's fees in the amount of $102,900.00 pursuant to S.C. Code Ann. § 15-77-300, plus taxable costs under Rule 54, SCRCP.

Respectfully submitted,



David E. Rothstein
ROTHSTEIN LAW FIRM, PA
1312 Augusta Street
Greenville, SC 29605
(864) 232-5870 (office)
(864) 241-1386 (facsimile)
drothstein@rothsteinlawfirm.com

Attorney for Respondent, James W. Davenport

April 16, 2018

Greenville, South Carolina.

STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

South Carolina Department of Health and Environmental Control, Petitioner, vs. James W. Davenport, Respondent.	)	Docket No. 17-ALJ-07-0003-CC **SUPPLEMENTAL AFFIDAVIT OF RESPONDENT'S COUNSEL, DAVID E. ROTHSTEIN**

STATE OF SOUTH CAROLINA)
)
COUNTY OF GREENVILLE)

PERSONALLY appeared before me David E. Rothstein, who, after being duly sworn, deposes and states the following:

1. My name is David E. Rothstein. I am older than eighteen years of age. The statements in this Supplemental Affidavit are based upon my own personal knowledge.

2. I am counsel for Respondent, James W. Davenport, in the above-captioned case.

3. In an effort to keep Mr. Davenport's costs as low as possible in this case, I decided not to order the transcript of the trial or split the cost of the transcript with Petitioner. This seemed especially prudent after the Court indicated that proposed orders did not need to include citations to the trial record.

4. Petitioner's brief in opposition to Respondent's Petition for Attorney's Fees and Court Costs included several citations to the trial transcript, as well as various representations about

testimony during the trial. I attempted to obtain the trial transcript from DHEC's counsel, who declined to provide an electronic copy to me. I also attempted to obtain the transcript directly from the Court, because I understood that DHEC had filed the original transcript as part of the record. I was informed by the Clerk of the Administrative Law Court that I would have to obtain the transcript directly from the court reporting firm.

5. On Wednesday, April 11, 2018, I requested a copy of the transcript from Creel Court Reporting in Columbia, SC. Creel's invoice for the copy of the transcript was $3,938.20, which I paid by firm credit card. A true and accurate copy of the invoice from Creel is attached hereto as Exhibit A.

6. I have spent an additional 19.2 hours in connection with this contested case since the Court's Final Decision and Order. Attached hereto as Exhibit B is a copy of my latest invoice summarizing my contemporaneous time entries relating to this case since March 20, 2018. I believe that all of the time recorded in Clio is reasonable and was necessary in the representation of Mr. Davenport.

7. Since March 20, 2018, my firm has also incurred $4,343.85 in expenses, the majority of which relates to obtaining the electronic copy of the trial transcript and printing a hard copy. After reviewing DHEC's brief in opposition to the Petition for Attorney's Fees and Court Costs, I realized that one of my previous invoices inadvertently had one expense from July 27, 2017 reported twice. I have now removed the extra $216.20 expense, which is shown as a credit on the current invoice.

8. I have also reviewed my previous invoices to count the time I spent on Mr. Davenport's file prior to the final agency decision in this matter. From April 21, 2016 to December

 DEP

7, 2016, I spent a total of 40.7 hours on this matter while the case was still at the agency levels of DHEC.

FURTHER AFFIANT SAYETH NOT.

David E. Rothstein

SWORN to and subscribed before me,

this 16th day of April, 2018

H. Lorraine Miller (L.S.)
Notary Public for South Carolina

My commission expires: 3/28/27

H. LORRAINE MILLER
NOTARY PUBLIC
State of South Carolina
My Commission Expires Mar. 28, 2027

Exhibit A

CREEL COURT REPORTING, INC.
1230 Richland Street
Columbia, SC 29201
(803) 252-3445

4/11/2018

Tax ID: 57-1016805

INVOICE NO. 18-0641

David E. Rothstein, Esquire
Rothstein Law Firm
1312 Augusta Street
Greenville, SC 29605

Attorney for Respondent

We accept:

RE: SC DHEC vs. James W. Davenport
Docket No. 17-ALJ-07-0003-CC

ONE COPY - Hearings before the Honorable Shirley C. Robinson	0.00
Transcript of Hearing 7.24.17	556.80
Transcript of Hearing 7.25.17	661.20
Transcript of Hearing 7.26.17	948.30
Transcript of Hearing 7.27.17	928.00
Transcript of Hearing 7.28.17	843.90
Condensed Transcript/Key Word Index	0.00
E-Transcript ONLY	0.00

For accounts that are 90 days past due a service charge of 2.5% will be applied.

After 120 days a service charge of 5.0% will be applied.

Total	$3,938.20
Payments/Credits	$0.00
Balance Due	$3,938.20

THANK YOU!
(Please return copy with remittance)

/tm

Visit Us On the Web and Book Your Upcoming Depositions Online at creelreporting.com

Exhibit B

Invoice # 680
Date: 04/15/2018
Due Upon Receipt

ROTHSTEIN LAW FIRM, PA
1312 Augusta Street ◆ Greenville, SC 29605

James W. Davenport
108 Burberry Drive
Williamston, SC 29697

16-042

James W. Davenport adv. SCDHEC 17-ALJ-07-0003-CC

Services

Attorney	Date	Description	Quantity	Rate	Total
DER	08/07/2017	Email from Mr. Wicevic about redacted copy of exhibits (0.1)	0.10	$300.00	$30.00
DER	03/12/2018	Email from Wicevic (0.1)	0.10	$300.00	$30.00
DER	03/21/2018	Email from Mr. Wicevic (0.1); legal research and prepare petition for attorney's fees (3.8); email from Ms. Davenport (0.2); prepare filing letter (0.1); email to court and opposing counsel with copy of fee petition (0.1); email to Mr. Davenport (0.1); email to James Smith about Judge Robinson's order (0.1)	4.50	$300.00	$1,350.00
DER	03/22/2018	Email from Ms. Hazel re: receipt of petition (0.1); email to Ms. Hazel about transcript (0.1); email from Ms. Hazel about transcript (0.1)	0.30	$300.00	$90.00
DER	03/30/2018	Email from DHEC's attorneys to court requesting extension (0.1); email to Ms. Hazel consenting to extension (0.1); email from court re: extension (0.1); email from Mr. Wicevic (0.1); email to Mr. Davenport (0.1); email from Mr. Davenport (0.1)	0.60	$300.00	$180.00
DER	04/05/2018	Email from DHEC with brief in opposition to attorney's fee petition (0.1); review brief (0.8)	0.90	$300.00	$270.00
DER	04/09/2018	Email to Mr. Davenport about DHEC brief (0.1); TC to Creel Court reporting about transcript (0.1); email to and from Mr. Davenport about transcript (0.1); email to Ms. Hazel (0.1); email from Ms. Hazel (0.1); email to Mr. Wicevic (0.1)	0.60	$300.00	$180.00
DER	04/10/2018	TC to Mr. Smith about transcript (0.3); email to Mr. Wicevic (0.1); email from Mr. Wicevic (0.1); research re: reply brief (0.4); email to Ms. Hazel about reply brief (0.1)	1.00	$300.00	$300.00

DER	04/11/2018	Email from Mr. Wicevic about consent to extension (0.1); email from Ms. Hazel about reply brief (0.1); email to Ms. Hazel about extension (0.2); email from Wicevic about transcript (0.1); email to Mr. Davenport (0.1); TC to Mr. Davenport (0.2); email from Mrs. Davenport (0.1); TC to court reporter to order transcript (0.1); emails to court reporter about transcript (0.2); receive transcript from Creel (0.1); emails to Mr. and Mrs. Davenport about transcript (0.1)	1.40	$300.00	$420.00
DER	04/14/2018	Work on reply brief (4.2)	4.20	$300.00	$1,260.00
DER	04/15/2018	Work on reply brief (4.6); update billing records (0.5); prepare supplemental affidavit (0.4)	5.50	$300.00	$1,650.00
				Quantity Subtotal	**19.2**
				Services Subtotal	**$5,760.00**

Expenses

Date	Description	Quantity	Rate	Total
03/21/2018	Filing fee for fee petition.	1.00	$25.00	$25.00
03/21/2018	Copies: 81 x .20	1.00	$16.20	$16.20
03/21/2018	Postage: $1.84 + $2.05 + 3.10	1.00	$6.99	$6.99
04/03/2018	WestLaw Legal Research charges - March 2018	1.00	$85.66	$85.66
04/11/2018	Copies: 1,359 x .20	1.00	$271.80	$271.80
04/11/2018	Transcript of Administrative Hearing [TBD]	1.00	$3,938.20	$3,938.20
04/15/2018	Adjustment for duplicate expense (7/27/2017)	1.00	-$216.20	-$216.20
			Expenses Subtotal	**$4,127.65**

Time Keeper	Quantity	Rate	Total
David Rothstein	19.2	$300.00	$5,760.00
		Quantity Total	**19.2**
		Subtotal	**$9,887.65**
		Total	**$9,887.65**

Detailed Statement of Account

Other Invoices

Invoice Number	Due On	Amount Due	Payments Received	Balance Due
677	03/21/2018	$107,291.20	$0.00	$107,291.20

Current Invoice

Invoice Number	Due On	Amount Due	Payments Received	Balance Due
680	04/15/2018	$9,887.65	$0.00	$9,887.65
			Outstanding Balance	**$117,178.85**
			Amount In Trust	**$0.00**
			Total Amount Outstanding	**$117,178.85**

Please make all amounts payable to: Rothstein Law Firm, PA

Payment is due upon receipt.

STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

South Carolina Department of Health and Environmental Control,	)	Docket No.: 17-ALJ-07-0003-CC
Petitioner,	)	
vs.	)	**ORDER GRANTING RESPONDENT'S PETITION FOR ATTORNEY'S FEES**
James W. Davenport,	)	
Respondent.	)	

APPEARANCES: Petitioner: Vito Wicevic, Esquire
Ashley Biggers, Esquire

Respondent: David Rothstein, Esquire

STATEMENT OF THE CASE

This matter comes before the Administrative Law Court ("ALC") for a determination of James W. Davenport's ("Respondent") entitlement to reasonable attorney's fees. On January 6, 2017, Respondent filed a Request for Contested Case Hearing challenging the South Carolina Department of Health and Environmental Control's ("DHEC") Administrative Order revoking his Emergency Medical Technician-Paramedic Certification ("EMT Certification"). In July of 2017, this Court held a hearing on the matter. After careful consideration, on March 20, 2018, the Court vacated DHEC's Administrative Order. On March 22, 2018, Respondent moved for attorney's fees and court costs pursuant to S.C. Code Ann. § 15-77-300 (Supp. 2017). DHEC filed its memorandum in opposition to Respondent's Petition on April 5, 2018. Respondent subsequently filed his reply to DHEC's opposition on April 16, 2018.[1] A hearing on the motion was held on June 13, 2018. Having reviewed the evidence and applicable law, Respondent is entitled to reasonable attorney fees pursuant to § 15-77-300.

LEGAL STANDARD

The fee-shifting statute promulgated in § 15-77-300 authorizes the allowance of attorney's

[1] Without leave of the Court, DHEC filed a supplemental memorandum of law on June 22, 2018. Respondent objected to the pleading on June 25, 2018. Respondent's objection is sustained. This Court took the motion under submission following the June 13, 2018 hearing. Both parties had ample opportunity to fully brief the matter prior to this date. Consequently, DHEC's supplemental filing was untimely.

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fees to the prevailing party "[i]n any civil action brought by the State . . . if: (1) the court finds that the agency acted without substantial justification in pressing its claim against the party; and (2) the court finds that there are no special circumstances that would make the award of attorney's fees unjust." The South Carolina Supreme Court has interpreted this statute as having the following three basic prerequisites to recovery: (1) the party seeking attorney's fees is the prevailing party; (2) the agency lacked substantial justification in pressing its claim against the contesting party; and (3) no special circumstances exist which would render an award of attorney's fees unjust. *Heath v. Aiken County*, 295 S.C. 416, 420, 368 S.E.2d 904, 906 (1988). Whether to award attorney's fees pursuant to § 15-77-300 is in this Court's discretion. *See Heath v. County of Aiken*, 302 S.C. 178, 182, 394 S.E.2d 709, 711 (1990).

DISCUSSION

I. Applicability

As a threshold matter, DHEC urges the Court to find § 15-77-300 inapplicable to the case *sub judice*. In support of its contention, DHEC claims that the underlying contested case is an administrative action, not a civil action. DHEC also maintains that its order revoking Respondent's EMT Certification constituted a disciplinary action by a state licensing board, thereby foreclosing an awarding of attorney's fees under § 15-77-300.

A. Civil Actions

The allowance of attorney's fees under § 15-77-300 is only permitted in "civil action[s] brought by the State . . . ." The term civil action has not been defined by statute or case law. As a result, the court must "interpret the term in accord with its usual and customary meaning." *State v. Hudson*, 336 S.C. 237, 246, 519 S.E.2d 577, 581 (Ct. App. 1999)(citing *Strother v. Lexington County Recreation Comm'n*, 332 S.C. 54, 504 S.E.2d 117 (1998)). Black's Law Dictionary defines "civil action" as "[a]n action brought to enforce, redress, or protect a private or civil right; a noncriminal litigation." (10th ed. 2014). The term "action" is further defined as "[a] civil or criminal judicial proceeding." *Id.* Thusly, the customary meaning of civil action is simply a judicial proceeding conducted to determine one's private or civil rights.

This Court is a court of record, has the same power as circuit court judges, and is a judicial entity. *See* S.C. Code Ann. §1-23-500 (Supp. 2017); S.C. Code Ann § 1-23-630(A)(2005). In fact, the ALC serves as the adjudicatory body for contested cases involving DHEC. *Berry v. S.C. Dep't. of Health and Envtl. Control*, 402 S.C. 358, 364, 742 S.E.2d 2, 5 (2013)(citing S.C. Code

Ann. § 1–23–600(A)). Moreover, a contested case is defined as "a proceeding . . . in which the legal rights, duties, or privileges of a party are . . . determined . . . after an opportunity for hearing." S.C. Code Ann § 1-23-505(3) (Supp. 2017). I find minimal difficulty in concluding that the underlying proceeding meets the customary definition of civil action.

Regarding DHEC's proposition that all contested cases before the ALC are administrative actions, rather than civil actions, I find the reasoning espoused in *McDowell v. South Carolina Department of Social Services*, 304 S.C. 539, 405 S.E.2d 830 (1991) instructive. In that case, our Supreme Court held that a civil action commences once an agency ceases being the administrative decision-maker and begins "pressing its claim" in litigation. *Id.* at 543, 833. Therefore, once an agency renders its final decision, and that decision is subject to judicial review, a civil action is created. *Id.* In the case before me, DHEC stood as the administrative decision-maker from the inception of the initial investigation to the issuance of its Administrative Order. However, once the claim was placed before this Court, and DHEC began pressing its objective to have Respondent's EMT Certification revoked, the otherwise administrative action transformed into a civil action. For these reasons, the Court concludes that Respondent's contested case hearing equates to a civil action for purposes of qualifying for attorney's fees under § 15-77-300.[2]

B. Licensing Board

DHEC also purports that Respondent is precluded from recovering attorney's fees pursuant to the exception listed in § 15-77-300(C). More specifically, DHEC refers the Court to the statutory exception that fee-shifting does "not apply to . . . disciplinary actions by state licensing boards." DHEC believes that it is a state licensing board and that it imposed disciplinary action upon Respondent. I disagree.

While DHEC's argument is compelling, I am unable to identify any statutory authority qualifying DHEC as a "state licensing board" having the power to institute "disciplinary actions." On the contrary, The Emergency Medical Services Act of South Carolina ("EMS Act"), S.C. Code Ann. § 44-61-10, *et seq.*, bestows upon DEHC, *inter alia*, the responsibilities of training and certifying EMS personnel. § 44-61-30(B)(4)(2018). There is no language in the EMS Act that creates within DHEC a licensing board, nor does it provide DHEC with the power to institute

[2] DHEC also argues that a civil action must commence by service of a summons and complaint per Rules 2 and 3(a) of the South Carolina Rules of Civil Procedure. However, in *McDowell*, the Court specifically rejected this argument. 304 S.C. at 543, 405 S.E.2d at 833.

disciplinary action proceedings. DHEC presents a cognizable argument that its enforcement actions are tantamount to disciplinary actions by state licensing boards. Yet, the legislature did not provide for such language in the EMS Act. To juxtapose, the legislature, in S.C. Code Ann. § 40-1-40 (2011), charged the Division of Professional and Occupational Licensing, within the South Carolina Department of Labor, Licensing and Regulation, with "protect[ing] the public through the regulation of professional and occupational licensees . . . ." Accordingly, the legislature created numerous licensing boards and authorized those boards to "take *disciplinary action* . . . ." S.C. Code Ann. § 40-1-90(A)(2011). The exception outlined in § 15-77-300 is referring precisely to these types of disciplinary actions. Consequently, DHEC does not qualify for exemption and is subject to the fee-shifting provision of § 15-77-300.

II. Merits

Turning to the factors listed in § 15-77-300, the Court must ascertain the prevailing party of the contested case, DHEC's justification in pursuing revocation, and any special circumstances that would render an award of attorney's fees unjust.

A. Prevailing Party

DHEC maintains that Respondent does not qualify as the prevailing party because the Court ultimately found that he committed patient abuse. This contention is unpersuasive and contrary to the law. In *Heath,* our Supreme Court explained that "a party need not be successful as to all issues in order to be found to be a prevailing party." 302 S.C. at 182, 394 S.E.2d at 711. Instead, this Court must analyze "the degree of success obtained." 302 S.C. at 183, 394 S.E.2d at 711 (citing *Comm'r, Immigration and Naturalization v. Marie Lucie Jean,* 496 U.S. 154, 110 S.Ct. 2316 (1990)). The issue in the underlying contested case concerned the validity of DHEC's order revoking Respondent's EMT Certification. The Court, unable to find any grounds for revocation, vacated DHEC's Administrative order in its entirety. Respondent was unquestionably the prevailing party, as the relief requested was granted. To the extent this Court found a violation of Anderson County EMS's patient abuse policy, this finding does not affect Respondent's status as the prevailing party. The record reflects that Respondent challenged DHEC's Administrative Order of revocation, not Anderson County's imposition of remedial action in its quality assurance review.

B. Substantial Justification

The second factor the Court must consider in awarding attorney's fees is whether DHEC

"acted without substantial justification in pressing its claim . . . ." § 15-77-300(A)(1). Substantial justification has been interpreted to mean "justified to a degree that could satisfy a reasonable person." *Heath,* 302 S.C. at 183, 394 S.E.2d at 712 (quoting *Pierce v. Underwood,* 487 U.S. 552, 108 S.Ct. 2541 (1988)). Moreover, substantial justification is predicated on a "reasonable basis in law and fact." *Layman v. State*, 376 S.C. 434, 445, 658 S.E.2d 320, 326 (2008). In evaluating DHEC's justification in pressing its claim, the Court has the benefit of considering the outcome of the contested case. *Id.* (citing Heath, 302 S.C. at 183, 394 S.E.2d at 712)). However, DHEC's "loss on the merits does not create a presumption that its position was not substantially justified." *Id.* (citing *Video Gaming Consultants, Inc. v. S.C. Dep't. of Revenue*, 358 S.C. 647, 650, 595 S.E.2d 890, 892 (Ct. App. 2004). In addition, in determining the existence of substantial justification, the Court will evaluate DHEC's litigation position rather than the administrative events giving rise to the litigation. *Id.* (citing *McDowell*, 304 S.C. at 542, 405 S.E.2d at 832)).

The claim DHEC pressed was the complete revocation of Respondent's EMT Certification based on misconduct proscribed in S.C. Code Ann. § 44-61-80(F)(6), (8), and (14)(2018)—respectively listed as: disregarding a physician's order concerning emergency treatment or transportation; discontinuing care or abandoning the patient without the patient's consent or without providing for further administration of care by an equal or higher medical authority; and, by actions or inactions, creating a substantial possibility of death or serious physical harm. DHEC also utilized the catch-all provision of § 41-61-80(F), which allows certification revocation if the emergency medical treatment was of an unacceptable quality. The Court's inquiry, then, is whether DHEC had substantial justification, or a reasonable basis in law or fact, that any one of these specified grounds existed. I will address DHEC's basis for each ground in turn.

First, DHEC asserted that Respondent ignored standing orders of a physician. Essentially, DHEC combed the Anderson County EMS Standards of Care and Treatment Protocols Handbook ("Anderson County Handbook") and found guidelines and protocols that Respondent purportedly failed to follow. DHEC pressed its claim believing that any deviation from the applicable Anderson County Handbook protocols or guidelines constituted "disregard[ing] appropriate order by a physician concerning emergency treatment or transportation."

DHEC's own witnesses had difficulty attesting that the applicable guidelines and protocols equated to standing orders. In addition, the Anderson County Handbook, by its own words, discourages blindly following a protocol checklists, and explains that an EMT may deviate from

the guidelines if it can be documented and explained. In other words, and as DHEC's witnesses alluded to, the particular guidelines at issue provided for discretion. For example, Dr. Kickman, the Anderson County EMS Medical Director and author of the Anderson County Handbook, conceded that not all guidelines and protocols constitute doctor's orders. In fact, Mr. Kickman agreed that Respondent could make judgment calls and deviate from a number of the applicable guidelines and protocols. Likewise, Dr. Deschamps, DHEC's State Medical Control Physician, admitted that protocols are not synonymous with orders. Nonetheless, Dr. Deschamps testified, "Whether you violate the standing order or violate the protocol, it's not necessarily a difference in our eyes." This contradiction perfectly demonstrates DHEC's untenable position that any breach of guideline or protocol, however slight or nonsensical, constitutes grounds for certification revocation. Such is not the law. DHEC's reliance on this erroneous conclusion prevented it from forming the requisite amount of justification needed to support its claim. *See McDowell,* 304 S.C. at 542-43, 405 S.E.2d at 832-33 (holding that the Department of Social Services' litigation position was not substantially justified as it relied on an unsupported conclusion). Consequently, I find that DHEC lacked a basis in law or fact to pursue revocation on this ground.

Second, DHEC alleged misconduct on the grounds that Respondent discontinued the patient's care without his consent or without providing for the further administration of care by an equal or higher medical authority. DHEC's justification for this violation was based on Respondent's decision to drive the ambulance and have his less experienced partner, an EMT Basic, ride the call. Yet, DHEC's witnesses could not provide a definition or standard by which to assess the discontinuation of care. DHEC's position was further negated by Anderson County's protocol which specifically permitted Respondent to delegate patient management and transportation to his partner. Moreover, as this Court aptly found, the patient was stable and Respondent was "readily available to resume care of the patient if anything changed en-route to the hospital." DHEC's witnesses, Dr. Kickman and Dr. Deschamps, attested to the permissibility of such a maneuver to the subject call. I find that DHEC acted without substantial justification in seeking revocation for discontinuation of care, as a reasonable person would have been unsatisfied with the evidence, or lack thereof.

For the third ground of misconduct, DHEC alleged that Respondent's actions or inactions created a substantial possibility that death or serious physical harm would result.[3] DHEC

[3] In closing arguments, DHEC, relying on Dr. Deschamps' testimony, claimed that Respondent's failure to establish

maintained that Respondent's decision to walk the patient to the ambulance and then place him in a subpine position on the stretcher created a substantial possibility of death or serious physical harm. The problem with DHEC's position, however, was that it was unable to prove that Respondent's methods were any more prone to substantial harm than its experts' offered approaches. DHEC admitted that any movement of the patient created a risk of further injury and even death, but it was unable to provide alternative approaches that would have alleviated those risks. In fact, this Court found that DHEC's suggested alternatives were as dangerous, if not more dangerous, than Respondent's methods. The Court questions DHEC's motives in seeking certification revocation on this ground, as Respondent was clearly in an unfeasible position. Faulting Respondent for his inability to remediate the risks which DHEC's own experts were unable to do was unreasonable. Therefore, DHEC was not substantially justified in pressing this claim of misconduct.

Lastly, DHEC claimed that grounds for revocation existed based on Respondent's failure to provide emergency medical treatment of a quality deemed acceptable. DHEC premised its argument on the following actions: Respondent's failure to supply the patient with an IV, oxygen, and a heart monitor; Respondent's choice to ambulate the patient and allow his partner to ride the call; and Respondent's language and demeanor towards the patient. All of these actions, DHEC claimed, fell below the generally acceptable standards of care. Once again, I find that DHEC's decision to pursue this ground for revocation was without substantial justification. DHEC failed to provide any credible evidence that Respondent was required to start an IV line. Anderson County's IV protocol utilized circular instructions, was unclear regarding when an IV is necessitated, and bestowed EMT discretion. In addition, DHEC's own expert testified that oxygen and a heart monitor were unneeded. Also, for the reasons already stated, DHEC lacked a reasonable basis to challenge Respondent's actions in ambulating and transporting the patient.

As for Respondent's language, this Court determined that it was inappropriate. Even so, the patient did not complain of Respondent's care, nor did the patient suffer any adverse consequences. Moreover, DHEC made no showing that Respondent's language was of such a degree of offensiveness, and so detrimental to the patient, as to qualify as unacceptable medical treatment. It must also be noted that Mr. Wronski, DHEC's EMS Bureau Chief, revealed that

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an intravenous line ("IV") created a substantial possibility of death or serious physical injury. Beyond Dr. Deschamps' recitation of possible injurious outcomes, DHEC failed to demonstrate that the possibility was substantial.

DHEC has never utilized a finding of unacceptable quality medical treatment to revoke an EMT's certification. After reviewing Respondent's language and manner towards the patient, a reasonable person would not conclude that it was of such an intolerable and pugnacious nature as to necessitate revocation on the grounds of unacceptable quality medical treatment.

In summation, DHEC lacked reasonable grounds in law and fact to pursue revocation of Respondent's EMT Certification.

C. Special Circumstances

The awarding of attorney fees pursuant to § 15-77-300 is not allowable if there are any special circumstances that would make the award unjust. DHEC claims that awarding attorney's fees in this situation would have a chilling effect on future enforcement actions. This argument is without merit. In the case before me, DHEC acted without substantial justification in seeking the highest form of punishment for a matter that was handled adequately at the local level. The aim of awarding attorney's fees pursuant to § 15-77-300 is to prevent this type of governmental action.

D. Reasonableness

Having determined that attorney's fees are proper, I also find that Mr. Rothstein's rate of $300.00 an hour is reasonable. He is a certified specialist in employment and labor law and has years of extensive experience in litigating employment disputes. The nature, extent, and difficulty of this case also supports Mr. Rothstein's rate. He has devoted a substantial amount of time to investigating and researching the matter. Mr. Rothstein also conducted extensive discovery and provided Respondent with beneficial results. In addition, Mr. Rothstein's rate appears to represent the customary amount for similar legal services.

Mr. Rothstein has provided an itemized invoice of billable hours. Included in the invoice are fees incurred prior to the inception of this contested case and fees earned for post-trial matters, neither of which I believe are recoverable pursuant to *McDowell*. 304 S.C. at 543, 405 S.E.2d at 833. In addition, § 15-77-300 only allows for the recovery of attorney's fees, not court costs or expenses.

CONCLUSION

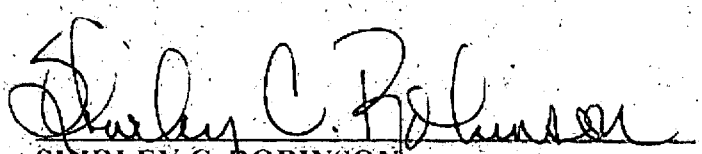
Respondent's motion for attorney's fees under S.C. Code Ann. § 15-77-300 is granted. Respondent is entitled to collect attorney's fees in the total amount of $91,120.00.

ORDER

Based upon the foregoing,

IT IS HEREBY ORDERED that James W. Davenport is awarded attorney's fees pursuant to S.C. Code Ann. § 15-77-300 in the amount of $91,120.00. On or before September 14, 2018, the South Carolina Department of Health and Environmental Control shall pay $91,120.00 in court costs to the Clerk of this Court. After receiving payment, the Clerk of this Court will disburse the full amount to James W. Davenport in payment of his attorney's fees.

AND IT IS SO ORDERED.



SHIRLEY C. ROBINSON
South Carolina Administrative Law Judge

August 1, 2018
Columbia, South Carolina

CERTIFICATE OF SERVICE

This is to certify that the undersigned has this date served this order in the above entitled action upon all parties to this cause by depositing a copy hereof, in the United States mail, postage paid, or in the Interagency Mail Service addressed to the party(ies) or their attorney(s).

This 1 day of August 2018

By: _____
Judicial Law Clerk

STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

South Carolina Department of Health and Environmental Control, Petitioner, vs. James W. Davenport, Respondent.	)	Docket No. 17-ALJ-07-0003-CC **PETITIONER'S MOTION TO ALTER OR AMEND (RECONSIDER) ORDER GRANTING PETITION FOR ATTORNEY'S FEES**

Pursuant to Rule 29(D) of the Rules of Procedure for the Administrative Law Court and Rules 59(e) and 60(b) of the South Carolina Rules of Civil Procedure, and reserving all of its rights and issues for appeal whether or not addressed herein[1], Petitioner South Carolina Department of Health and Environmental Control (the Department) hereby moves the Court to reconsider its August 1, 2018 Order Granting Respondent's Petition for Attorney's Fees (Order). The Department moves the Court to vacate and/or amend its Order on the grounds that it misapprehended or overlooked the following in making its decision.

I. This matter is a disciplinary action by a state licensing board.

Section 15-77-300(C) provides, "The provisions of this section do not apply to civil actions relating to . . . disciplinary actions by state licensing boards . . . ." The Court remarks it was "unable to identify any statutory authority qualifying DHEC as a 'state licensing board' having the power to institute 'disciplinary actions.'" (Order, p. 3). The Court then explains, "[t]he exception outlined in § 15-77-300 is referring to [disciplinary actions taken by the Department of Labor,

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[1] In moving for reconsideration, the Department addresses those issues and matters which the Court failed to consider or address adequately in its Order. The Department reserves the right to appeal, but does not necessarily raise herein, those issues which the Court considered or addressed, but decided incorrectly.

Licensing and Regulation Professional and Occupational Licensing Boards (POL Boards)]" and, accordingly, DHEC does not qualify for the exception. (Order, p. 4). The Court's narrow interpretation, which injects new material terms, is contrary to the plain ordinary meaning and legislative intent of Section 15-77-300(C). *See Charleston County Sch. Dist. v. State Budget and Control Bd.*, 313 S.C. 1, 5, 437 S.E.2d 6, 7 (1993) ("The cardinal rule of statutory construction is to ascertain and effectuate the intent of the legislature."); *Strother v. Lexington Cty. Recreation Comm'n*, 332 S.C. 54, 62, 504 S.E.2d 117, 122 (1998) ("When faced with an undefined statutory term, the court must interpret the term in accord with its usual and customary meaning."); and *Hodges v. Rainey*, 341 S.C. 79, 87, 533 S.E.2d 578, 582 (2000) ("When the language of a statute is clear and explicit, a court cannot rewrite the statute and inject matters into it which are not in the legislature's language . . . ."). Moreover, the Court's interpretation leads to absurd results. *See Wade v. State*, 348 S.C. 255, 259, 559 S.E.2d 843, 845 (2002) ("[A] court must reject a statute's interpretation leading to absurd results not intended by the Legislature."). A plain ordinary reading of Section 15-77-300(C) reveals the Department's action against Respondent was a disciplinary action by a state licensing board and, accordingly, is not subject to attorney's fees.

A. The Department is a "state licensing board."

Section 15-77-300 does not define "state licensing board." A "board" is defined as "a group of people elected or appointed to take the care and management of a public trust or institution, or conduct the business of a municipal or private corporation, e.g., *a board of health*, a board of trade, a board of directors." *Ballentine's Law Dictionary*, Board (3rd ed. 2010) (emphasis added). A "license" is defined as a "privilege conferred by a public body on a person for the doing of something which otherwise he would not have the right to do." *Id.*, License. Utilizing these definitions and in the context of applicable law, the Department is a "state licensing board"

because it is a group of designated individuals mandated by the S.C. Code of Laws to administer a program regarding privileges to practice emergency medical services. The Department's fulfillment of this responsibility is for the benefit of the public health of South Carolinians.

Applicable South Carolina law supports the Department being a "board" as used in Section 15-77-300. At the outset, the General Assembly established the Board of Health and Environmental Control as the governing body of the Department. *See* S.C. Code Ann. Section 44-1-20. Various statutory provisions refer to the Department as a board. *See, e.g., id.* § 1-5-40(A)(43) (describing the Department as a "board or commission"). Moreover, boards, departments, and agencies are used interchangeably by the S.C. Code of Laws and Rules of Procedure for the Administrative Law Court. *See, e.g., id.* § 1-23-310(2) (defining "agency" as "each state board, commission, department, or officer, other than the legislature, the courts, or the Administrative Law Court, authorized by law to determine contested cases.") and SCALC Rule 2(C) ("Agency means a state agency, department, board or commission whose action is the subject of a contested hearing, an appeal heard by an administrative law judge, or a public hearing on a proposed regulation presided over by an administrative law judge."). Accordingly, the Department is a board.

Applicable law also demonstrates the Department's regulatory program involves the "licensing" of EMTs. Pursuant to the *Emergency Medical Services Act of South Carolina* (the Act), S.C. Code Ann. Sections 44-61-10, *et seq.*, and *Emergency Medical Services* (the Regulation), Regulation 61-7, the Department is the state board responsible for certifying EMTs. *See* S.C. Code Ann. § 44-61-30(A) and –(B)(3). The Act defines "certificate" as an:

> *official acknowledgment* by the department that an individual has completed successfully one of the appropriate emergency medical technician training courses referred to in this article in addition to completing successfully the requisite

examinations, *which entitles that individual to perform the functions and duties as delineated by the classification for which the certificate was issued.*

S.C. Code Ann. § 44-61-10(6) (emphasis added). To distinguish between the different types of privileges or authorizations issued in the EMS industry (*e.g.*, to operate as an ambulance service or first responder agency, to utilize vehicles as ambulances, and to practice as an EMT), the Act and Regulation utilize the terms "license" and "permit," in addition to "certificate."[2] In EMS, where there are multiple different regulated entities, individuals, and items, the use of different terms provides clarity and ease of understanding for the Department and the regulated community. The Act even defines "licensee" to encompass not only those individuals holding licenses to operate ambulance services, but also those individuals holding certificates to practice as an EMT. *See id.* § 44-61-20(2) (defining "licensee" to mean "any person, firm, corporation, or governmental division or agency possessing authorization, permit, license or certification to provide emergency medical service in this State."). The *South Carolina Administrative Procedures Act*, which governs this matter, also defines "license" to "include[] the whole or part of any agency permit, franchise, *certificate*, approval, registration, charter, *or similar permission required by law*, but does not include a license required solely for revenue purposes." *Id.* § 1-23-310(4) (emphasis added). "Licensing" and "certification" have the same substantive meaning.

The guidance of the National Registry of EMTs (the National Registry), the statutorily established credentialing body for South Carolina EMTs[3], aptly explains that regardless of labels,

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[2] *See* S.C. Code Ann. Section 44-61-20(19) (defining "license" as "an authorization to a person, firm, corporation, or governmental division or agency to provide emergency medical services in the State.") and 44-61-20(27) (defining "permit" as "an authorization issued for an ambulance vehicle which meets the standards adopted pursuant to this article."); *see also id.* §§ 44-61-20 (describing the required licenses and permits for the provision of emergency medical response or ambulance services) and 44-61-80 (describing the required certificate for practicing as an EMT).

[3] To be certified as an EMT in South Carolina, the Act requires passing the National Registry examination and maintaining a National Registry credential or registration. *See id.* § 44-61-80(C) and –(E); *see also id.* § 44-61-20(22) (defining the National Registry).

state authorizations to practice as an EMT have the legal effect of a license. Specifically, the National Registry published the following clarification:

> Confusion between the terms "certification" and "licensure" arises because many states call their licensure processes "certification," particularly when they incorporate the standards and requirements of private certifying bodies in their licensing statutes and require that an individual be certified in order to have state authorization to practice. The use of a certification issued by the National Registry by some states as a basis for granting individuals the right to practice as EMTs and calling the authorization granted "certification" is an example of this practice. Nevertheless, certification by the National Registry, by itself, does not give an individual the right to practice.
>
> **Regardless of what descriptive title is used by a state agency, if an occupation has a statutorily or regulatorily defined scope of practice and only individuals authorized by the state can perform those functions and activities, the authorized individuals are licensed. It does not matter if the authorization is called something other than a license; the authorization has the legal effect of a license.**

https://www.nremt.org/rwd/public/document/certification_licensure. June 22, 2018. In conclusion, "state licensing board," as used in Section 15-77-300(C), includes the Department.

B. This matter is a disciplinary action.

Section 15-77-300 does not define "disciplinary action." "Discipline" means a "rule or system of rules governing conduct or activity." https://www.merriam-webster.com/dictionary/discipline. June 22, 2018. This matter concerned the Department's allegations that Respondent failed to comply with the system of rules governing EMT conduct and activity, *i.e.*, the Act and Regulation. The Act uses the terms "disciplinary action" and "enforcement action" interchangeably. *See* S.C. Code Ann. §§ 44-61-20(30) (requiring the State Medical Control Physician duties to include "provide recommendations for *disciplinary actions* in cases involving inappropriate patient care;") and 44-61-80(F) (providing "The department may take *enforcement action* against the holder of a certificate . . . .") (emphasis added). Disciplinary and enforcement action refer to the imposition of administrative sanctions based upon statutory or

regulatory violations whereby alleged perpetrators have the right to appeal through applicable law. This was a disciplinary action.

C. The Court's interpretation erroneously inserts new terms and leads to absurd results.

Utilizing a plain, ordinary English reading of Section 15-77-300(C), this matter is a disciplinary action by a state licensing board. In drafting Section 15-77-300(C), the General Assembly intentionally used general, broad, open-ended language. If the exception was only intended to cover actions taken by the POL Boards, as the Court concludes, the General Assembly would have used more directed and narrow language, such as, ". . . disciplinary actions by state licensing boards *established in title 40 of the S.C. Code of Laws* . . . ." The General Assembly declined to do so. Contrary to the legislative intent, the Court's interpretation erroneously adds such limiting language to the Section 15-77-300(C). *See Hodges*, 341 S.C. at 87 ("When the language of a statute is clear and explicit, a court cannot rewrite the statute and inject matters into it which are not in the legislature's language . . . .").

Furthermore, because of the similarities between the functions and responsibilities of the Department in this context and the POL Boards, the Court's conclusion to exclude the Department from being a "state licensing board" leads to an absurd result. Both the POL Boards and the Department in the EMT context regulate professionals[4] through licensure/certification schemes that are aimed at protecting the health, safety, and welfare of South Carolinians. These agencies exercise the same general quasi-legislative and quasi-judicial functions over their respective professionals. The POL Boards and the Department even follow the same general steps with

[4] The Department regulates and licenses other professionals in addition to EMTs, including athletic trainers, midwives, and hearing aid specialists. *See Practice of Specializing in Hearing Aids Act*, S.C. Code Ann. §§ 40-25-10, et seq.; *The Athletic Trainers' Act of South Carolina*, S.C. Code Ann. §§ 44-75-10, *et seq.*; *The Practice of Selling and Fitting Hearing Aids*, 3 S.C. Code Ann. Regs. 61-3; *Licensed Midwives*, 4 S.C. Code Ann. Regs. 61-24; and *Athletic Trainers*, 8 S.C. Code Ann. Regs. 61-96.

regards to discipline or enforcement – (1) Receipt of initial complaint; (2) Investigation by staff; (3) Review of evidence by an IRC; (4) IRC recommendation; (5) Presentation of facts to the Board (POL Board or DHEC Board); and (6) final decision. *See* Melina Mann, Holly G. Pisarik, and Benjamin P. Mustian, *Professional and Occupational Licenses*, in South Carolina Administrative Practice and Procedure 6, 276-277 (Randolph R. Lowell 3rd ed. 2013). The policy rationale behind Section 15-77-300(C) of not hindering or obstructing action against professionals by regulatory bodies exercising their lawful police powers is present with both the POL Board actions and the Department actions against EMTs. Accordingly, to hold the POL Boards are subject to the Section 15-77-300(C) exception, but the Department, which exercises the same responsibilities, wields the same disciplinary authority, and follows similar processes, is not, leads to absurd results. *See Wade*, 348 S.C. at 259 ("[A] court must reject a statute's interpretation leading to absurd results not intended by the Legislature.").

II. The Department had reasonable legal and factual bases for the alleged misconduct and unacceptable treatment and the process the Department undertook for making such findings further demonstrates the reasonableness.

To award attorney's fees pursuant to Section 15-77-300, a court must "must[] find that the agency acted without substantial justification in pressing its claim against the party." S.C. Code Ann. § 15-77-300(A)(1). "Substantial justification" does not mean "justified to a higher degree," but rather "justified to a degree that could satisfy a reasonable person." *Heath v. County of Aiken*, 302 S.C. 178, 183, 394 S.E.2d 709, 712 (1990). The Act and Regulation set clear bases in which the Department may proceed with action against an EMT. Specifically, an EMT may be guilty of one of the proscribed misconducts or the EMT may fail to provide to patients treatment of a quality deemed acceptable by the Department. *See* S.C. Code Ann. § 44-61-80(F) and 3 S.C. Code Ann. Regs. 61-7 § 1100(B). The Department alleged Respondent committed various misconducts and failed to provide acceptable emergency medical treatment. As described below, the Department's

allegations had reasonable bases in law and in fact. Further, the Court failed to consider the administrative process undertaken by the Department in proceeding with this action, which supports its reasonableness. The Department had substantial justification in pressing its allegations.

A. The Department had a reasonable basis in alleging Respondent disregarded appropriate orders by a physician concerning emergency treatment.

The Department alleged Respondent committed misconduct, as defined by S.C. Code Ann. Section 44-61-80(F)(6) and Regulation 61-7 Section 1100(B)(6), by disregarding appropriate[5] orders concerning emergency treatment. "Order" is not defined by the Act or Regulation. The plain ordinary English meaning of "order" is "an authoritative indication to be obeyed; a command or direction." *The American Heritage College Dictionary* 979 (4th ed. 2002). This definition is logical and reasonable in the context of the relationship between EMTs and their medical control physicians. All licensed ambulance services must have a medical control physician. *See* S.C. Code Ann. § 44-61-40(C). Medical control physicians are the authorities allowing EMTs to practice. *See* 3 S.C. Code Ann. Regs. 61-7 § 402. Medical control physicians supervise and maintain control of the care provided by EMTs. *Id.*; *see also* Rick L Hindman & W. Ann Maggiore, *Medical Control of Emergency Medical Services*, 4 J. Health & Life Sci. L. 65 (2011).

[5] Regarding appropriateness, Dr. Edgar DesChamps testified that Dr. Thomas Kickham's orders in the Anderson County Standards of Care & Treatment Protocols were in acceptance with general practice and principles of emergency medicine and in accordance with the scopes of practice of different certification levels of EMTs. Respondent did not contest the appropriateness of the orders. Notably, the Court confuses the distinction between appropriate physician orders regarding emergency treatment and the generally accepted standards of emergency medical treatment. The generally accepted standards of emergency medical treatment are the minimum levels of care to be provided by EMTs. Medical control physician orders have to be appropriate – meaning the orders must at least meet the generally accepted standards of emergency medical treatment, but cannot exceed the scopes of practice of EMTs. Appropriate orders of medical control physicians certainly can (as they do in this case) exceed the generally accepted standards of emergency medical treatment – *e.g.*, while Dr. Kickham's orders directed Respondent to administer oxygen and apply a heart monitor, the generally accepted standards did not require administration of oxygen or application of a heart monitor. The Court's emphasis on the inconsistencies between the appropriate orders and generally accepted standards is misplaced. (*See* Order, p. 7).

As such, EMTs must comply with their medical control physician's directives, whether written or oral, regarding emergency medical treatment and transportation.[6]

Dr. Thomas Kickham, Respondent's medical control physician, developed, approved, and signed the Anderson County Standards of Care & Treatment Protocols (the Standards & Protocols), which contains various orders concerning treatment. The Standards & Protocols explicitly indicate they are "considered minimum standards by Anderson County EMS."[7] In conjunction, the plain ordinary meaning of "order," the Standards & Protocols' explanation of Anderson County EMT responsibilities, and the statutorily-prescribed relationship between medical control physicians and EMTs are consistent with the Department's position that "orders" are policies that prescribe a definitive action to be taken for a particular condition or situation. The Department presented substantial evidence that Respondent disregarded various orders by Dr. Kickham that prescribed a definitive treatment for a particular condition or situation. *See* Exh. 1 (demonstrative of cites to the record).

In holding the Department acted without substantial justification, the Court equates the Department's position to that of the Department of Social Services (DSS) in *McDowell v. S.C. Dep't of Social Services*, 304 S.C. 539, 405 S.E.2d 830 (1991), which is clearly distinguishable. In *McDowell*, a case involving the denial of food stamp benefits, DSS ruled that a car titled jointly in the applicant's and her son's names was the applicant's asset, thereby placing her over the

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[6] An "off-line medical control physician" is a provider's medical control physician who takes responsibility for treatment of patients in the prehospital setting, by standing orders or protocols. 3 S.C. Code Ann. Regs. 61-7 § 201(R). An "on-line medical control physician" is a provider's medical control physician who directly communicates with EMTs regarding appropriate patient care procedures en-route. *Id.* § 201(S).

[7] While the Standards & Protocols do "discourage[] blindly following a protocol" and allow for deviations "if . . . documented and explained," the Standards & Protocols do not allow for blatant disregard of the medical control physician's orders. As noted, the Standard & Protocols are the "minimum standards" for practicing under Dr. Kickham, Respondent's medical control physician. Further, the Standard & Protocols require contacting the medical control physician when an EMT is unsure of the correct course of action. Additionally, any deviation from compliance must be documented and explained. Respondent never contacted Dr. Kickham. Respondent never documented or explained his deviations.

resource limit for food stamp eligibility. DSS erroneously held for a trust to arise, the property could not be titled jointly. *See id.* at 542. In awarding applicant attorneys' fees pursuant to Section 15-77-300, the Court of Appeals explained how DSS lacked a reasonable basis in law and fact:

> DSS ruled . . . that for a resulting trust to arise, the property could not be jointly titled. This conclusion is incorrect under established South Carolina precedent. When property is titled jointly, a resulting trust does not arise unless there is evidence to the contrary, as in this case. *See Legendre v. South Carolina Tax Comm'n*, 215 S.C. 514, 56 S.E.2d 336 (1949). DSS therefore relied on an erroneous legal conclusion in defending its decision in proceedings before the circuit court and Court of Appeals. DSS's litigation position was not substantially justified because it had no reasonable basis in law and fact.

Id. at 542-543. In this matter, the Department's action was not against established precedent. To the contrary, this action is in many regards a case of first impression. *See Cody v. Caterisano*, 631 F.3d 136, 142 (4th Cir. 2011) ("litigating cases of first impression is generally justifiable").

While the Court may disagree with the Department's interpretation of "order," the Department's interpretation was reasonable and consistent with rules of statutory interpretation. Both the Court's Final Decision and Order and Order Granting Respondent's Petition for Attorney's Fees are devoid of any conclusion of law as to the meaning of "order." In fact, the Court's Orders are devoid of any case law or analysis of the meaning of "order." While the Department resorted to a plain ordinary definition of "order," if the Court were to find that "order" is ambiguous, the Court failed to accord the Department deference, as is required by *Kiawah Dev. Partners, II v. S.C. Dep't of Health & Envtl. Control*, 411 S.C. 16, 766 S.E.2d 707 (2014).[8] For

[8] In *Kiawah Dev. Partners II*, the Supreme Court delineated the following two-step process for interpreting and applying statutes and regulates administered by an agency:

> First, a court must determine whether the language of a statute or regulation directly speaks to the issue. If so, the court must utilize the clear meaning of the statute or regulation. *See Brown v. Bi-Lo, Inc.*, 354 S.C. 436, 440, 581 S.E.2d 836, 838 (2003) ("We recognize the Court generally gives deference to an administrative agency's interpretation of an applicable statute or its own regulation. Nevertheless, where, as here, the plain language of the statute is contrary to the agency's interpretation, the Court will reject the agency's interpretation." (citations omitted)); *Brown v. S.C. Dep't of Health & Envtl. Control*, 348 S.C. 507, 515, 560 S.E.2d 410, 414 (2002) ("Where the terms of the statute are clear, the court must apply those terms according to their literal meaning."). If the

the above stated reasons, the Department had a reasonable basis for its allegation that Respondent disregarded appropriate physician orders concerning emergency medical treatment.

B. The Department had a reasonable basis in alleging Respondent discontinued care without the patient's consent and without providing further administration of care by an equal or higher authority.

The Department alleged Respondent committed misconduct, as defined by S.C. Code Ann. Section 44-61-80(F)(8) and Regulation 61-7 Section 1100(B)(8), by discontinuing care of the patient without the patient's consent and without providing for further administration of care by a paramedic or higher level authority. "Discontinue" is not defined by the Act or Regulation. The plain ordinary English meaning of "discontinue" is "to stop doing or providing (something) . . . ." *The American Heritage College Dictionary* 404 (4th ed. 2002). Respondent, a certified paramedic, discontinued care when he ceased providing care to the patient, transferred care responsibilities to his EMT partner (a lower level authority), and took over the driving responsibilities. Respondent did not obtain the patient's consent for the discontinuation.

Despite utilizing the plain English definition of "discontinue," the Court notes, "DHEC's witnesses could not provide a definition or standard by which to assess the discontinuation of care." (Order, p. 6). In its Order, the Court states "Respondent was '*readily available to resume care* of the patient if anything changed en-route to the hospital." (*Id.*) (emphasis added). If one "resumes care", there necessarily was a "discontinuation" of care.

The Court remarks that "DHEC's position was further negated by Anderson County's protocol which specifically permitted Respondent to delegate patient management and

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statute or regulation "is silent or ambiguous with respect to the specific issue," the court then must give deference to the agency's interpretation of the statute or regulation, assuming the interpretation is worthy of deference. *Chevron, U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 843, 104 S. Ct. 2778, 81 L. Ed. 2d 694 (1984); *see also Brown v. Bi-Lo*, 354 S.C. at 440, 581 S.E.2d at 838.

Kiawah Dev. Partners, II, 411 S.C. at 32-33.

transportation to his partner." (*Id.*). The Court also states, "DHEC's witnesses, Dr. Kickham and Dr. DesChamps, attested to the permissibility of [allowing the EMT partner to ride in the patient compartment] to the subject call."[9] (*Id.*). These statements are misleading because Respondent's discontinuation was in contravention of the Regulation and the Standards & Protocols. As testified by the Department's and Respondent's witnesses, the patient required advanced life support (ALS) care, which the EMT partner was not able to provide. Accordingly, the delegation allowed by Policy-07 "to others who are qualified to meet the patient's immediate needs or reasonably perceived needs" was inappropriate. Policy-26 also explains that patients suffering from multiple trauma and patients needing ALS intervention, which include the patient in question, cannot be transferred to a lower level certification. Similarly, Regulation 61-7 Section 1000(A) provides that when ALS procedures are required, an advanced EMT or paramedic must attend the patient in the patient compartment. Policy-26 also requires paramedics accompany a patient if an EMT expresses discomfort with assuming care, as Respondent's EMT partner did when asked by Respondent multiple times about riding the call. The record is replete with evidence supporting these facts and the Department's interpretation of this misconduct. *See* Exh. 1. Accordingly, the Department had a reasonable basis for its allegation that Respondent discontinued patient care

[9] This is incorrect. Dr. Kickham simply recited the Standards & Protocols policies, which allow EMT-basics to ride calls for patients only requiring basic life support. (July 25th Trial Tr. 203:23-206:25). Regarding the subject call, Dr. Kickham testified the EMT partner was not qualified to meet the patient's immediate needs during the transport because the patient required ALS level care, which only Respondent, a paramedic, could perform. (*Id.* 119:4-120:16). Further, as testified by Dr. Kickham, the policy prohibits transfer of certain patients to lower level certifications, including patients suffering from multiple trauma and patients requiring ALS care. (*Id.* 122:9-123:3). Dr. DesChamps testified that for the subject call, "the highest qualified person [Respondent] should have been in the back. . . . . It's a failure to oversee the entire picture of the call. The higher level person should have been in the back." (July 26th Trial Tr. 258:15-24). On cross-examination, Dr. DesChamps indicated that an EMT can ride the patient compartment despite having a paramedic partner "[i]n certain circumstances." (*Id.* 277:6-11). However, Dr. DesChamps did not testify that it was permissible for the EMT-basic partner to ride the subject call. In fact, Dr. DesChamps clarified "patients who have severe or significant injuries or where there's likely decompensation" require the highest appropriately trained EMT to ride in the patient care compartment. (*Id.* 275:21-276:21). Dr. DesChamps also explained that generally accepted pre-hospital EMS medical knowledge requires EMTs to assess the patients' potential outcomes, as opposed to only assessing their current state, in deciding who to ride the call. (*Id.*).

without consent and without providing for further administration of care by an equal or higher medical authority.

C. The Department had a reasonable basis in alleging Respondent created a substantial possibility of death or serious physical harm as a result of his actions and inactions.

The Department alleged Respondent committed misconduct, as defined by S.C. Code Ann. Section 44-61-80(F)(14) and Regulation 61-7 Section 1100(B)(15), by creating a substantial possibility of death or serious physical harm could result from his actions and inactions. Specifically, the Department alleged Respondent's ambulation of the patient to the ambulance, failure to establish intravenous (IV) access, and failure to ride in the patient care compartment created a substantial possibility of death or serious physical harm. While the Court ultimately disagreed, the Department had a reasonable basis in law and fact for this alleged misconduct.

The patient had a knife of unknown length impaled in his abdomen, a significant physical injury that ultimately required surgical intervention. While the patient's vital signs were normal, the injury combined with the uncertainties placed the patient at risk to rapidly decompensate. There was expert testimony regarding the vicinity of the knife wound, the movement of the impaled knife associated with walking the patient, and potential lethal consequences of puncturing vital organs. The Court concludes, "[t]he problem with DHEC's position, however, was that it was unable to provide that Respondent's methods were any more prone to substantial harm than its experts' offered approaches" and, further, "DHEC's suggested alternatives were as dangerous, if not more dangerous, than Respondent's methods." (Order, p. 7). There was expert testimony reasonably disputing the Court's conclusion, which raises the question of when, if ever, should an EMT utilize a carrying device (e.g., stairchair, stretcher, or spine board), which by design is used for patient safety and minimization of patient movement.

There was also expert testimony regarding the importance of establishing IV access and, thereby, maintaining blood pressure of the patient. The window of opportunity to establish IV access may be limited, particularly if the patient has undiagnosed internal bleeding or slow or late developing internal bleeding. If IV access cannot be established, a patient may be deprived of potential life-saving medications and fluids. While the Court may disagree, there is evidence in the record reasonably supporting that there was a substantial possibility of death or serious physical harm by failing to establish IV access. *See* Exh. 1.

Finally, because the education and experience of a paramedic exceeds that of an EMT, paramedics are better suited to assess patients and identify life-threatening complications. As noted, Respondent did not ride this call and provide the various ordered ALS treatment and monitor the patient for any other required treatments. While the patient did not decompensate and successfully underwent surgery at a trauma center, there was a reasonable basis in the Department's position that Respondent's failure to ride in the patient care compartment created a substantial possibility of death or serious physical harm. Moreover, in conjunction, the ambulation, the failure to establish the IV, and the failure to ride the call strengthen the Department's basis for this alleged misconduct.

D. The Department had a reasonable basis in alleging Respondent failed to provide acceptable treatment.

The Department alleged that, based upon generally accepted emergency medical standards[10], Respondent failed to provide acceptable emergency medical treatment in violation of S.C. Code Ann. Section 44-61-80(F), as a result of: (1) his failure to treat the patient with dignity and respect; (2) his ambulation of the patient to the ambulance instead of using a carrying device;

[10] *See supra* FN5 regarding the relation between "appropriate order[s] by a physician concerning emergency treatment" and generally accepted standards of emergency medical treatment.

(3) his failure to establish IV access on the patient; and (4) his failure to accompany the patient in the ambulance's patient compartment during transport. Dean Douglas, an experienced paramedic and prehospital care instructor, provided expert testimony regarding the education of EMTs, the generally accepted standards of prehospital care, and how Respondent ran afoul of such standards. Again, while the Court disagreed with the alleged unacceptable treatment, the record is replete with testimony and evidence that support the reasonableness of the Department's position. *See* Exh. 1.

In finding Respondent's inappropriate language did not "qualify as unacceptable medical treatment," the Court erroneously injected additional standards for this alleged violation. *See Hodges*, 341 S.C. at 87 ("When the language of a statute is clear and explicit, a court cannot rewrite the statute and inject matters into it which are not in the legislature's language . . . .").[11] Specifically, the Court states, "DHEC made no showing that Respondent's language was *of such a degree of offensiveness*, and *so detrimental to the patient*" and a "reasonable person would not conclude that [Respondent's language and manner] was of such an *intolerable* and *pugnacious nature* as to necessitate revocation . . . ." (Order, pp. 7 and 8) (emphasis added). Section 44-61-80(F) makes no reference to standards regarding a degree of offensiveness, detriment to a patient, intolerability, or pugnacity.

[11] It is concerning the Court refuses to find patient abuse as unacceptable medical treatment in light of the criminal offenses established in the S.C. Code of Laws for abuse of vulnerable adults. *See* S.C. Code Ann. §§ 43-35-10(1) (defining "abuse" as "physical or psychological abuse."), 44-35-10(10) (defining "psychological abuse" as "deliberately subjecting a vulnerable adult to threats or harassment or other forms of intimidating behavior causing fear, humiliation, degradation, agitation, confusion, or other forms of serious emotional distress."), 44-35-10(11) (defining "vulnerable adult" as "a person eighteen years of age or older who has a physical or mental condition which substantially impairs the person from adequately providing for his or her own care or protection. This includes a person who is impaired in the ability to adequately provide for the person's own care or protection because of the infirmities of aging including, but not limited to, organic brain damage, advanced age, and physical, mental, or emotional dysfunction."), and 44-35-85(B) (making it a felony punishable by not more than five years imprisonment to knowingly and willfully abuse a vulnerable adult).

The Court also erroneously characterizes the alleged unacceptable emergency treatment as a "catch-all provision of § 44-61-80(F)." (Order, p. 5). While the unacceptable emergency medical treatment provision is not a "misconduct" defined by Section 44-61-80(F), it serves as a separate and independent basis for disciplinary action against certified EMTs. The Court also notes "DHEC has never utilized a finding of unacceptable quality medical treatment to revoke an EMT's certification." (Order, p. 8). This is an irrelevant and erroneous consideration. The Court of Appeals held that an agency's disparity of sanctions imposed on licensees is not a basis for reversal of an agency's sanction. *See Deese v. S.C. State Bd. of Dentistry*, 286 S.C. 182, 185, 332 S.E.2d 539, 541 (Ct. App. 1985) ("An agency need not exercise its discretion identically in every case. 'A penalty that is within the authority of the agency is not rendered invalid in a particular case because it is more severe than sanctions imposed in other cases' and 'mere unevenness in the application of the sanction does not render its application in a particular case unwarranted in law.'"). For the above reasons, the Department was reasonable in alleging Respondent failed to provide acceptable treatment.

E. The Court erroneously failed to consider the administrative process the Department undertook in taking this action,

This matter went through several administrative filters prior to reaching the Court. In evaluating the investigation and potential action, the Department consulted Dr. DesChamps, the State Medical Control Physician who has decades of experience in the EMS industry and is responsible for "provid[ing] recommendations for disciplinary actions in cases involving inappropriate patient care." *See* S.C. Code Ann. § 44-61-20(30)(c). The Department then convened the Investigative Review Committee (IRC), a professional peer review committee composed of experienced and unbiased EMS professionals, which reviewed information gathered during the Department's investigation, heard from Respondent, and issued recommendations. *See*

id. § 44-61-20(16). The IRC for this matter included the State Medical Control Physician, three regional EMS office representatives, a paramedic, and an emergency room physician who is also a medical control physician. The Department adopted the recommendations of the IRC's in proceeding with this action. Additionally, the DHEC Board reviewed Respondent's request for final review and Department staff's administrative order and ultimately declined to conduct a final review conference. The fact that the decision was formulated utilizing this process of undergoing review by multiple seasoned and unbiased professionals supports the reasonableness of the Department's action.

Citing *McDowell*, the Court states "in determining the existence of substantial justification, the Court will evaluate DHEC's litigation position *rather than the administrative events giving rise to the litigation.*" (Order, p. 5) (emphasis added). While *McDowell* requires evaluation of the litigation position, it does not foreclose from consideration the events giving rise to litigation. In fact, the administrative events leading to the litigation are undoubtedly relevant to the reasonableness of an action and the litigation position. For example, if the IRC and/or State Medical Control Physician recommended no action and, despite the recommendation(s), the Department proceeded with action, the reasonableness of such action would be called into question. To turn a blind eye to the IRC which was required by statute to be convened when an investigation may warrant suspension or revocation is erroneous. Further, Regulation 61-7 Section 301 directs the Department to utilize, among other things, consultations, which would include the IRC, in enforcing the Regulation. Disregarding the events leading to the contested case when assessing the reasonableness of the Department's action ignores the legislatively-established framework for investigating and enforcing alleged violations of the Act and Regulation.

III. Special circumstances, including chilling of future actions, make award of fees unjust.

To award attorney's fees, a court must "find[] that there are no special circumstances that would make the award of attorney's fees unjust." S.C. Code Ann. § 15-77-300(A)(2). Special circumstances exist in this matter that make an award unjust. Awarding attorney's fees against an agency having reasonable evidence and basis in law for a good faith action will undoubtedly chill future actions aimed at protecting and promoting the public health. The Court erroneously equates the "special circumstances" prong of the Section 15-77-300 analysis to the "substantial justification" prong. Specifically, the Court dismisses the "special circumstances" prong stating, "DHEC acted without substantial justification in seeking the highest form of punishment for a matter that was handled adequately at the local level."[12] (Order, p. 8).

The South Carolina Supreme Court has noted the similarity between Section 15-77-300 and the *Equal Access to Justice Act* (the EAJA)[13] and there are instructive federal cases addressing the EAJA special circumstances. *See, e.g., Heath*, 302 S.C. 178 (1990) and *McDowell*, 304 S.C. 539 (1991). The EAJA special circumstances exception was held to act as a safety valve and serves at least two purposes. *The Taylor Group, Inc. v. Johnson*, 919 F.Supp. 1545 (M.D. Ala 1996); *see also* 32 Am Jur 2d Federal Courts 263. The exception insures the government is not

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[12] In addition to confusing the Department's authority in enforcing the Act and Regulation with Anderson County's authority in its employment matters, the Court confuses the facts regarding Anderson County's sanctions against Respondent. At the time Anderson County issued its sanctions (*i.e.*, the PEPL class), it did not have the benefit of reviewing the body-cam video. Therefore, Anderson County was unaware of, among other things, the patient abuse and ambulation of the patient to the ambulance. *See* July 25th Trial Tr. 124-125 (Dr. Kickham testifying that the County's remediation was prior to review of the video.), 153:7-8 (Dr. Kickham explaining that "After I saw the video, then we agreed to send it on to DHEC and let them deal with it."), 177-188 (Dr. Kickham explaining he was unaware before the video that the patient was ambulated to the ambulance.), and 129 (Dr. Kickham explaining that with the benefit of the video, he would have had a different decision regarding the remediation or sanctions than the originally ordered PEPL class.).

[13] 28 U.S.C. § 2412(d)(1) states, "Except as otherwise specifically provided by statute, a court shall award to a prevailing party other than the United States fees and other expenses, in addition to any costs awarded pursuant to subsection (a), incurred by that party in any civil action (other than cases sounding in tort), including proceedings for judicial review of agency action, brought by or against the United States in any court having jurisdiction of that action, unless the court finds that the position of the United States was substantially justified or that special circumstances make an award unjust."

deterred from advancing in good faith the novel, but credible extensions and interpretations of the law that often underlie vigorous enforcement efforts, and gives the court discretion to deny awards where equitable considerations dictate an award should not be made. *Id.*

The special circumstances exception is precisely applicable to this matter. The Department was advancing a good faith and credible extension of the Act and Regulation in pursuing an enforcement or disciplinary effort. Further, the taxpayers of South Carolina should not be responsible for nearly $100,000 in attorney's fees to an individual who verbally abused a patient. Equitable considerations dictate that an award not be granted.

The present case is unlike any case in which a South Carolina court has awarded attorney's fees pursuant to Section 15-77-300. *Cf. with McNaughton v. Charleston Charter Sch. for Math & Sci., Inc.*, 411 S.C. 249, 768 S.E.2d 389 (2015) (awarding attorney's fees to a teacher in a breach of contract claim), *Heath*, 302 S.C. 178 (1990) (awarding attorney's fees when a county violated an unambiguous state statute), *Layman v. State*, 376 S.C. 434 (2008) (awarding attorney's fees when the State and retirement system breached an unambiguous contract), *McDowell*, 304 S.C. 539 (1991) (awarding attorney's fees when DSS relied on an erroneous legal conclusion in denying food stamp benefits), *Simpkins v. City of Gaffney*, 315 S.C. 26 (Ct. App. 1993) (awarding attorney's fees when the City clearly had no authority to suspend operation of a zoning ordinance and to put a moratorium in place), *Brown v. City of N. Charleston*, 314 S.C. 298 (Ct. App. 1994) (awarding attorney's fees when City's position that displaced tenants were not entitled to statutory displacement and relocation costs because the project causing the displacement did not receive federal funds was contrary to the unambiguous statute in question), and *Cornelius v. Oconee County*, 369 S.C. 531 (2006) (awarding attorney's fees where the County could cite to no viable authority to support its position that it was not bound by a referendum's terms that authorized the

County to own and operate a utility). In the context of a state agency exercising its lawful police powers, special circumstances exist to make an award of attorney's fees unjust.

IV. The awarded attorney's fees are unreasonable and the Court failed to make the requisite written findings.

While Respondent should not be entitled to attorney's fees as explained above, if the Court maintains that an award is appropriate, the Court's award of $91,120.00 is grossly unreasonable. Further, the Court failed to make "specific written findings regarding each factor listed in [Section 15-77-300(B)]," as required by Section 15-77-300(B).

Section 15-77-300(B) requires that any award of attorney's fees "be limited to a *reasonable time expended* at a *reasonable rate*." (Emphasis added). Section 15-77-300(B) then provides a listing of "[f]actors to be applied in determining a reasonable rate", and requires the court to "make specific written findings regarding each factor listed . . . in making the award of attorney's fees." Finally, Section 15-77-300(B) provides that "in no event shall a prevailing party be allowed to shift attorney's fees . . . that exceed the fees the party has contracted to pay counsel personally for work on the litigation."

Beyond reciting the factors, the Court failed to make specific written findings for the various Section 15-77-300(B) factors. Mr. Rothstein's rate of $300 an hour may be reasonable for employment/labor law case; however, this is an administrative law case, not an employment/labor law case. Further, utilizing the erroneous rate and based upon the award of $91,120, it appears the Court calculated 303.7333 hours. It is unknown how the Court came to this calculation. Over 300 billed hours is far beyond reasonable for an administrative case of this nature. There are a number of unreasonable billed hours, including, among other things, nearly 24 hours in travel time, duplicate billing entries[14], and multiple days in which Mr. Rothstein billed over 15 hours.

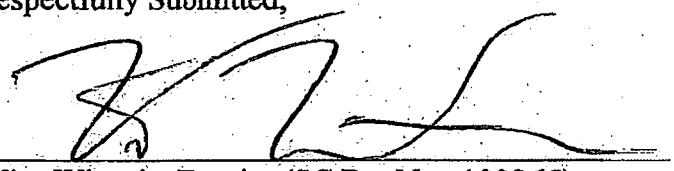
[14] *See, e.g.*, invoice entries on 06/18/2017 and 06/19/2017.

Additionally, in determining the reasonableness, the Court should consider the intertwining of the present case with Respondent's employment issues with Anderson County. For these reasons, the awarded fees should be significantly reduced.

Conclusion

For the reasons stated, the Department respectfully requests the Court alter or amend its Order to address the matters misapprehended or overlooked as set forth above and to vacate its Order and not award attorney's fees.

Respectfully Submitted,



Vito Wicevic, Esquire (SC Bar No.: 100265)
Ashley Biggers, Esquire (SC Bar No.: 17225)
South Carolina Department of Health and Environmental Control
2600 Bull Street
Columbia, SC 29201
P: (803) 898-3350
F: (803) 898-3367
E-mail: biggerac@dhec.sc.gov
E-mail: wicevivm@dhec.sc.gov
Paralegal: decarlrd@dhec.sc.gov

Columbia, South Carolina
August 13, 2018

EXHIBIT 1

(Demonstrative of cites to the record)

Alleged misconducts/violation	*Witness*	*Transcript/record cite*
Discontinued care of the patient without the patient's consent and without providing for further administration of care by a paramedic or higher medical authority	Kim Aiken	7/24/17 at p. 48 (explaining she felt the patient suffered a traumatic injury and required ALS care).
Discontinued care of the patient without the patient's consent and without providing for further administration of care by a paramedic or higher medical authority	Kim Aiken	7/24/17 at pp. 53-54 (describing her discussions with Respondent regarding whether the patient required ALS or BLS care).
Discontinued care of the patient without the patient's consent and without providing for further administration of care by a paramedic or higher medical authority	Kim Aiken	7/24/17 at pp. 56-57 (explaining her concerns about whether she could meet the patient's immediate needs or reasonably perceived needs).
Disregarded appropriate physician order concerning emergency treatment and transportation / Discontinued care of the patient without the patient's consent and without providing for further administration of care by a paramedic or higher medical authority	Keith Eudy	7/25/17 at pp. 15-20, 21-22, 36-41, and 62-68 (explaining his review of the call and his concerns including the patient requiring ALS care, a paramedic needing to ride with the patient, intravenous needing to be established, and a cardiac monitor needing to be applied).
Disregarded appropriate physician order concerning emergency treatment and transportation	Dr. Kickham	7/25/17 at pp. 86-88 (discussing GP-16 and the directives to not ambulate patients and to transport patients via appropriate carrying devices).
Created a substantial possibility of death or serious physical harm	Dr. Kickham	7/25/17 at pp. 87-88 (discussing concerns with ambulating patients and the potential to cause further injury and/or death).
Disregarded appropriate physician order concerning emergency treatment and transportation	Dr. Kickham	7/25/17 at pp. 89-92 (discussing GP-18 and the directive to demonstrate professionalism and courtesy).
Disregarded appropriate physician order concerning emergency treatment and transportation	Dr. Kickham	7/25/17 at pp. 92-96 (discussing GP-19 and the directive to document vital signs).
Disregarded appropriate physician order concerning	Dr. Kickham	7/25/17 at pp. 96-99 (discussing GP-1 and the directive to administer oxygen).

emergency treatment and transportation		
Disregarded appropriate physician order concerning emergency treatment and transportation	Dr. Kickham	7/25/17 at pp. 99-100 (discussing M-1 and the directive to administer oxygen).
Disregarded appropriate physician order concerning emergency treatment and transportation	Dr. Kickham	7/25/17 at pp. 100-102 (discussing GP-3 and the directive to establish intravenous access).
Created a substantial possibility of death or serious physical harm	Dr. Kickham	7/25/17 at pp. 101-102 (discussing reasons for establishing intravenous access, including potential for patients to rapidly decompensate and thereby prevent or make more difficult to obtain access).
Disregarded appropriate physician order concerning emergency treatment and transportation	Dr. Kickham	7/25/17 at pp. 103-105 (discussing T-1 and the directives to establish intravenous access and administer oxygen).
Disregarded appropriate physician order concerning emergency treatment and transportation	Dr. Kickham	7/25/17 at pp. 106-111 (discussing T-3 and the directives to minimize unnecessary movement, administer oxygen, establish intravenous access, and initiate a cardiac monitor-lead II).
Disregarded appropriate physician order concerning emergency treatment and transportation	Dr. Kickham	7/25/17 at pp. 111-116 (discussing M-9 and the directive to introduce oneself and be supportive to patients suffering psychiatric emergencies).
Discontinued care of the patient without the patient's consent and without providing for further administration of care by a paramedic or higher medical authority	Dr. Kickham	7/25/17 at pp. 117-120 (discussing Policy 7 and Respondent's obligation to attend to the patient's immediate needs).
Discontinued care of the patient without the patient's consent and without providing for further administration of care by a paramedic or higher medical authority	Dr. Kickham	7/25/17 at pp. 120-123 (discussing Policy 26 and the need for paramedic care).
Disregarded appropriate physician order concerning emergency treatment and transportation	Dr. Kickham	7/25/17 at pp.132-133 (clarifying that while Respondent did not violate a verbal order, he violated standing orders).
Disregarded appropriate physician order concerning emergency treatment and transportation	Dr. Kickham	7/25/17 at pp. 192-194 (explaining the directives to use carrying devices and not walk patients to ambulances and opining that EMTs need to keep patients in the position you find them in).

Disregarded appropriate physician order concerning emergency treatment and transportation	Dr. Kickham	7/25/17 at pp. 202-203 (stating that regardless of Respondent's assessment, the patient needed oxygen, intravenous access, and a cardiac monitor).
Disregarded appropriate physician order concerning emergency treatment and transportation	Dr. Kickham	7/25/17 at p. 219 (explaining there are standing orders for oxygen and intravenous access).
Created a substantial possibility of death or serious physical harm	Dean Douglas	7/26/17 at pp. 114-117 (discussing the injury and the potential of serious bodily injury or death based upon unnecessary movement and failure to provide ALS care).
Provided unacceptable emergency medical treatment	Dean Douglas	7/26/17 at pp. 118-120 and 210-214 (discussing generally accepted standards of care regarding EMT affect and Respondent's failure to meet this standard).
Provided unacceptable emergency medical treatment	Dean Douglas	7/26/17 at pp. 125-129 and 169-181) (discussing generally accepted standards of care regarding ambulation of patients and use of carrying devices and Respondent's failure to meet this standard).
Provided unacceptable emergency medical treatment	Dean Douglas	7/26/17 at pp. 131-135 and 193 (discussing generally accepted standards of care regarding establishment of intravenous access and Respondent's failure to meet this standard).
Provided unacceptable emergency medical treatment/ Discontinued care of the patient without the patient's consent and without providing for further administration of care by a paramedic or higher medical authority	Dean Douglas	7/26/17 at pp. 135-136 (discussing generally accepted standards of care regarding the EMT riding the call and Respondent's failure to meet this standard).
Provided unacceptable emergency medical treatment	Dean Douglas	7/26/17 at p. 209 (explaining that you treat the patient based upon his needs and potential needs and that is the standard of care).
Disregarded appropriate physician orders concerning emergency treatment and transportation	Dr. DesChamps	7/26/17 at pp. 242-244 (discussing GP-18 and Respondent's failure to comply with the directive to demonstrate professionalism and courtesy).
Disregarded appropriate physician orders concerning emergency treatment and transportation	Dr. DesChamps	7/26/17 at pp. 245-246, 249-250, and 291-293 (discussing GP-16 and Respondent's failure to comply with the directive to transport patients on appropriate carrying devices).
Disregarded appropriate physician orders concerning	Dr. DesChamps	7/26/17 at pp. 247-258 (discussing GP-19 and Respondent's failure to comply with the directive

emergency treatment and transportation		to document findings and information associated with assessment and performed procedures).
Disregarded appropriate physician orders concerning emergency treatment and transportation	Dr. DesChamps	7/26/17 at pp. 251-254 and 255-256 (discussing T-1 and T-3 and Respondent's failure to initiate a cardiac monitor lead II, initiate the intravenous access protocol, and initiate the airway management protocol).
Disregarded appropriate physician orders concerning emergency treatment and transportation	Dr. DesChamps	7/26/17 at pp. 254-255 (discussing GP-1 and Respondent's failure to administer oxygen).
Disregarded appropriate physician orders concerning emergency treatment and transportation	Dr. DesChamps	7/26/17 at pp. 256-257, 287-291, 321-323, and 326 (discussing GP-3 and Respondent's failure to establish intravenous access).
Discontinued care of the patient without the patient's consent and without providing for further administration of care by a paramedic or higher medical authority	Dr. DesChamps	7/26/17 at p. 258 (discussing the need for the higher level certification to ride the call and Respondent's failure to do so).
Created a substantial possibility of death or serious physical harm	Dr. DesChamps	7/26/17 at pp. 259-260 (discussing his determination that Respondent's actions and inactions created a substantial possibility of death or serious bodily harm).
Disregarded appropriate physician orders concerning emergency treatment and transportation	Robert Wronski	7/27/17 at pp. 50-51 and 165-166 (discussing GP-18 and Respondent's failure to demonstrate professionalism and courtesy).
Disregarded appropriate physician orders concerning emergency treatment and transportation	Robert Wronski	7/27/17 at pp. 51-52 (discussing T-1 and Respondent's failure to establish intravenous lines).
Disregarded appropriate physician orders concerning emergency treatment and transportation	Robert Wronski	7/27/17 at pp. 52-55 (discussing T-3 and Respondent's failure to implement the airway management policy, establish the cardiac monitor, and establish intravenous access).
Disregarded appropriate physician orders concerning emergency treatment and transportation	Robert Wronski	7/27/17 at pp. 55-57 (discussing GP-1 and Respondent's failure to administer oxygen).
Discontinued care of the patient without the patient's consent and without providing for further administration of	Robert Wronski	7/27/17 at pp. 57-58, 157-158, 179-182 (discussing the distinction between discontinuation and abandonment, and explaining Respondent's discontinuation of care for the Patient without

care by a paramedic or higher medical authority		obtaining the Patient's consent and without providing for an equal or higher medical authority).
Created a substantial possibility of death or serious physical harm	Robert Wronski	7/27/17 at pp. 59-61 (explaining how Respondent's ambulation of the patient, failure to establish intravenous access, and failure to ride the call created a substantial possibility of death or serious physical harm).
Provided unacceptable emergency medical treatment	Robert Wronski	7/27/17 at pp. 61-63 (discussion of Respondent's failure to provide acceptable emergency medical treatment).
Provided unacceptable emergency medical treatment	Leo Deason	7/27/17 at pp. 276-281 (discussion of the *International Trauma Life Support* treatise's of generally accepted standards of care relating to abdominal traumas, including providing supplemental oxygen and establishment of intravenous access).
Provided unacceptable emergency medical treatment	Leo Deason	7/27/17 at pp. 292-293 (discussion of Respondent's rude verbal interaction with the Patient).
Provided unacceptable emergency medical treatment/disregarded appropriate physician orders concerning emergency treatment and transportation	Sheila Kaiser	7/28/17 at pp. 164-167 (discussing the protocol regarding establishment of intravenous access and the fact that she would have established intravenous access).
Provided unacceptable emergency medical treatment/disregarded appropriate physician orders concerning emergency treatment and transportation	Scott Stoller (deposition designations)	pp. 118-119 (discussing concerns about care provided by Respondent, including no paramedic riding with the patient, protocol noncompliance regarding intravenous access and cardiac monitors, and ambulating the patient to ambulance); and 132-134 (discussing concerns about Respondent's interactions with the Patient).

STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

South Carolina Department of Health and Environmental Control,	)	Docket No. 17-ALJ-07-0003-CC
Petitioner,	)	
vs.	)	**RESPONDENT'S MEMORANDUM OF LAW IN OPPOSITION TO PETITIONER'S MOTION FOR RECONSIDERATION OF ATTORNEY FEE ORDER**
James W. Davenport,	)	
Respondent.	)	

Respondent, James W. Davenport, by and through his undersigned counsel, hereby submits this Memorandum of Law in Opposition to Petitioner's Motion for Reconsideration of Attorney Fee Order. Petitioner has misapprehended the nature of a motion for reconsideration under Rule 59(e), SCRCP,[1] which is not supposed to be used as a "second bite at the apple" or merely to ask the judge to change her mind. Instead, motions for reconsideration should be granted only in the following "very narrow set of circumstances": "(1) to accommodate an intervening change in the controlling law; (2) to account for new evidence not available at trial; or (3) to correct a clear error of law or prevent manifest injustice." Hill v. Braxton, 277 F.3d 701, 708 (4th Cir. 2002). Another proper use of a Rule 59(e) motion is to preserve issues on appeal that were raised to the trial judge, but not ruled

[1]Petitioner also attempts to invoke Rule 60(b), SCRCP, as a basis for its motion for reconsideration. Rule 60(b) allows relief from a judgment or order because of the following reasons: "(1) mistake, inadvertence, surprise, or excusable neglect; (2) newly discovered evidence which by due diligence could not have been discovered in time to move for a new trial under Rule 59(b); (3) fraud, misrepresentation, or other misconduct of an adverse party; (4) the judgment is void; [or] (5) the judgment has been satisfied, released, or discharged, or a prior judgment upon which it is based has been reversed or otherwise vacated, or it is no longer equitable that the judgment should have prospective application." Rule 60(b), SCRCP. Petitioner never explains how any of the reasons enumerated in Rule 60(b) might apply to this case.

on. See Chastain v. Hiltabidle, 381 S.C. 508, 515, 673 S.E.2d 826, 829 (Ct. App. 2009) ("When an issue is raised but not ruled upon by the trial court, the issue is preserved for appeal only if the party raises the same issue in a Rule 59(e) motion."). Of course, it is well-settled that "[a]n issue may not be raised for the first time in a motion for reconsideration." Johnson v. Sonoco Prods. Co., 381 S.C. 172, 177, 672 S.E.2d 567, 570 (2009); see also Hill, 277 F.3d at 708 ("Rule 59(e) motions may not be used to make arguments that could have been made before the judgment was entered.").

Petitioner's motion fails to identify any intervening change in the controlling law or any newly discovered evidence that was not available at trial. In addition, Petitioner has not identified any "clear error of law" in the Court's attorney's fee order that must be corrected or any "manifest injustice" caused by that order that must be righted. For the most part, Petitioner's motion for reconsideration is nothing more than a re-hashing of the exact arguments it raised in its previous brief and at oral argument on this matter. Petitioner literally seems to have cut-and-pasted entire passages from its prior brief into the motion for reconsideration.

The Court's attorney's fee order thoroughly addressed why the statutory exception in S.C. Code Ann. § 15-77-300(C) for "disciplinary actions by state licensing boards" does not apply here, which was an enforcement action against a certificate holder. Petitioner's citation to guidance issued by the National Registry of EMTs on June 22, 2018 (almost a year after the trial of this contested case) is completely misplaced. Not only is this something that Petitioner has never raised before, see Johnson, 381 S.C. at 177, 672 S.E.2d at 570 ("An issue may not be raised for the first time in a motion for reconsideration"), but equally as important, the NREMT's interpretation of the terms "certification" or "license" has nothing whatsoever to do with how those terms were intended by the South Carolina General Assembly when it passed the attorney's fee statute, S.C. Code Ann.

§ 15-77-300, and the Emergency Medical Services Act of South Carolina, S.C. Code Ann. § 44-61-10 et seq. Moreover, although Petitioner argues that the Court should have afforded deference to DHEC's interpretation of the statute and its regulations (citing Kiawah Dev. Partners II v. SC Dep't of Health & Envtl. Ctrl., 411 S.C. 16, 766, S.E.2d 707 (2014)), Petitioner neglects to mention that its own EMS Director, Robert Wronski, was particularly careful during the trial of this matter to distinguish between licenses and certificates in the EMS context and between disciplinary actions and enforcement actions. Simply put: words matter in statutes and regulations. The terms "license," "permit," and "certificate" each have very specific meanings under the EMS Act.

Petitioner's footnote citation to DHEC's statutory and regulatory schemes for athletic trainers, midwives, and hearing aid specialists is, frankly, puzzling. This is another argument that DHEC never raised before and, therefore, should not be allowed to raise on a Rule 59(e) motion. Johnson, 381 S.C. at 177, 672 S.E.2d at 570. More importantly, however, the statutes and regulations governing midwives and hearing aid specialists specifically use the defined terms "license" and "licensee." See S.C. Code Ann. § 40-25-20(3) (defining the term "license" in the Practice of Specializing in Hearing Aids Act; 4 S.C. Code. Regs., 61-24(A)(9) (defining "licensed midwives"). In contrast, athletic trainers, like EMTs and paramedics, are issued "certificates" not licenses. S.C. Code Ann. § 44-75-20(b). In other words, the General Assembly and DHEC have deliberately used different statutory terms to refer to different types of authorizations or credentials for certain types of professionals under its supervision.

With regard to the "without substantial justification" issue, the Court properly found that DHEC's litigation positions in the underlying contested case did not have any reasonable basis in law or in fact. Petitioner now argues that "the Court failed to consider the administrative process

undertaken by the Department in proceeding with this action." (Pet. Motion, at 8; 16). Petitioner's argument completely disregards the de novo nature of the contested case hearing process. When it came time to excluding Respondent's attorney's time spent during the administrative agency process from recoverable fees pursuant to the holding of McDowell v. South Carolina Department of Social Services, 304 S.C. 539, 405 S.E.2d 830 (1991), Petitioner was all for disregarding the administrative agency proceedings. It is disingenuous for Petitioner now to try to rely on those prior agency proceedings to bolster its decision to press its claims in litigation.

Perhaps most outrageously, Petitioner argues that Mr. Davenport's actions with regard to the stabbing patient were analogous to the felony criminal charge of abuse of a vulnerable adult under the Omnibus Adult Protection Act, S.C. Code Ann. § 43-35-5 et seq. (Pet. Motion, at 15, n. 11). This argument has never been raised by Petitioner at any point in this case, so it is clearly not a proper matter for a Rule 59(e) motion for reconsideration. Johnson, 381 S.C. at 177, 672 S.E.2d at 570. Nevertheless, such unfounded and irresponsible attacks on a decorated Army veteran and dedicated career public servant such as Mr. Davenport should not be tolerated by the Court. Rule 11, SCRCP still applies in the Administrative Law Court, which provides that an attorney's signature on any paper filed in any Court in this state is an implicit certification that the assertions made in such paper are supported by good legal and factual grounds. At a minimum, Petitioner's counsel should immediately withdraw footnote 11 from its motion and should issue a public retraction and apology to Mr. Davenport.

In Section IV of its motion for reconsideration, Petitioner now attempts to challenge the reasonableness of the attorney's fee award by attacking Respondent's counsel's hourly rate and the amount of time devoted to the case. With all due respect, Petitioner expressly waived these

arguments during the hearing on the petition for attorney's fees. At the June 13, 2018 hearing, the Court asked, "Now, also, Mr. Wicevic, do you have any argument that you wanted to place on the record with respect to the reasonableness of the hourly fees that's - - - ." Mr. Wicevic responded, "I think he - - Mr. Rothstein included an affidavit. We would appreciate it - - if the [court is agreeable] to it, we'd be appreciative of being able to research that. At this time, no, we have no reason to dispute Mr. Rothstein's affidavit." (Hearing Tr., at 50, ll. 16-25) (excerpts attached hereto as Exhibit A). Although the undersigned counsel completely stands by the statements in his Affidavit and the itemized statement of his time spent in connection with this matter, this is clearly not a proper basis for a Rule 59(e) motion. Johnson, 381 S.C. at 177, 672 S.E.2d at 570. Furthermore, it is astounding that Petitioner would now complain about the undersigned's hourly rate and 15-plus-hour days of logged time in connection with the trial, especially when DHEC paid one of its own expert witnesses (a paramedic) $250.00 per hour, and the expert testified that he spent approximately 60 hours getting ready for the trial from Friday afternoon before the trial until the first day of trial on the following Monday afternoon. The Court will also recall that Petitioner's case in chief took approximately three-and-a-half days of trial, and Respondent put on his defense case in chief in less than one full day of trial.

Finally, Petitioner asserts that "in determining the reasonableness [of the attorney's fees requested], the Court should consider the intertwining of the present case with Respondent's employment issues with Anderson County." (Pet. Motion, at 21) (emphasis added). Throughout the entire proceeding in the Administrative Law Court, Petitioner repeatedly and consistently maintained that the contested case had nothing to do with the Respondent's potential employment disputes with Anderson County. The Court carefully limited Respondent from introducing at trial evidence of the

whistleblower retaliation and the underlying collusion between the former Anderson County EMS Director, Scott Stoller, and his long-time friend and former EMS partner, Arnold Alier, who is now DHEC's EMS Chief. Petitioner now attempts to argues that the two matters are "intertwin[ed]." Petitioner should be barred by judicial estoppel from now taking such an inconsistent position. See Hayne Fed. Credit Union v. Bailey, 327 S.C. 242, 251, 489 S.E2d 472, 477 (1997) ("Judicial estoppel precludes a party from adopting a position in conflict with one earlier taken in the same or related litigation."). In any event, Respondent's counsel has not included any time relating to Mr. Davenport's employment grievance with Anderson County in the fee petition in this case.

For all of the foregoing reasons, Petitioner's motion for reconsideration should be denied.

Respectfully submitted,

David E. Rothstein
ROTHSTEIN LAW FIRM, PA
1312 Augusta Street
Greenville, SC 29605
(864) 232-5870 (office)
(864) 241-1386 (facsimile)
drothstein@rothsteinlawfirm.com

Attorney for Respondent, James W. Davenport

August 27, 2018

Greenville, South Carolina.

Exhibit A

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 W. Davenport,	)
Respondent,	)

MOTION HEARING

****

Wednesday, June 13, 2018
10:13 a.m. - 11:12 a.m.

The motion 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 13th day of June 2018, before Cortney N. Glover, Court Reporter and Notary Public in and for the State of South Carolina.

APPEARANCES

Vito Wicevic, Esquire
Ashley Biggers, Esquire
South Carolina Department of
Health and Environmental Control
2600 Bull Street
Columbia, South Carolina 29201
Attorney for Petitioner

David E. Rothstein, Esquire
Rothstein Law Firm, P.A.
1312 Augusta Street
Greenville, South Carolina 29605
Attorney for Respondent

Also Present:
James W. Davenport, Respondent

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EXHIBITS

(There were no exhibits marked during this hearing.)

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.

1 **THE COURT:** But isn't there a difference between
2 authority and justification?
3 **MR. WICEVIC:** Yes, your Honor. But in this case, we
4 felt like the appropriate sanction we could
5 take as an agency was to go with -- go forward
6 with revocation. Like I said, I think the --
7 that the reason that the staff proposed a
8 consent order with the suspension and the
9 requirements of psychiatric treatment was
10 because the members of the IRC felt there might
11 have been some anger management, if I recall
12 correctly. So that's the basis of proposing
13 that.
14 **THE COURT:** Okay.
15 **MR. WICEVIC:** Thank you.
16 **THE COURT:** Now, also, Mr. Wicevic, do you have any
17 argument that you wanted to place on the record
18 with respect to the reasonableness of the
19 hourly fee that's ---
20 **MR. WICEVIC:** I think he -- Mr. Rothstein included
21 an affidavit. We would appreciate it -- if the
22 boards are agreeing to it, we'd be appreciative
23 of being able to research that. At this time,
24 no, we have no reason to dispute
25 Mr. Rothstein's affidavit.

STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

South Carolina Department of Health and Environmental Control,	)	Docket No.: 17-ALJ-07-0003-CC
Petitioner,	)	
vs.	)	**ORDER ON PETITIONER'S MOTION TO ALTER OR AMEND**
James W. Davenport,	)	
Respondent.	)	

APPEARANCES: Petitioner: Vito Wicevic, Esquire
Ashley Biggers, Esquire
Respondent: David Rothstein, Esquire

This matter comes before the South Carolina Administrative Law Court ("ALC") pursuant to the Department of Health and Environmental Control's ("DHEC") Motion to Alter or Amend (Reconsider) Order Granting Petition for Attorney's Fees. On August 1, 2018, this Court issued an order granting Respondent's, James W. Davenport, petition for attorney's fees in the amount of $91,120.00 ("Order Granting Fees"). DHEC has since moved the Court to alter or amend its ruling pursuant to ALC Rule 29(D) and Rule 59(e), SCRCP.[1]

Generally, Rule 59(e), SCRCP is utilized to correct factual errors in a final order and preserve issues for appeal. *See Home Med. Sys., Inc. v. S.C. Dep't of Revenue*, 382 S.C 556, 562, 677 S.E.2d 582, 586 (2009); *Doe v. Doe*, 324 S.C. 492, 501, 478 S.E.2d 854, 859 (Ct. App. 1996). However, courts have also utilized motions to alter or amend to provide relief in the following situations: "(1) to accommodate an intervening change in controlling law; (2) to account for new evidence not available at trial; or (3) to correct a clear error of law or prevent manifest injustice." *Collison v. Int'l Chem. Workers Union*, 34 F.3d 233, 236 (4th Cir. 1994) (interpreting Fed. R. Civ. P. 59(e)). Irrespective of the aforementioned grounds, it is in this Court's discretion to grant a motion for reconsideration. *See Sullivan v. Hawker Beechcraft Corp.*, 397 S.C. 143, 153, 723 S.E.2d 835, 841 (Ct. App. 2012).

FILED
SEP 26 2018
SC ADMIN. LAW COURT

[1] DHEC cites Rule 60(b), SCRCP in its request for relief. However, DHEC does not purport that any of the grounds listed therein exist.

With these standards in mind, I turn to the substance of DHEC's motion. DHEC does not allege a change in controlling law, that any new evidence has become available, that the Court committed clear error, or that factual errors in the Court's order need correcting. Instead, DHEC's motion focuses on its staunch disagreement with the following Court rulings: (1) DHEC does not qualify for exemption as a state licensing board with the power to institute disciplinary action; (2) DHEC did not have substantial justification in pressing its claim against Respondent; and (3) the award of attorney's fees is reasonable and just. While mere disagreements with the Court's decision does not qualify as sufficient grounds for reconsideration, this Court will briefly address each alleged error in turn.

1. ***Disciplinary Action by a State Licensing Board***

This Court carefully considered the applicability of the statutory exception listed in S.C. Code § 15-77-300(C). Namely, whether the underlying contested case was a disciplinary action by a state licensing board. The Court's thorough analysis revealed that DHEC is not a state licensing board and that the underlying contested case did not qualify as a disciplinary action within the meaning of the statute. In its motion, DHEC disputes the Court's interpretation of the terms "disciplinary action" and "state licensing board." DHEC's arguments, however, are simply a reiteration of the same contentions made in its underlying opposition to Respondent's petition. Consequently, this Court is unable to identify any legitimate ground to support reconsideration.

2. ***Substantial Justification***

DHEC's justification in pressing its claim against Respondent has been scrupulously evaluated by the Court. Nonetheless, DHEC now purports that the Court erroneously focused on its litigation position without regard to the underlying administrative process. As this Court's opinion correctly stated, *McDowell v. S.C. Dep't of Soc. Services*, 304 S.C. 539, 405 S.E.2d 830 (1991), requires an agency's justification to be analyzed in light of its litigation position, rather than the agency action giving rise to the litigation. In addition to disagreeing with the Court's reliance on this clear precedential authority, DHEC also challenges the Court's ultimate conclusion that it lacked substantial justification in seeking complete revocation of Respondent's certification. The crux of DHEC's argument is that the Court misunderstood witness testimony. However, the fact that the Court perceived the evidence and testimony differently than DHEC does not necessitate this Court's reconsideration.

3. ***Attorney's Fees***

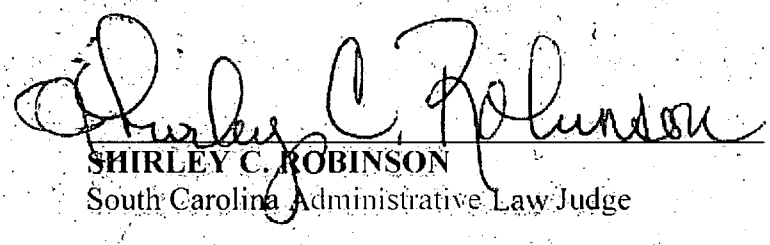
DHEC brings forth several arguments regarding the attorney's fees awarded. First, DHEC disagrees with this Court's determination that no special circumstances existed which would have rendered the award of attorney's fees unjust. In doing so, DHEC supplies the same arguments as found in its briefs in opposition to Respondent's petition for fees. Once again, disagreement is not a sufficient ground for reconsideration. Second, DHEC complains that the Court failed to make statutorily required findings regarding the reasonableness of the rate at which Respondent's attorney charged. There is no merit to this argument. This Court, on page eight of its Order Granting Fees, did indeed render findings for each requisite factor listed in § 15-77-300(B)(1)-(5). Lastly, DHEC challenges the Court's calculation of allowable billable hours. Upon further review, the Court agrees that it was error to include the hours Appellant's attorney spent travelling to and from Columbia on July 20, 2017, and July 24, 2017 through July 28, 2017. Considering the numerous hotels within the Columbia area, the significant amount of billable hours Respondent's attorney incurred for traveling was unreasonable.

For the reasons set forth herein, DHEC has demonstrated a sufficient need for relief pursuant to ALJ Rule 29(d) and Rule 59(e), SCRCP. Accordingly, I find it appropriate to grant DHEC's motion for the limited purpose of amending the amount of attorney's fees awarded to Respondent.[2]

IT IS THERFORE ORDERED that DHEC's Motion to Alter or Amend (Reconsider) the Order of this Court dated August 1, 2018, is granted for the limited purpose of amending the amount of attorney's fees awarded from $91,120.00 to $87,670.00.

IT IS FURTHER ORDERED that the remainder of Appellant's Motion to Alter or Amend (Reconsider) the Order of this Court dated August 1, 2018, is denied.

AND IT IS SO ORDERED.



SHIRLEY C. ROBINSON
South Carolina Administrative Law Judge

September 20, 2018
Columbia, South Carolina

[2] In calculating the award in the Order Granting Fees, this Court excluded 7.5 hours of travel time Respondent's attorney billed for attending the July 25, 2017 through July 28, 2017, contested case hearing. Thusly, while the Court now rules that nineteen hours of travel time must be deducted, the aggregate amount to be deducted in the Court's amended award will be 11.5 hours—a deduction of fees in the amount $3,450.00.

THE STATE OF SOUTH CAROLINA
THE DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL

IN RE: James W. Davenport
SC EMT – Paramedic Certification No. SC010854

ADMINISTRATIVE ORDER

The South Carolina Department of Health and Environmental Control (the Department) is the agency of the State of South Carolina responsible for administering the Emergency Medical Services Act of South Carolina (the Act), S.C. Code Ann. Sections 44-61-10 et seq. (Supp. 2015), and Emergency Medical Services (the Regulation), S.C. Code Ann. Regs. 61-7[1]. Pursuant to the Act, the Department is charged with the training and certification of EMS personnel. S.C. Code Ann. § 44-61-30(B)(4) (Supp. 2015). There are three levels of certification for emergency medical technicians: basic, intermediate/advanced, and paramedic. See S.C. Code Ann. Regs. 61-7 § 901.

James W. Davenport is the holder of an Emergency Medical Technician - Paramedic (EMT-Paramedic) certificate. As a result of an investigation, the Department found Mr. Davenport guilty of "misconduct," as defined by the Act and Regulation. The Department met with Mr. Davenport, but was unable to reach an agreement concerning this matter. After careful consideration, the Department decided to issue this Administrative Order revoking Mr. Davenport's EMT-Paramedic certificate.

FINDINGS OF FACTS

1. James W. Davenport is the holder of EMT-Paramedic certificate no. SC010854, issued by the Department, which expires March 15, 2020.

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[1] Regulation 61-7 was amended, effective June 24, 2016, with the publication of Volume 40, Issue 6 of the State Register. Violations of Regulation 61-7 correspond to the version of Regulation 61-7 in effect at the time of the occurrence of the violation.

2. On April 13, 2016, the Department received a complaint involving alleged conduct by Mr. Davenport. The Department initiated an investigation into the allegations of the complaint. As a result of the investigation, the Department found that:

a. On March 19, 2016, while working for the Iva Rescue Squad, Mr. Davenport and his EMT partner responded to a 44-year old patient who suffered a stab wound. The patient had an approximate seven-inch knife embedded in the upper left quadrant of his abdomen. The patient was in his residence.

b. Iva Rescue Squad operates under the Anderson County EMS protocols which are approved and signed by its medical control physician.

c. Upon arrival to the scene and through assessment and treatment, Mr. Davenport was unprofessional and verbally abusive to the patient. Anderson County Protocol GP-18, Universal Patient Care, requires EMT-Paramedics demonstrate professionalism and courtesy.

d. Mr. Davenport provided a deficient and incomplete initial assessment of the patient. Mr. Davenport did not obtain the patient's pulse, blood pressure, or Glasgow Coma Scale (GCS). Additionally, Mr. Davenport did not obtain the patient's history or appropriately assess the patient's pain. In fact, Mr. Davenport disregarded the patient's complaints regarding pain. Protocol GP-18 requires EMTs obtain vital signs on every patient contact including pulse, blood pressure, and GCS. Anderson County Protocol GP-19, Adult Assessment, requires EMTs perform a focused history of the patient and an assessment of the patient's pain.

e. As noted, the patient was a 44-year-old male with a knife embedded in his abdomen. Accordingly, the patient was a trauma patient necessitating trauma care and transport. Mr. Davenport did not evaluate the patient's weakness, mechanism of injury, DCAPBTLS (deformities, contusions, abrasions, punctures, bruises, tenderness, laceration, and swelling), and rigid guarded abdomen. Additionally, Mr. Davenport did not initiate the airway management protocol, a cardiac monitor-lead II, or the intravenous access protocol. These treatments were not provided on-scene or en route to AnMed Health Medical Center (AnMed), the Level II trauma center the patient was transported to. According to Anderson County EMS Protocol T-02, Trauma Transport, penetrating abdominal injuries are traumatic injuries requiring trauma care and transport. Anderson County EMS Protocol T-03, Multiple Trauma/Shock, requires EMTs to evaluate the weakness, mechanism of injury, DCAPBTLS, and rigid guarded abdomen of trauma patients. Protocol T-03 also requires EMT-paramedics initiate the airway management protocol (GP-1), a cardiac monitor-lead II, and the intravenous access protocol (GP-3). Similarly, Protocol GP-19 requires EMT-paramedics to complete critical interventions which, in this case, would include the airway management protocol (GP-1), the cardiac monitor-lead II, and the intravenous access protocol (GP-3). Additionally, Protocols T-01 and T-03 specify that intravenous therapy is to be initiated en route to the medical facility unless the patient is trapped.

f. After providing incomplete and deficient assessment and treatment, Mr. Davenport stood up the patient, who still had the knife embedded in his

abdomen, and walked him out of the patient's residence to the stretcher which was at the rear of the ambulance. Mr. Davenport did not transport the patient via a carrying device. Instead, Mr. Davenport provided minimal assistance in the patient's walk to the ambulance. Mr. Davenport also denied the patient's requests to be made more comfortable. Anderson County EMS Protocol GP-16, Patient Safety, specifies that patients should not ambulate to the ambulance; instead, EMTs are to transport all patients via an appropriate carrying device. Additionally, while Mr. Davenport bandaged the patient's wound and stabilized the knife embedded in the patient's abdomen, the additional and unnecessary movements facilitated by Mr. Davenport created a substantial possibility of death or serious physical injury.

g. After ambulating the patient to the ambulance, Mr. Davenport discontinued care and transferred care to a lower level of provider, his EMT partner, for care during the transport to the emergency room. Mr. Davenport drove the ambulance to AnMed.

3. On June 23, 2016, the Department convened the Investigative Review Committee (the IRC) to review the investigation of Mr. Davenport. Mr. Davenport and his counsel attended the IRC meeting.

4. Department representatives and Mr. Davenport met and attempted to resolve this matter via a consent order, but were unsuccessful. As a result of the foregoing and after careful consideration, the Department decided to issue this Administrative Order revoking Mr. Davenport's EMT-Paramedic certificate no. SC010854.

CONCLUSIONS OF LAW

1. Pursuant to S.C. Code Ann. Section 44-61-30(A) (Supp. 2015), the Department is the agency of the State of South Carolina that is responsible for enforcing the rules and regulations promulgated pursuant to the Act.

2. The Department is authorized to conduct inspections and investigations regarding EMTs in order to enforce the Act and Regulation. S.C. Code Ann. Regs. 61-7 § 301(A).

3. The Department may take enforcement action against the holder of a certificate at any time it is determined that the holder has failed to provide to patients emergency medical treatment of a quality deemed acceptable by the Department or is guilty of misconduct. S.C. Code Ann. § 44-61-80(F) (Supp. 2015); see also 3 S.C. Code Ann. Regs. 61-7 § 1100(B) (2011).

4. S.C. Code Ann. Section 44-61-80(F) (Supp. 2015) states, "Misconduct means that, while holding a certificate, the holder:

> . . .
>
> (6) disregarded an appropriate order by a physician concerning emergency treatment or transportation;
>
> . . .
>
> (8) after initiating care of a patient at the scene of an accident or illness, discontinued care or abandoned the patient without the patient's consent or without providing for the further administration of care by an equal or higher medical authority;
>
> . . .

(14) by his actions or inactions, created a substantial possibility that death or serious bodily harm could result;

. . . ."

5. Similarly, 3 S.C. Code Ann. Regs. 61-7 Section 1100(B) (2011) states, "'Misconduct,' which constitutes grounds for a revocation or suspension or other restriction of a certificate, shall be a satisfactory showing of any of the following:

. . . .

(6) That the holder of a certificate is guilty of disregarding an appropriate order by a physician concerning emergency treatment and transportation.

. . . .

(8) That the holder of a certificate has, after initiating care of a patient at the scene of an accident or illness, discontinued such care or abandoned the patient without the patient's consent or without providing for the further administration of care by an equal or higher medical authority.

. . . .

(15) That the holder of a certificate has, by his actions, or inactions, created a substantial possibility that death or serious physical harm could result therefrom.

. . . ."

6. Based upon the foregoing findings of fact, the Department finds:

a. James W. Davenport committed "misconduct," as defined by S.C. Code Ann. Section 44-61-80(F)(6) (Supp. 2015) and 3 S.C. Code Ann. Regs. 61-7 Section 1100(B)(6) (2011), by disregarding appropriate patient assessment and

treatment protocols that were signed and approved by Iva Rescue Squad's medical control physician.

i. Mr. Davenport disregarded GP-18, Universal Patient Care, by: being unprofessional and rude to the patient under his care; and failing to obtain vital signs including pulse, blood pressure, and GCS as part of the initial assessment.

ii. Mr. Davenport disregarded GP-16, Patient Safety, by: ambulating a patient to the ambulance; and failing to transport a patient using an appropriate carrying device.

iii. Mr. Davenport disregarded GP-19, Adult Assessment, by: failing to perform a focused history of the patient; failing to assess the patient's pain; and failing to complete critical interventions including the airway management protocol (GP-1), the cardiac monitor-lead II, and the intravenous access protocol (GP-3).

iv. Mr. Davenport disregarded T-03, Multiple Trauma/Shock, by: failing to evaluate the patient's weakness, mechanism of injury, DCAPBTLS, and rigid guarded abdomen; and failing to initiate the airway management protocol (GP-1), a cardiac monitor-lead II, and the intravenous access protocol (GP-3)

b. James W. Davenport committed "misconduct," as defined by S.C. Code Ann. Section 44-61-80(F)(8) (Supp. 2015) and 3 S.C. Code Ann. Regs. 61-7 Section 1100(B)(8) (2011), discontinuing care of a patient without providing for the further administration of care by an equal or higher medical authority. Mr.

Davenport left the patient in the care of his EMT partner and not with someone of equal or higher medical authority.

c. James W. Davenport committed "misconduct," as defined by S.C. Code Ann. Section 44-61-80(F)(14) (Supp. 2014) and 3 S.C. Code Ann. Regs. 61-7 Section 1100(B)(15) (2011), by creating a substantial possibility that death or serious physical harm could result from his actions and inactions. Mr. Davenport did not provide safe and appropriate means of movement of the patient from inside the residence to the ambulance. Mr. Davenport stood the patient up and walked him with little to no assistance to a stretcher waiting at the rear of the ambulance. Upon laying the patient down on the stretcher, Mr. Davenport refused to place him in a position of comfort and one that would minimize the movement of the approximate seven-inch knife that was still embedded in the upper left quadrant of his abdomen. The additional unnecessary movements and positioning facilitated by Mr. Davenport created a substantial possibility of death or serious bodily injury to the patient.

d. James W. Davenport failed to provide emergency medical treatment of a quality deemed acceptable by the Department. Mr. Davenport's language and demeanor to the patient throughout the course of care was unacceptable. Further, as explained above, Mr. Davenport disregarded appropriate physician orders concerning emergency medical treatment. Mr. Davenport's actions created a substantial possibility of death or serious bodily injury to the patient under his care.

7. In arriving at a decision to take enforcement, the Department considered the factors enumerated in Regulation 61-7 Section 304(F). Mr. Davenport's actions and omissions

had the impact or potential impact to harm the health, safety, or well-being of the patient under his care. Mr. Davenport derided and demonstrated a lack of compassion to a patient, thereby negatively impacting or having the potential to negatively impact the patient's well-being. Further, Mr. Davenport disregarded several appropriate physician orders concerning emergency treatment, thereby negatively impacting or having the potential to negatively impact the patient's health, safety, or well-being. Further, throughout the Department's investigation, Mr. Davenport provided contradictory and inconsistent statements. Additionally, Mr. Davenport failed to take responsibility for his behavior and failed take actions to correct or otherwise remediate his "misconduct." Finally, as EMTs are in a position of public trust, Mr. Davenport's behavior demonstrates a capacity for inappropriate behavior towards individuals within his trust and reflects poorly on the EMS profession.

8. As a result of such "misconduct" and unacceptable treatment, the Department determined the following sanctions are warranted.

NOW, THEREFORE IT IS ORDERED, pursuant to S.C. Code Ann. Section 44-61-80(F) (Supp. 2015) and Regulation 61-7 Sections 303 and 1100(B), that James W. Davenport's South Carolina EMT-Paramedic certification no. SC010854 be revoked. "Revocation" means the Department has permanently voided a certificate and the holder may no longer perform the function associated with the certificate. See S.C. Code Ann. § 44-61-20(28) (Supp. 2015) and S.C. Code Ann. Regs. 61-7 § 200(DD). The Department will not reissue the certificate for a period of four years. Id. At the end of the four-year period, Mr. Davenport may

petition for reinstatement. Id. Mr. Davenport shall return his certification card to the Department at 2600 Bull Street, Columbia, S.C., 29201, Attn: Robert Wronski, Bureau Chief, Bureau of EMS.

IT IS SO ORDERED.

Instructions regarding the appeals process are attached.

THE SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL

Shelly B. Kelly, Esquire, Director
Health Regulation

Date: 10-21-16

Robert A. Wronski, Bureau Chief
Bureau of Emergency Medical Services

Date: 10/21/2016

Reviewed by:

Vito Wicevic, Esquire
Counsel for Health Regulation

Date: October 20, 2016

Healthy People. Healthy Communities.

Board:
Allen Amsler, *Chairman*
Ann B. Kirol, DDS, *Secretary*
R. Kenyon Wells
Charles M. Joye II, P.E.
L. Clarence Batts, Jr.
David W. Gillespie, MD

December 7, 2016

U.S. Mail – Certified
9214 8969 0099 9790 1406 7896 26
David E. Rothstein, Esquire
Rothstein Law Firm, PA
1312 Augusta Street
Greenville, South Carolina 29605

Via Electronic Mail Delivery
Vito M. Wicevic
SCDHEC – Office of General Counsel
2600 Bull Street
Columbia, SC 29201

RE: **Docket No. 16-RFR-122, James W. Davenport,** Administrative Order revoking SC EMT Paramedic Certification No. SC010854

Dear Counsel of Record:

The South Carolina Board of Health and Environmental Control will not conduct a Final Review Conference on the above-referenced matter.

CONTESTED CASE GUIDANCE

S.C. Code Section 44-1-60 provides that if the Board declines in writing to schedule a final review conference, the staff decision becomes the final agency decision, and an applicant, permittee, licensee, or affected person may request a contested case hearing before the Administrative Law Court (ALC) within thirty calendar days after notice is mailed to the applicant, permittee, licensee, and affected person that the Board declined to hold a final review conference.

A request for a contested case hearing before the Administrative Law Court must be filed within the time allowed and in accordance with the Rules of the ALC, including payment of the ALC's filing fee, at the following address:

Clerk's Office
South Carolina Administrative Law Court
Edgar A. Brown Building
1205 Pendleton St., Suite 224
Columbia, SC 29201

The ALC's Notice of Request for Contested Case Hearing form and the Rules of the ALC can be found at the ALC's website: http://www.scalc.net. Further information on filing a request for a contested case hearing before the ALC may be obtained by calling the Clerk's Office at the Administrative Law Court (803-734-0550).

If a party files a request for a contested case hearing with the ALC, the party must serve a copy of the request on DHEC and any other parties at the same time the request is filed with the ALC. A copy of the request for a contested case hearing must be delivered or mailed to DHEC at the address at the top of this memorandum.

Sincerely,

Lisa Lucas Longshore

Lisa Lucas Longshore
Clerk

The above information on filing a request for a contested case hearing before the Administrative Law Court is provided as a courtesy; parties before the ALC are responsible for complying with all applicable requirements of the Court.

South Carolina Administrative Law Court (SC ALC)

Request for Contested Case Hearing FORM

Mail to: 1205 Pendleton St., Suite 224, Columbia, SC 29201

Last Name:	First:	Middle:	☒ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Docket No. (To Be Completed by ALC)
Davenport,	James	W.		

Mailing Address:	City:	State and Zip:
108 Burberry Drive	Williamston	SC 29697

Home Number:	Work Number:	Cell Number:	*E-Mail Address:
(864) 385-5714	(864) 385-5714	(864) 385-5715	jdavenport0272@gmail.com

*By providing your e-mail address, you consent to receive court orders and notices via electronic transmission

REPRESENTATION

Are you representing yourself? ☐ Yes ☒ No

Are you represented by an Attorney? ☒ Yes ☐ No

Name of Attorney: David E. Rothstein

Attorney Mailing Address: 1312 Augusta Street

City, State and Zip: Greenville, SC 29605

Attorney Work Number and Cell Number: (864) 232-5870 (office) (803) 920-3571 (cell)

Attorney E-Mail Address: drothstein@rothsteinlawfirm.com

CASE INFORMATION

Name of Agency that Issued the Decision:
(Example – Dept. of Revenue, Dept. of Insurance, DHEC) DHEC

In order to have your case processed, **you must attach the agency decision.** Is it attached?:
☒ Yes ☐ No

If no, please explain:

Date the decision was issued: Dec. 7, 2016

Date the decision was received: Dec. 10, 2016

Please provide a brief statement regarding why the hearing is being requested and the relief sought:

Petitioner requests a contested case on DHEC's decision to revoke his paramedic certificate. Petitioner does not believe that he committed any misconduct that would warrant such a harsh disciplinary action against his license. Petitioner request that DHEC's efforts to revoke his license be denied.

Payment via ☒ Check ☐ Money Order ☐ Cash for $ (applicable **filing fee pursuant to** ALC Rule 71) is being submitted today to the Administrative Law Court via ☐ U.S. Postal Service ☐ Hand-delivery

X *Your Signature or Signature of Attorney*

January 6, 2017
Date

PROOF OF SERVICE (MUST BE COMPLETED)

Your Name: David E. Rothstein Date: Jan. 6, 2017 City: Greenville State: SC

I hereby certify that on the date and place listed above, I served a copy of the foregoing Request for Contested Case Hearing **on all other parties** to this matter by depositing the same in the United States Mail, postage paid, and addressed as follows (use the reverse side for any additional names):

Name and/or Agency Name	Address	City, State and Zip
Vito Wicevic, Esq.	2600 Bull St.	Columbia, SC 29201
Robert Wronski, Bureau Chief	2600 Bull St.	Columbia, SC 29601

X *Your Signature or Signature of Attorney*

January 6, 2017
Date

Attention: All cases filed in the Administrative Law Court are subject to the Rules of Procedure found at the Court's website www.scalc.net or from the Clerk of Court. Failure to follow these rules may result in dismissal of your case.

Healthy People. Healthy Communities.

Board:
Allen Amsler, *Chairman*
Ann B. Kirol, DDS, *Secretary*
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THE STATE OF SOUTH CAROLINA
THE DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL

IN RE: James W. Davenport
SC EMT – Paramedic Certification No. SC010854

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f. After providing incomplete and deficient assessment and treatment, Mr. Davenport stood up the patient, who still had the knife embedded in his

abdomen, and walked him out of the patient's residence to the stretcher which was at the rear of the ambulance. Mr. Davenport did not transport the patient via a carrying device. Instead, Mr. Davenport provided minimal assistance in the patient's walk to the ambulance. Mr. Davenport also denied the patient's requests to be made more comfortable. Anderson County EMS Protocol GP-16, Patient Safety, specifies that patients should not ambulate to the ambulance; instead, EMTs are to transport all patients via an appropriate carrying device. Additionally, while Mr. Davenport bandaged the patient's wound and stabilized the knife embedded in the patient's abdomen, the additional and unnecessary movements facilitated by Mr. Davenport created a substantial possibility of death or serious physical injury.

g. After ambulating the patient to the ambulance, Mr. Davenport discontinued care and transferred care to a lower level of provider, his EMT partner, for care during the transport to the emergency room. Mr. Davenport drove the ambulance to AnMed.

3. On June 23, 2016, the Department convened the Investigative Review Committee (the IRC) to review the investigation of Mr. Davenport. Mr. Davenport and his counsel attended the IRC meeting.

4. Department representatives and Mr. Davenport met and attempted to resolve this matter via a consent order, but were unsuccessful. As a result of the foregoing and after careful consideration, the Department decided to issue this Administrative Order revoking Mr. Davenport's EMT-Paramedic certificate no. SC010854.

CONCLUSIONS OF LAW

1. Pursuant to S.C. Code Ann. Section 44-61-30(A) (Supp. 2015), the Department is the agency of the State of South Carolina that is responsible for enforcing the rules and regulations promulgated pursuant to the Act.

2. The Department is authorized to conduct inspections and investigations regarding EMTs in order to enforce the Act and Regulation. S.C. Code Ann. Regs. 61-7 § 301(A).

3. The Department may take enforcement action against the holder of a certificate at any time it is determined that the holder has failed to provide to patients emergency medical treatment of a quality deemed acceptable by the Department or is guilty of misconduct. S.C. Code Ann. § 44-61-80(F) (Supp. 2015); see also 3 S.C. Code Ann. Regs. 61-7 § 1100(B) (2011).

4. S.C. Code Ann. Section 44-61-80(F) (Supp. 2015) states, "Misconduct means that, while holding a certificate, the holder:

   . . .

   (6) disregarded an appropriate order by a physician concerning emergency treatment or transportation;

   . . .

   (8) after initiating care of a patient at the scene of an accident or illness, discontinued care or abandoned the patient without the patient's consent or without providing for the further administration of care by an equal or higher medical authority;

   . . .

(14) by his actions or inactions, created a substantial possibility that death or serious bodily harm could result;

. . . ."

5. Similarly, 3 S.C. Code Ann. Regs. 61-7 Section 1100(B) (2011) states, "'Misconduct,' which constitutes grounds for a revocation or suspension or other restriction of a certificate, shall be a satisfactory showing of any of the following:

. . . .

(6) That the holder of a certificate is guilty of disregarding an appropriate order by a physician concerning emergency treatment and transportation.

. . . .

(8) That the holder of a certificate has, after initiating care of a patient at the scene of an accident or illness, discontinued such care or abandoned the patient without the patient's consent or without providing for the further administration of care by an equal or higher medical authority.

. . . .

(15) That the holder of a certificate has, by his actions, or inactions, created a substantial possibility that death or serious physical harm could result therefrom.

. . . ."

6. Based upon the foregoing findings of fact, the Department finds:

a. James W. Davenport committed "misconduct," as defined by S.C. Code Ann. Section 44-61-80(F)(6) (Supp. 2015) and 3 S.C. Code Ann. Regs. 61-7 Section 1100(B)(6) (2011), by disregarding appropriate patient assessment and

treatment protocols that were signed and approved by Iva Rescue Squad's medical control physician.

i. Mr. Davenport disregarded GP-18, Universal Patient Care, by: being unprofessional and rude to the patient under his care; and failing to obtain vital signs including pulse, blood pressure, and GCS as part of the initial assessment.

ii. Mr. Davenport disregarded GP-16, Patient Safety, by: ambulating a patient to the ambulance; and failing to transport a patient using an appropriate carrying device.

iii. Mr. Davenport disregarded GP-19, Adult Assessment, by: failing to perform a focused history of the patient; failing to assess the patient's pain; and failing to complete critical interventions including the airway management protocol (GP-1), the cardiac monitor-lead II, and the intravenous access protocol (GP-3).

iv. Mr. Davenport disregarded T-03, Multiple Trauma/Shock, by: failing to evaluate the patient's weakness, mechanism of injury, DCAPBTLS, and rigid guarded abdomen; and failing to initiate the airway management protocol (GP-1), a cardiac monitor-lead II, and the intravenous access protocol (GP-3)

b. James W. Davenport committed "misconduct," as defined by S.C. Code Ann. Section 44-61-80(F)(8) (Supp. 2015) and 3 S.C. Code Ann. Regs. 61-7 Section 1100(B)(8) (2011), discontinuing care of a patient without providing for the further administration of care by an equal or higher medical authority. Mr.

Davenport left the patient in the care of his EMT partner and not with someone of equal or higher medical authority.

c. James W. Davenport committed "misconduct," as defined by S.C. Code Ann. Section 44-61-80(F)(14) (Supp. 2014) and 3 S.C. Code Ann. Regs. 61-7 Section 1100(B)(15) (2011), by creating a substantial possibility that death or serious physical harm could result from his actions and inactions. Mr. Davenport did not provide safe and appropriate means of movement of the patient from inside the residence to the ambulance. Mr. Davenport stood the patient up and walked him with little to no assistance to a stretcher waiting at the rear of the ambulance. Upon laying the patient down on the stretcher, Mr. Davenport refused to place him in a position of comfort and one that would minimize the movement of the approximate seven-inch knife that was still embedded in the upper left quadrant of his abdomen. The additional unnecessary movements and positioning facilitated by Mr. Davenport created a substantial possibility of death or serious bodily injury to the patient.

d. James W. Davenport failed to provide emergency medical treatment of a quality deemed acceptable by the Department. Mr. Davenport's language and demeanor to the patient throughout the course of care was unacceptable. Further, as explained above, Mr. Davenport disregarded appropriate physician orders concerning emergency medical treatment. Mr. Davenport's actions created a substantial possibility of death or serious bodily injury to the patient under his care.

7. In arriving at a decision to take enforcement, the Department considered the factors enumerated in Regulation 61-7 Section 304(F). Mr. Davenport's actions and omissions

had the impact or potential impact to harm the health, safety, or well-being of the patient under his care. Mr. Davenport derided and demonstrated a lack of compassion to a patient, thereby negatively impacting or having the potential to negatively impact the patient's well-being. Further, Mr. Davenport disregarded several appropriate physician orders concerning emergency treatment, thereby negatively impacting or having the potential to negatively impact the patient's health, safety, or well-being. Further, throughout the Department's investigation, Mr. Davenport provided contradictory and inconsistent statements. Additionally, Mr. Davenport failed to take responsibility for his behavior and failed take actions to correct or otherwise remediate his "misconduct." Finally, as EMTs are in a position of public trust, Mr. Davenport's behavior demonstrates a capacity for inappropriate behavior towards individuals within his trust and reflects poorly on the EMS profession.

8. As a result of such "misconduct" and unacceptable treatment, the Department determined the following sanctions are warranted.

NOW, THEREFORE IT IS ORDERED, pursuant to S.C. Code Ann. Section 44-61-80(F) (Supp. 2015) and Regulation 61-7 Sections 303 and 1100(B), that James W. Davenport's South Carolina EMT-Paramedic certification no. SC010854 be revoked. "Revocation" means the Department has permanently voided a certificate and the holder may no longer perform the function associated with the certificate. See S.C. Code Ann. § 44-61-20(28) (Supp. 2015) and S.C. Code Ann. Regs. 61-7 § 200(DD). The Department will not reissue the certificate for a period of four years. Id. At the end of the four-year period, Mr. Davenport may

petition for reinstatement. Id. Mr. Davenport shall return his certification card to the Department at 2600 Bull Street, Columbia, S.C., 29201, Attn: Robert Wronski, Bureau Chief, Bureau of EMS.

IT IS SO ORDERED.

Instructions regarding the appeals process are attached.

THE SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL

Shelly B. Kelly, Esquire, Director
Health Regulation

Date: 10-21-16

Robert A. Wronski, Bureau Chief
Bureau of Emergency Medical Services

Date: 10/21/2016

Reviewed by:

Vito Wicevic, Esquire
Counsel for Health Regulation

Date: October 20, 2016

STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL,
Petitioner,
vs.
JAMES W. DAVENPORT,
Respondent.

ACTION NO.
17-ALJ-07-0003-CC

DEPOSITION OF SCOTT JAY STOLLER

DATE TAKEN: June 8, 2017

TIME BEGAN: 9:02 a.m.

TIME ENDED: 1:57 p.m.

LOCATION: Anderson County Courthouse
100 South Main Street
Third Floor
Anderson, South Carolina

REPORTED BY: Eileen Thompson, CCR
EveryWord, Inc.
P.O. Box 1459
Columbia, South Carolina 29202
803-212-0012

1 APPEARANCES:

2

3 DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL
BY: VITO M. WICEVIC, ESQUIRE
4 SUSAN H. NELSON, ESQUIRE
2600 Bull Street
5 Columbia, South Carolina 29201
803-898-3353
6 wicevivm@dhec.sc.gov.
nelsonsh@dhec.sc.gov.
7 Representing the Petitioner

8

9 ROTHSTEIN LAW FIRM, P.A.
BY: DAVID E. ROTHSTEIN, ESQUIRE
10 1312 Augusta Street
Greenville, South Carolina 29605
11 864-232-5870
drothstein@rothsteinlawfirm.com
12 Representing the Respondent

13

14 ANDERSON COUNTY IN-HOUSE ATTORNEY
BY: LEON HARMON, ESQUIRE
15 101 South Main Street
Anderson, South Carolina 29624
16 864-222-2123
lharmon@andersoncountysc.org.
17 Representing Scott Jay Stoller

18

19 Also Present: James W. Davenport

20

21

22

23

24

25

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1 (It is hereby stipulated and agreed
2 by and between counsel for the respective
3 parties that this deposition is being
4 taken in accordance with the
5 Administrative Law Court Rules of
6 Procedure, and that the deponent reserves
7 reading and signing of this deposition
8 transcript.)
9 - - -
10 SCOTT JAY STOLLER, after having been
11 first duly sworn, was examined and
12 testified as follows:
13 - - -
14 EXAMINATION
15 - - -
16 BY MR. ROTHSTEIN:
17 Q. Good morning, Mr. Stoller. I'm David
18 Rothstein. We met about two seconds ago. I
19 represent James Davenport.
20 Can you state your full name for the
21 record, please.
22 A. Scott Stoller.
23 Q. And where do you currently work?
24 A. Anderson County.
25 Q. What is your address?

1 document. Patient was placed in the back of the
2 stretcher. The stretcher was placed in Medic 61,
3 and it says, "Medic Davenport asked me if I was
4 ready to go," and then she says, "I stated to him
5 that I was not sure if that was a call for me to
6 run." She says, "Medic Davenport then stated it was
7 a basic life support call and that I would be fine."
8 She didn't indicate that she had any further
9 objection to Mr. Davenport at that time, right?
10 A. It looks like she was hesitant but not
11 objecting.
12 Q. Did you and Dr. Kickham discuss with Ms.
13 Aiken the quality and the thoroughness of her
14 patient care record during that meeting?
15 A. I believe we did.
16 Q. Were there concerns about the adequacy of
17 her documentation in the patient care record?
18 A. I believe so. This is a vague memory.
19 Q. Okay. It wasn't to the level that any
20 type of disciplinary action or remediation was
21 imposed on Ms. Aiken though, right?
22 A. Not that I'm aware of, not that we did.
23 Q. Do you recall any discussion either with
24 Mr. Davenport or Ms. Aiken about Mr. -- or how the
25 patient got to the ambulance from the house?

1 A. We asked James whether -- or I don't know
2 whether we asked or said, but I remember the
3 discussion of how he got there, and he said the
4 patient didn't want or refused the stretcher, I
5 don't remember the exact word, the patient wouldn't
6 go on a stretcher.
7 Q. Okay. If you'll look at Exhibit 5 in the
8 stack -- I think you've already identified the first
9 three pages as the stabbing incident patient report,
10 right?
11 A. Uh-huh.
12 Q. Do you know what that patient's oxygen
13 level was en route to the hospital or at the scene?
14 I think it's on the first page of that document.
15 A. 98, 99.
16 Q. Okay. Is that within the protocol of the
17 normal range of not needing oxygen?
18 A. For oxygen, typically.
19 Q. Is oxygen something that even basic
20 paramedics are competent to provide? Is that a
21 skill that an EMT basic is authorized to administer?
22 A. Absolutely.
23 Q. Is that something that even a first
24 responder is authorized to administer?
25 A. It depends on the system and where they

1 see what their skin was like and so forth, but also,
2 there is not what they are, there is what can
3 happen. You have a knife sticking out of your gut,
4 and seeing we don't have x-ray vision, you could
5 move the slightest bit, turn what's a seemingly
6 stable patient into a dead patient.
7 Q. And I understand there's a risk there, but
8 that never happened with this patient, to your
9 knowledge, right?
10 A. Right.
11 Q. I mean there was no change in his
12 condition from the time Mr. Davenport laid hands on
13 him until the transfer of care at the emergency
14 department?
15 A. To the best of my knowledge, correct.
16 Q. So would you consider this a bad clinical
17 outcome of this particular patient?
18 A. To the best of my knowledge, no.
19 Q. Okay. Now, I know the chief's initial --
20 the police chief's initial report to you was some
21 concern that Mr. Davenport let a basic EMT ride in a
22 stabbing patient, correct?
23 A. Right.
24 Q. As you and Dr. Kickham were reviewing the
25 patient's care records and doing your investigation,

1 did you develop any additional concerns about the
2 clinical care provided by Mr. Davenport?
3 A. No, at first the lack of paramedic riding
4 in, riding in the back with the patient; the lack of
5 the patient's hands being immobilized; the threat
6 that he already stabbed himself, could he pull out,
7 stab James, or Kim, or hurt himself, pull a knife in
8 more, pull it out, whatever. We were concerned that
9 protocol wasn't followed in any type of trauma with
10 starting an IV, putting a patient on a cardiac
11 monitor, which goes hand in hand. I'm trying to
12 remember if there was anything else. The walking to
13 the ambulance, that was one of the biggest things
14 that stood out.
15 Q. Okay. Did you view the three patient care
16 incidents that you discussed with Mr. Davenport on
17 Friday, March 25th as having some sort of
18 commonality or similar trend?
19 A. No, other than, I think, Dr. Kickham and I
20 discussed the -- let me look at this again. I think
21 we discussed that last patient, I'm trying to
22 remember which it was.
23 Q. The elderly gentleman?
24 A. That it probably should have been a
25 paramedic ridden call. If I remember correctly,

1 Q. Are you pretty certain about that?
2 A. I'm pretty sure it was a Saturday and --
3 because I think we went back and forth, Are you sure
4 it's okay, and Yeah, of course it is, you did what
5 you're supposed to do, go.
6 Q. What happened next with regard to Mr.
7 Davenport?
8 A. Next thing I can remember is the chief of
9 police -- I went for a meeting -- and there may be
10 something in the middle that I'm not remembering.
11 The chief of police, again, Hawkins, I went for a
12 school safety meeting down in Iva at one of the
13 elementary schools, I think. I walked in, and he
14 handed me a DVD and said, You need to watch this,
15 and so I says, Okay, and took it home, and went and
16 watched it that night.
17 Q. What was your reaction to the video?
18 A. I was shocked.
19 Q. So this was the video of the body camera
20 of the police officer that was on the scene?
21 A. Correct.
22 Q. And tell me what your -- why you say you
23 were shocked by it?
24 A. The language, the lack of empathy and
25 compassion for the patient, the lack of complete

1 survey of the patient, walking out the patient to
2 the ambulance, which is a contradiction to what he
3 had told us in the meeting with Dr. Kickham. He
4 said the patient didn't want to be on the stretcher,
5 and James came out and said, Let's go.
6 Q. Okay. Anything else that you can think of
7 that caused you concern?
8 A. Evaluation, treatment, walking, lack of
9 safety for his partner, himself, and the others, and
10 securing hands. He was put on a stretcher. I
11 think, if I remember correctly in the video, he
12 wanted to sit up, and he said, You don't get to sit
13 up today, or something. It was just an -- it wasn't
14 what I would expect for my family member regardless
15 of what mental state they were in.
16 Q. Okay. Was this sort of out of character
17 from your interactions with James?
18 A. I've rarely seen James practice, but if
19 you had told me about this and I hadn't seen the
20 video, I wouldn't have expected it.
21 Q. What did you do after you saw the video?
22 A. I came in, I showed it to our emergency
23 manager, who is also a paramedic and a nurse.
24 Q. Who is that?
25 A. Taylor Jones, he shares an office with us.

1 I said, I don't know what to do, I just don't know
2 how to handle this. And his response, I'd send it
3 to DHEC, and I have to give it to Dr. Kickham. So I
4 went ahead and went over and met Dr. Kickham at the
5 hospital, played it for him probably on my iPad or
6 something like that, and he said, This changes
7 things, and I said, Okay, what do we do? We went
8 back and forth, and we spoke a few more times during
9 the day. And I said, Obviously, it's not what we
10 were told during our meeting, and this shows it in a
11 different light.
12 Q. Were you and Dr. Kickham concerned about
13 James' -- more so about his sort of attitude or
14 outlook toward the patient, or was it more the
15 clinical technical skills that he displayed during
16 the call?
17 A. It was both, and they go hand in hand.
18 You know, health care is -- I hate that word --
19 holistic. Being nice to someone is just as
20 important as covering their wound, it's part of the
21 treatment process. It doesn't mean you have to do
22 everything for them, but everyone deserves respect.
23 Q. Do you know how many times Mr. Davenport
24 had been to this particular patient's residence on a
25 rescue call or an emergency call?

1 further. They may have some questions for you,
2 but that's it for me.
3 - - -
4 EXAMINATION
5 - - -
6 BY MS. NELSON:
7 Q. We'll just get started while we're pulling
8 that up. Mr. Stoller, I'm Susan Nelson, and I am
9 assistant general counsel with DHEC. I've only been
10 with DHEC since January. Before that, I've
11 represented doctors and hospital on the defense
12 side, so there may be some EMT questions or acronyms
13 that I'm not familiar with, and then I'm just going
14 to ask you to clarify if there's anything I'm not
15 clear about.
16 A. Okay.
17 Q. Also, if you need me to rephrase a
18 question, if you don't understand, certainly feel
19 free to do that.
20 A. Okay.
21 Q. We've never spoken before today, correct?
22 A. I don't think so, unless you're the one
23 that called me to tell me that we're having the
24 meeting coming up.
25 Q. I don't remember that.

1 A. I don't know. Mr. Rothstein brought up a
2 number.
3 Q. And I'll represent to you that in this
4 packet, there are nine, but I do think there are
5 perhaps one or two missing, so I don't disagree with
6 the number 11 that Mr. Rothstein said earlier. So I
7 wanted to just bring your attention to the front of
8 this report. There has been an allegation that Mr.
9 Davenport was unable to put this patient on a
10 stretcher. Were you aware of that. Mr. Davenport
11 said he was unable to transport the patient?
12 A. When Dr. Kickham and I were interviewing
13 him in my office, he made the comment that the
14 patient, I think, didn't want to ride on the
15 stretcher or wouldn't ride on the stretcher.
16 Q. Okay. There was also a statement by Mr.
17 Davenport that he was unable to get a stretcher
18 through the front door during the IRC. Were you
19 aware of that?
20 A. No.
21 Q. Okay. I just wanted to go through this
22 report to get a better picture of this patient, who
23 was reported to DHEC. Do you see on the second page
24 that this patient -- is he seizing, he has epilepsy?
25 A. On the next --

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

****

Monday, July 24, 2017
1:12 p.m. - 5:41 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 24th day of July, 2017 before Travis McLeod, Court Reporter and Notary Public in and for the State of South Carolina.

APPEARANCES

Vito M. Wicevic, Esquire
DHEC Office of General Counsel
2600 Bull Street
Columbia, South Carolina 29201
Attorney for the Petitioner

Ashley C. Biggers, Esquire
DHEC Chief Counsel for Health Regulation
2600 Bull Street
Columbia, South Carolina 29201
Attorney for the Petitioner

David E. Rothstein, Esquire
Rothstein Law Firm, P.A.
1312 Augusta Street
Greenville, South Carolina 29605
Attorney for the Respondent

Also Present:
Tia Hazel, Law Clerk

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EXHIBITS

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Petitioner's Exhibit Number 1 21
(Anderson County Standards of Care and Treatment Protocols)
Petitioner's Exhibit Number 2 66
(Iva Police Officer Body-Cam Footage Video File)

Petitioner's Exhibit Number 3 53
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(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.

1 **(Petitioner's Exhibits 1-14 and Respondent's Exhibits**
2 **1-22 were marked prior to the hearing.)**
3 **THE COURT:** I'm going to go ahead and call the
4 hearing to order at this point. This is the
5 case involving the South Carolina Department of
6 Health and Environmental Control, petitioner
7 versus James W. Davenport is the respondent.
8 It's docket number 17-ALJ-07-0003, and it is a
9 contested case hearing. We've got Ashley
10 Biggers and Vito Wicevic representing the
11 Department in this matter, and we've got David
12 Rothstein representing the respondent, Mr.
13 Davenport. Okay. We did have a hearing on,
14 was it Thursday?
15 **MR. WICEVIC:** Yes, Your Honor.
16 **THE COURT:** To resolve some exhibit issues that I
17 think we worked out to everyone's satisfaction.
18 And at this point we -- I'm ready to hear brief
19 opening statements beginning with the
20 Department. And since we are involved this is
21 a licencing matter. The Department has the
22 burden of persuasion.
23 **MR. WICEVIC:** That's correct, Your Honor. Before I
24 get started, is it okay if I stand right here?
25 **THE COURT:** Yes, it is.

1 **MR. WICEVIC:** Okay. I just want to make sure
2 everyone could hear me and it's picked up by
3 the court reporter. May it please The Court?
4 Good afternoon, Your Honor. My name is Vito
5 Wicevic, and I am one of the attorneys for the
6 Department of Health and Environmental Control.
7 As you mentioned, I have Ms. Biggers our Chief
8 Counsel of Health Regulation here. I have
9 Robert Wronski who is our Bureau Chief of
10 Emergency Medical Services Bureau along with
11 Dr. Arnold Alier. He is the Director of our
12 division of EMS that's in the Bureau of EMS.
13 We have Dr. Deschamps. He is the State Medical
14 Control Physician. Ryan Nix is a compliance
15 officer within the Bureau of EMS. Dean
16 Douglas, our paramedic expert. And last but
17 not least we have Richard Naugler. He is the
18 investigator with our Bureau of EMS. Don't
19 have a lot of contested cases with our EMS
20 folks, so we thought it'd be a good idea for
21 them to attend and see this.
22 **THE COURT:** Okay. Thank you, Mr. Wicevic.
23 **OPENING STATEMENT - MR. WICEVIC:**
24 **MR. WICEVIC:** So, as you know, this is a contested
25 case hearing regarding the Department's

1 decision to revoke Mr. Davenport's paramedic
2 certificate. DHEC certifies and regulates
3 EMT's. There are three levels of EMT's. We
4 have an EMT basic, advanced EMT, and paramedic.
5 Now to perform as an EMT you have to be first
6 of all certified by DHEC. You also have to be
7 employed by a licensed ambulance service, which
8 is a transporting service, or an EMT first
9 responder service, which is non-transporting.
10 And each licenced service has a Medical Control
11 Physician, and the EMT's operate under this
12 Medical Control Physician's license in pursuant
13 to the orders and protocols of the Medical
14 Control Physicians. And they really do this by
15 two ways. One, we have an offline medical
16 control, which consists of written standing
17 orders and protocols. Then we also have online
18 medical control, which would be verbal contact
19 from the EMT's to the Medical Control
20 Physician, whether that's a radio or cell
21 phone. So the Department in this matter issued
22 an AO revoking Mr. Davenport's paramedic
23 certificate based upon one patient care
24 incident. It was March 19th, 2016. It
25 involved a self inflicted stab wound patient.

1 This patient in question had significant
2 psycho-social history, multiple instances of
3 attempted suicides. What the Department found
4 was wrong, we found that, and we believe that
5 we'll prove by preponderance of evidence, is
6 that Mr. Davenport committed misconduct by
7 disregarding the protocols of -- which were
8 signed by his Medical Control Physician.
9 Namely he failed to institute -- or attempt to
10 establish and intravenous access, and IV. He
11 was unprofessional and rude in his care of this
12 patient. He ambulated the patient from the
13 scene of the accident to the ambulance with a
14 knife wound, an impaled knife in his stomach.
15 He failed to apply oxygen therapy, and he
16 failed to apply a cardiac monitor. Other
17 misconduct, he discontinued care while treating
18 this EMT. Namely he transferred care over to
19 an EMT basic. He being the higher level
20 certified EMT should have rode this call. By
21 riding this call I mean he should have been in
22 the patient care compartment during the
23 transport from the scene of the accident to the
24 ambulance -- or to the Emergency Department.
25 We also content that Mr. Davenport committed

1 misconduct by creating a substantial
2 possibility of death or serious physical harm.
3 Specifically he walked this patient, like I
4 said, with an impaled knife in his stomach of
5 unknown length bouncing through the trailer
6 down some stairs to the ambulance. And,
7 finally, we determined based upon all those, we
8 determined that he provided unacceptable
9 medical treatment, he was rude and
10 intimidating, he disregarded his protocols and
11 orders, and just generally disregarded the
12 safety and care of this patient. I think in
13 the end the facts of this case are relatively
14 simple. I think there are going to be a number
15 of diversions and distractions that are going
16 to be offered by the respondent. They're going
17 to try to muddy the water by pointing to
18 biases, alleged biases by his former boss, by
19 showing his former employer didn't follow their
20 internal policies, whether that's employment or
21 discipline or quality assurance, and other kind
22 of extraneous irrelevant matters. These items
23 should not be the focus in this Court. This is
24 a de novo hearing. The Court's going to act as
25 the fact finder in this matter. Instead I

1 think the focus needs to be the facts of Mr.
2 Davenport and his actions on March 19th, 2016.
3 You're going to see video footage of this
4 matter. You'll hear from Mr. Davenport
5 himself. You'll hear from his partner. You'll
6 review a number of patient care reports
7 concerning this patient and medical records.
8 And I strongly believe that the facts of this
9 matter will show that the Department's decision
10 to revoke is correct and should be upheld. Now
11 Mr. Davenport, I think it's important to say he
12 really is an incredible man. He is a
13 legitimate war hero. His decorated carrier is
14 tremendously admirable. He's been present
15 throughout depositions and various proceedings.
16 I can tell you he's nothing but a joy to talk
17 to. He's pleasant, he's friendly,
18 professional. However I think the evidence
19 that you'll see concerning this patient
20 encounter on March 19th shows a completely
21 different individual. It shows a paramedic
22 who's verbally abusive, it shows a paramedic
23 that disregarded the basic tenets of paramedic
24 care, pre-hospital care. So, a significant
25 concern that I think you'll hear from our

1 staff, they don't take revocation lightly.
2 It's kind of a last resort sanction that we
3 have. A significant concern that we have was
4 his failure to understand that the care the he
5 provided on that day was deficient. We're
6 charged with protecting the public health and
7 we cannot turn a blind eye to issues we see
8 that could harm the public health. So, in
9 conclusion, I believe strongly that we will
10 present a preponderance of evidence, and we
11 respectfully request that Your Honor uphold our
12 decision to revoke. Thank you.
13 **THE COURT:** Thank you. Mr. Rothstein.
14 **MR. ROTHSTEIN:** Good afternoon, Your Honor. May it
15 please The Court?
16 **THE COURT:** Yes.
17 **OPENING STATEMENT - MR. ROTHSTEIN:**
18 **MR. ROTHSTEIN:** And again, I'm David Rothstein from
19 Greenville. It's my pleasure, Your Honor, to
20 represent Mr. Davenport in this matter. James
21 Davenport, as Mr. Wicevic indicated, is a
22 genuine indisputable American hero on many
23 different levels. He is a highly decorated
24 combat veteran of the Green Berets, U.S. Army
25 Special Forces almost 14 years of active

1 service under his belt. That includes multiple
2 tours of duty in Iraq and Afghanistan most
3 recently, as well as covert special operations
4 around the world. His military honors include
5 a Legion of Merit Medal, which is the fourth
6 highest honor that can be bestowed upon a
7 military person. He has two Bronze Stars, two
8 Purple Hearts, and three Meritorious Service
9 Awards. And that just scratches the surface of
10 the recognitions that he's received in the
11 Army. He's a Special Forces Medic, which is
12 one of the most highly trained, competent, non-
13 physician medical professionals in the world.
14 He was actually the distinguished honor
15 graduate for his Special Forces training class,
16 not only in the medical part of the training,
17 but also in his entire Special Forces team
18 training. That means he was number one in the
19 class on two different occasions in Special
20 Forces training. He has saved literally
21 hundreds of lives if his Special Forces teams
22 mates and other U.S. Military personnel, as
23 well as innocent civilians and even enemy
24 combatants in the theater of war, Your Honor.
25 He is a wounded warrior. He was medically

1 retired from the Army in October of 2015 after
2 he stepped on an IED, or an improvised
3 explosive device in Afghanistan. And that
4 incident blew off his left leg and caused
5 substantial injuries to most of the lower half
6 of his body. His teammates were able to save
7 him on the battlefield because of the things
8 that Mr. Davenport taught them about emergency
9 treatment of critical casualties. I know that
10 my remarks are making Mr. Davenport somewhat
11 uncomfortable because he's a very humble and a
12 very private person. He frankly doesn't like
13 public recognition or accolades. Nothing he's
14 ever done in his career has been for fame or
15 for glory. Another one of his -- probably the
16 most important role or accomplishment that Mr.
17 Davenport has had in his life is family
18 related, being a husband to Tiffany of 17 years
19 and being a father to a 15 year old daughter.
20 His daughter was actually the inspiration for
21 Mr. Davenport's first foray into the armed
22 forces. The very day after the September 11th
23 attacks happened, Your Honor, Mr. Davenport was
24 in the military recruiter's office. At that
25 time his wife was nine months pregnant with

1 their daughter, and he wanted to do what he
2 could to ensure that his daughter grew up in a
3 world that was safe and free from terrorism.
4 He signed up for the infantry because that was
5 the quickest way for him to get into the
6 battlefield, and while he was in his basic
7 training, and into the infantry school, he
8 caught the attention of the Special Forces
9 recruiter who asked Mr. Davenport to try out or
10 consider being a part of the Special Forces.
11 Mr. Davenport will explain what was involved in
12 the training and selecting process in some more
13 detail, but it really is an incredible amount
14 of knowledge that is provided to Special Forces
15 Medics. Prior to his military career, Mr.
16 Davenport was an EMT, he was a volunteer
17 firefighter, and also a paramedic. He first
18 became a nationally registered paramedic in
19 1995. He's never had any type of disciplinary
20 action during his career as an EMT or a
21 paramedic, never a write-up, never a complaint,
22 never a talking to by his supervisors, he's
23 never even had a QA or quality assurance
24 officer raise a question about his care based
25 on the run reports that are provided by the

1 EMT's and paramedics. He's never had a patient
2 complaint or a family member of a patient
3 complain about his care. He's never had any
4 type of malpractice claim or legal action filed
5 against him during his career. He's never had
6 to speak to anyone at DHEC about his paramedic
7 certification prior to this incident. Mr.
8 Davenport's national paramedic certification
9 that he first obtained in '95 lapsed while he
10 was on his military training and in active
11 duty. And in 2012, he decided to retake the
12 national registry exam. Interestingly it's a
13 computerized test that was taken at the time,
14 and the test has about 150 to 175 questions on
15 it. The test actually -- the computer shut
16 down after 49 questions because Mr. Davenport
17 at that point had aced every question up to
18 that point. The computer went ahead and passed
19 him without him having to complete the rest of
20 the exam. Now, in looking at the allegations
21 that have brought us here today, I think it's
22 important to keep several things in mind, Your
23 Honor. First of all, none of the three patient
24 encounters that initially lead Mr. Stoller to
25 bring this matter to DHEC involved any adverse

1 outcome to the patient. No complications,
2 certainly no risk of death or anything that Mr.
3 Davenport did in the care of these patients in
4 the pre-hospital setting. Mr. Davenport
5 responded to the patient, emergency call, took
6 them perfectly to the hospital. The patients
7 were not worse off than when Mr. Davenport
8 arrived on the scene. The second thing you
9 need to keep in mind, Your Honor, is that there
10 were actually three cases that were involved in
11 the initial complaint. DHEC now wants to focus
12 only on one of those cases, which I think is
13 telling. The other two cases were so weak that
14 DHEC now wants to pretend they never happened.
15 Importantly those two cases which happened in
16 February -- mid February of 2016, more than a
17 month prior to the stabbing case that you'll
18 hear mostly about, is clearly an effort to dig
19 dirt on Mr. Davenport and pile on allegations
20 in an effort to bolster the complaint against
21 Mr. Davenport. These complaints were initiated
22 by Scott Stoller, who is the Anderson County
23 EMS Director, and his intention was to try and
24 remove Mr. Davenport from his job within
25 Anderson County. Mr. Davenport had raised a

1 number of concerns about mismanagement of the
2 Department and misappropriation of Department
3 assets and County funds, and we'll get into
4 that slightly. I know Your Honor doesn't want
5 to focus on that, but I think it is important
6 to show the context in which these complaints
7 were raised. The fourth thing Your Honor needs
8 to keep in mind is there was never really an
9 investigation done by DHEC. I know when I
10 mention that at last week's hearing, Mr.
11 Wicevic almost came out of his chair disputing
12 that yes there was in investigation. I think
13 the most telling thing is that DHEC, if you
14 look at DHEC's witness list, DHEC didn't even
15 list the lead investigator in the case, Mr.
16 Naugler as a potential witness in this case,
17 Your Honor. They also didn't list Dr. Arnold
18 Alier, the EMS Director as a witness in this
19 case. We specifically made the decision to
20 list Mr. Naugler and Mr. Alier as witnesses
21 because we want to ask them questions to show
22 that there really was no investigation done
23 here, Your Honor. I think it's also important
24 to look at the timing of the complaint that Mr.
25 Stoller made with DHEC. The initial concern

1 about these three cases came to the attention
2 of Mr. Stoller. He involved Dr. Kickham, who
3 was the Anderson County Medical Control
4 Physician. There was about a two day, three
5 day period that they looked at the case, and
6 they called Mr. Davenport in on Friday, March
7 the 21st in the morning, the first time they'd
8 interviewed Mr. Davenport about this case.
9 Approximately two -- sometime shortly after
10 lunch, Dr. Kickham decided to essentially hand
11 down his decision on what to do about Mr.
12 Davenport. And he recommended no real
13 substantive remediation. The only remediation
14 he recommended was what Mr. Stoller had asked
15 for, which was called a PEPL class. It's like
16 a professional ethics and personal leadership.
17 It's sort of an attitude adjustment type of
18 class for lack of a better word. Mr. Stoller,
19 after 5:00 on that Friday afternoon, the same
20 day that Dr. Kickham put Mr. Davenport back to
21 work, Mr. Stoller sent a complaint to Dr. Alier
22 at DHEC about Mr. Davenport. Mr. Stoller was
23 not able to get rid of Mr. Davenport on the
24 local level, so when Dr. Kickham said, I'm
25 going to restore him back to his medical

1 control, Mr. Stoller went outside and went to
2 DHEC to try and get Mr. Davenport fired. The
3 last thing Your Honor needs to keep in mind in
4 this case is the severity of the enforcement
5 action that's been taken by DHEC in this case.
6 I think it's remarkable, Your Honor -- we asked
7 in discovery in this case for a listing of all
8 the enforcement actions taken against
9 paramedics since January 1st of 2011. They
10 identified about 50 cases in that list. 30 of
11 those cases were resolved by consent order, 19
12 of those cases were emergency suspensions where
13 a paramedic is arrested for a crime, or a
14 serious crime, or felony, or a crime of moral
15 turpitude. The only case in that list that was
16 not resolved by consent order is Mr.
17 Davenport's case, Your Honor. And
18 interestingly DHEC has chose to impose the
19 harshest penalty on Mr. Davenport that it has
20 imposed in the last six or seven years. And we
21 intend to call two highly regarded and well
22 credentialed expert witnesses in this case,
23 Your Honor. One's an emergency physician
24 trauma surgeon. The other is a paramedic
25 educator in one of the leading training

1 institutions for paramedics in the country.
2 Both experts will testify that Mr. Davenport's
3 clinical care of the patients in question was
4 appropriate and well within the applicable
5 standards of care for a pre-hospital provider.
6 They will also testify that treating the actual
7 needs of the patient as opposed to blindly
8 following the checklist in a protocol is more
9 important in actually providing pre-hospital
10 care to patients. As Your Honor knows, this is
11 a contested case that's before you on a de novo
12 hearing. DHEC has the burden of proof in this
13 case, and they have to prove their matter or
14 their case by preponderance of the evidence
15 with no deference given to the administrative
16 order that was issued here, Your Honor. And
17 although Mr. Davenport is a humble and
18 unassuming person, he has very strong
19 convictions. As you can imagine this case has
20 been a tremendous sacrifice for him financially
21 as well as emotionally. Not only for Mr.
22 Davenport but also for his family. He feels
23 very strongly about this case. I think a lot
24 of the reasons that so few of these cases
25 actually make it past a consent order is

1 because paramedics are so sort of scared for
2 their license that they'll sort of do whatever
3 DHEC wants them to do to allow them to continue
4 as a paramedic. Mr. Davenport had no choice in
5 this case. They were from day one were pushing
6 to have Mr. Davenport's certification revoked.
7 I thank you and I know Mr. Davenport thanks you
8 for this opportunity. This is really the first
9 time he's had a chance or any type of due
10 process in this entire matter. He's actually
11 relieved and happy to have the opportunity to
12 finally clear his name and reputation. I thank
13 you in advance for your thoughtful and
14 considerate deliberation in this case. At the
15 close of evidence we will ask that Your Honor
16 dismiss the charges against Mr. Davenport.
17 Thank you.
18 **THE COURT:** Thank you, Mr. Rothstein. Before we get
19 to the first witness's testimony, we are
20 streaming to other court personnel, and I
21 wanted to let you all know that. Does anyone
22 have a problem with that? Okay. Do we know
23 how to discontinue if necessary at this point?
24 Okay. It's a learning process for all of us.
25 Okay. Thanks. Mr. Wicevic, you can call your

1 first witness.
2 **MR. WICEVIC:** Yes, Your Honor. The Department would
3 like to call Kimberly Aiken to the stand. And,
4 Your Honor?
5 **THE COURT:** Yes.
6 **MR. WICEVIC:** We were planning on using some media
7 during this direct examination.
8 **THE COURT:** Uh-huh.
9 **MR. WICEVIC:** My understanding is, Ms. Hazel, you
10 can turn it on. I have my computer hooked up.
11 Should I just cue ---
12 **MS. HAZEL:** Yes.
13 **MR. WICEVIC:** Okay. Thank you.
14 **THE COURT:** If you will, before taking your seat if
15 you will face the court reporter. Raise your
16 right hand, he will swear you.
17 **MS. AIKEN:** Okay.
18 **KIMBERLY AIKEN**, having been duly sworn, testifies as
19 follows:
20 **MS. AIKEN - DIRECT EXAMINATION BY MR. WICEVIC:**
21 Q: All righty. Good afternoon, Ms. Aiken. Can
22 you just please state your full name for the
23 record?
24 A: Kimberly Patton Aiken.
25 Q: Ms. Aiken, we've met before. I deposed you.

1 My name is Vito. I represent the Department of
2 Health and Environmental Control in this
3 contested case. Let's begin with some
4 background about yourself. Can you provide us
5 with your educational background beginning out
6 high school or GED?
7 A: I received my GED, and then I went to Upstate
8 EMS in Greenville, and received my EMT basic.
9 And then I had took my anatomy and physiology
10 class.
11 Q: Okay. So you're currently certified as an EMT?
12 A: Yes, sir.
13 Q: An EMT basic?
14 A: Basic. Yes, sir.
15 Q: Okay. And you received your training and
16 education to become an EMT at Upstate EMS
17 Council?
18 A: Yes, sir.
19 Q: Okay. And when was that?
20 A: It's been about eight years ago, I believe.
21 Q: Okay. So 2009, 2010?
22 A: Yes, sir. Close to that.
23 Q: Okay. Did you take the national registry of
24 EMT's exam shortly there after?
25 A: Yes, sir.

1 Q: Okay. Did you pass that exam?
2 A: Yes, sir.
3 Q: Okay. So I assume 2009, 2010 is when you
4 received your certification?
5 A: Yes, sir.
6 Q: Okay. Now after receiving your South Carolina
7 EMT certification, did you begin practicing as
8 an EMT?
9 A: I did. I started as a transport EMT.
10 Q: Okay. Can you explain what that is?
11 A: It's basically just you have the same patients
12 that you take for doctor's appointments,
13 dialysis, different things like that. If they
14 have to go for physical therapy, you take them
15 back and forth. No emergency calls.
16 Q: Okay. And where was that at?
17 A: At Iva Rescue Squad.
18 Q: Okay. Where did you go from there?
19 A: I worked in transports for about a year, and
20 then I moved to an emergency truck that just
21 answers 9-1-1 calls.
22 Q: Okay. Was that also with Iva Rescue Squad?
23 A: Yes, sir.
24 Q: Okay. How long have you worked at Iva?
25 A: For about eight years.

1 Q: Okay.
2 A: So pretty much as soon as I got certified
3 that's where I went.
4 Q: Have you worked for other licensed services?
5 A: I worked for Williamston EMS whenever they were
6 still Williamston.
7 Q: And what did you do there?
8 A: I was also an EMT there.
9 Q: Okay. Responding to emergent calls?
10 A: Either or.
11 Q: Okay. Do you currently work for Iva Rescue
12 Squad?
13 A: Yes, sir.
14 Q: Okay. And I assume you worked there at the
15 time of this incident on March 19th, 2016?
16 A: Yes, sir.
17 Q: Can you explain to The Court your job duties as
18 an EMT?
19 A: Basically I'm like the first defense I guess.
20 Like the first responder I can administer
21 oxygen, vital signs, the first steps to taking
22 care of, you know, their assessment as far as,
23 you know, taking temperature, taking their
24 vitals, seeing how they're breathing, putting
25 them on oxygen if they need it. And then I

1 turn my care over to an advanced, someone over
2 me, either advanced EMT or a paramedic.
3 Whatever is necessary for that patient.
4 Q: Okay. Now in your eight or so years as an EMT,
5 have you had any kind of disciplinary action --
6 -
7 A: Yes, sir.
8 Q: --- by your employers? Could you explain that
9 for The Court?
10 A: At one time I had rode in a couple of calls
11 that were questionable that maybe should have
12 went to a paramedic instead of me. I rode the
13 calls in, and I was called into the office by
14 my Chief to start with. And we had a
15 conversation. And then Scott Stoller, who was
16 the EMS Director came down to the station and
17 we had a conversation about what I could do,
18 what I couldn't do, what I should be doing,
19 what I shouldn't be doing according to our
20 protocols in Anderson County. And I actually
21 had to ride with another experienced EMT for a
22 few shifts just so he could show me this is
23 what you need to do and this is what you don't
24 need to do.
25 Q: Okay. Now, Ms. Aiken, before we get into the

1 incident in question, let me hand you the DHEC
2 proposed exhibit packet.
3 **MR. WICEVIC:** Mr. Rothstein, do you have a copy?
4 **MR. Rothstein:** I do.
5 **MR. WICEVIC:** Okay. Your honor, I believe you have
6 a copy of our proposed exhibits. I have extras
7 if anybody needs.
8 Q: All right. Well let's talk some about general
9 EMS standards of cares, protocols, services.
10 Could you explain your role as an EMT basic in
11 relation to the Med. Control Physician?
12 A: As far as like what he is to me?
13 Q: Uh-huh.
14 A: Our Med. Control is who we practice under. In
15 An- -- well I guess anywhere that you practice
16 EMS you're Med. Control is whose license you
17 practice under. So anything that I do, I do it
18 because he allows me to do it under his
19 license. It's a protocol that you can or you
20 can't do this under his protocols.
21 Q: Okay. With that being said, let's turn to it's
22 Exhibit 1 of the packet that I just handed you.
23 And I'll allow you to look through it. And
24 when you get a chance, could you identify it?
25 A: It's the Anderson County Protocol Book.

1 Q: Okay. And when is it dated?
2 A: This one's dated 2013.
3 Q: Now who develops the standards of care and
4 treatment protocols?
5 A: Dr. Kickham is actually, he was our Med.
6 Control prior to recently. He's the one that
7 signs off on all the protocols.
8 Q: Okay. And if you turn to Bates page 2, what
9 agencies are subject to this protocol?
10 A: Anderson County.
11 Q: So all of the Anderson County agencies?
12 A: Yes, sir.
13 Q: Would that include Iva Rescue Squad?
14 A: Yes, sir.
15 Q: Okay. Would Exhibit 1 be in effect as of March
16 19th, 2016?
17 A: Yes, sir.
18 **MR. WICEVIC:** Your Honor, the Department would like
19 to admit Exhibit 1 into evidence.
20 **MR. ROTHSTEIN:** I don't have any objection.
21 **THE COURT:** Okay. It's admitted. No objections.
22 **(Petitioner's Exhibit Number 1 was admitted into**
23 **evidence.)**
24 Q: Okay. Ms. Aiken, when did you receive a copy
25 of Exhibit 1, the standards of care and

1 treatment protocols?
2 A: As soon as they set them down from Anderson
3 County, our company actually goes out and they
4 get them printed in little books, and then they
5 hand them out to us. So not exactly sure when
6 they gave them to me.
7 Q: Do you know what formats you received them? Is
8 it a hard copy?
9 A: It's not a hard copy. It's paperback but it's
10 in a book form is how I receive it.
11 Q: Okay. Can you explain to The Court how you use
12 the standards of care and treatment protocols?
13 A: I'm not sure how everybody else uses it except
14 for it's instructions to go by as far as you
15 can look up what's going on with a patient, and
16 it tells you steps to help and take care of the
17 patient, what you should be doing. For more
18 advanced, such as paramedics, it tells you
19 steps as far as like the drug treatment to give
20 somebody. Pretty much just the standard of
21 care that you can and can't give to a patient.
22 Q: Ms. Aiken, what kind of education and training
23 do you receive regarding the standards of care
24 and treatment protocols?
25 A: We have IST once a month that we have to go to.

1 Every month is like a different topic from the
2 protocol book. As far as how to treat a
3 patient. And then once a month we also have a
4 test on a different drug, how you can give it,
5 who can give it, how much to give if you are
6 allowed to give it.
7 Q: Ms. Aiken, you said IST. Could you explain ---
8 A: It's in service training that we go to once a
9 month.
10 Q: Okay. Any kind of orientation regarding these
11 protocols?
12 A: We're tested on it once a year. They make a
13 protocol test that you have to take once a
14 year. And if you're an EMT basic you take so
15 many questions, EMT advanced takes so many, and
16 a paramedic takes the whole test.
17 Q: Okay. What are your general obligations as an
18 EMT with regards to following these protocols
19 and orders?
20 A: As far as I'm concerned, like the standard of
21 care is what I have to go by. This is my
22 instructions on what I can and what I can't do,
23 what needs to be done in all patients.
24 Q: I think you might have mentioned ALS or
25 advanced life support. What does that mean?

1 A: Well like an EMT basic is considered a BLS.
2 That means I give basic life support. I can't
3 give you certain drugs that you need if it's an
4 emergency situation. I'm not allowed to start
5 an IV or anything like that. Advanced life
6 support pretty much gives you full range of
7 stuff like that. You can put somebody on a
8 heart monitor and read a heart monitor, you can
9 IV, you can administer drugs if you need to.
10 Q: Okay. And for the record, let's turn to page
11 6 of Exhibit 1. It's actually 6 and 7. Does
12 this provide more details about the distinction
13 between ALS and BLS?
14 **MR. ROTHSTEIN:** You said Bates number 6 and 7?
15 **MR. WICEVIC:** Yes, sir.
16 **MR. ROTHSTEIN:** Okay.
17 Q: Is that correct?
18 A: Yes, sir.
19 Q: Okay. So for example, looking on Bates page 7,
20 the adult table for BLS and ALS skills, oxygen
21 administration, it looks like bases upon the
22 table, an EMT as exhibited by the x can perform
23 that skill.
24 A: Yes, sir.
25 Q: And then, for intravenous -- moving down to

1 medication administration, intravenous can only
2 be performed by either an EMT intermediate or
3 a paramedic?
4 A: Yes, sir.
5 Q: Okay. All right. Well let's move on to a
6 different subject. The patient -- now let me
7 begin, were you part of the response to this
8 March 19th, 2016 self inflicted stabbing?
9 A: Yes, sir.
10 Q: Okay. And we'll call this patient John Doe or
11 the patient. I'd like to maintain his
12 confidentiality. Did you have a partner on
13 this call?
14 A: Yes, sir.
15 Q: Who was that?
16 A: James Davenport.
17 Q: Okay. Had you cared for this patient before?
18 A: Yes, sir.
19 Q: What were your previous encounters with this
20 patient?
21 A: I've been to this patient anywhere from
22 seizures to suicidal thoughts to OD attempts.
23 Q: How had this patient attempted to commit
24 suicide?
25 A: On one of the calls that I've been on he took

1 a lot of pills. But there was another call
2 that I didn't respond to where there was a
3 gunshot wound from this patient.
4 Q: Okay. How would you characterize this
5 patient's recognition among Iva Rescue Squad
6 EMT's?
7 A: He's very familiar with everybody that works at
8 the Rescue Squad. Everybody that works there
9 on a regular basis, he's familiar with.
10 Q: How would others within the Rescue Squad become
11 familiar with him, or is it just some water
12 cooler talk?
13 A: Well I mean everybody at the station's been to
14 his house multiple times. We actually have two
15 people that went to school with him in our
16 department, so ...
17 Q: How would you characterize Iva?
18 A: A small town.
19 Q: Do you know how big it is?
20 A: No, bit it's very small.
21 Q: Okay. Let's turn to Exhibit 11h. Ms. Aiken,
22 can you identify this exhibit?
23 A: A patient care report.
24 Q: Okay. And when is it dated?
25 A: I believe that's June the 9th, 2015.

1 Q: Okay. And can you explain to The Court what a
2 patient care report is?
3 A: This is actually a paper copy. We do copies on
4 the computer. Basically just tells the
5 patient's information, their address, what
6 you're there for, their vital signs that you
7 took either on scene or en route or both, the
8 assessment of the patient, what their chief
9 complaint was. That's basically it.
10 Q: And can you explain as an EMT how you create
11 one?
12 A: We have a system set on our laptops that we
13 have in every truck. And as far as like you
14 get any kind of information like insurance
15 information, ID from the patient, you do their
16 vital signs with the equipment that you have in
17 the truck. Your assessments can be done in
18 different ways.
19 Q: Okay. When would you create a patient care
20 report?
21 A: Most of the time you create part of it while
22 you're with the patient, and then the rest of
23 it you finish after you release the patient so
24 you're not constantly doing a patient care
25 report with them.

1 Q: Do you transfer the patient care report?
2 A: Yes, sir. Whenever we do it -- when a computer
3 report is done, as soon as you finish the
4 report it's a button that you fax it, and it
5 goes straight to the hospital that you took the
6 patient to.
7 Q: Who is supposed to create the patient care
8 report?
9 A: Whoever rides the call. Whoever's in the
10 patient compartment with the patient.
11 Q: Okay. And whoever creates it has knowledge of
12 the fact within the patient care report?
13 A: Yes, sir.
14 Q: Okay. Is it your regular practice as an EMT
15 whenever you have a patient care encounter to
16 create one of these PCR's?
17 A: Yes, sir.
18 Q: All right. Focusing on Exhibit 11h, were you
19 involved with this particular call?
20 A: I don't see it.
21 Q: Can you turn to the third page of 11h?
22 A: Yes, sir. I was.
23 Q: Okay. And what was your role?
24 A: I was the driver in this call.
25 Q: Okay. And where did this injury or illness

1 occur?
2 A: At the home of the patient.
3 Q: And what was the injury or illness?
4 A: It was an overdose.
5 Q: Okay. Moving back to the first page, what was
6 the history concerning this patient?
7 A: The behavior, bi-polar disorder.
8 Q: Okay. And according to the narrative, what did
9 this patient overdose on?
10 A: I believe it was Xanax.
11 Q: Okay. What type of care was provided to this
12 patient?
13 A: He was monitored on the heart monitor. He had
14 an ALS assessment and he had IV therapy.
15 Q: Okay. What was the patient's blood pressure?
16 A: The first reading was 133 over 72.
17 Q: Is that within normal range?
18 A: Yes, sir.
19 Q: Okay. Now did you transfer the patient to the
20 hospital?
21 A: Yes, sir.
22 Q: Which hospital?
23 A: AnMed.
24 Q: And what was your role in the transport?
25 A: I was the driver.

1 Q: Okay.
2 A: I mean I assisted the paramedic with like
3 getting the patient out of the back of the
4 truck, getting them transferred into the
5 hospital.
6 Q: Okay.
7 **MR. WICEVIC:** Your Honor, the Department would like
8 to admit Exhibit 11h.
9 **THE COURT:** Mr. Rothstein?
10 **MR. ROTHSTEIN:** No objection.
11 **THE COURT:** Okay. It's admitted.
12 **(Petitioner's Exhibit Number 11h was admitted into**
13 **evidence.)**
14 Q: All right, Ms. Aiken. Besides this March 19th,
15 2016 incident, did you ever provide care to
16 this patient, patient John Doe, with Mr.
17 Davenport?
18 A: Yes, sir.
19 Q: Okay. Let's turn to Exhibit 11e. Now, Ms.
20 Aiken, can you identify this document?
21 A: It's another patient care report.
22 Q: Okay. And when is it dated?
23 A: 9/19/2015. I believe that's a 9.
24 Q: And who were the EMT's involved with this call?
25 A: Me and Mr. Davenport.

1 Q: Okay. And where was the scene of the patient's
2 injury or illness?
3 A: At his home.
4 Q: What was the estimate of this patient's weight?
5 A: 135.
6 Q: What was the patient's history?
7 A: Psychiatric disorder and epilepsy.
8 Q: Okay. What was the chief complaint with
9 regards to this call?
10 A: Coughing up blood.
11 Q: Now, looking at the narrative what did the
12 patient indicate was bothering him?
13 **MR. ROTHSTEIN:** Your Honor, I am going to object to
14 this one. This has nothing to do with the
15 disciplinary action that was brought against
16 Mr. Davenport.
17 **MR. WICEVIC:** I think it does. It's the patient in
18 question to the call that the Department based
19 its action on. I think you'll find out there
20 was knowledge on Mr. Davenport's part about
21 this patient's history and he should have
22 adjusted his care based upon that knowledge.
23 Mr. Davenport was involved with this call.
24 **MR. ROTHSTEIN:** There's never been an allegation Mr.
25 Davenport did anything wrong on this particular

1 call. My concern is they're reaching for
2 something that DHEC has never before brought
3 up.
4 **THE COURT:** Is it DHEC's position that there was
5 some wrong doing relative to this call?
6 **MR. WICEVIC:** No, ma'am.
7 **THE COURT:** Okay. Well then what's the purpose? If
8 you would just review that with me again.
9 **MR. WICEVIC:** The purpose is that this patient had a
10 history of attempted suicides, overdoses. And
11 our position is Mr. Davenport knew about that
12 ---
13 **THE COURT:** Okay.
14 **MR. WICEVIC:** --- and his care should have been
15 adjusted appropriately. And the call in
16 question serves as a basis of the Department's
17 action.
18 **THE COURT:** Thank you. Your objection is overruled.
19 Q: Okay. So, Ms. Aiken, what was bothering the
20 patient?
21 A: He stated that he had been coughing up blood
22 for a few days before we got there.
23 Q: And what's your understanding as far as the
24 injury he incurred, I guess, two or three weeks
25 before this call?

1 A: He had a chest tube from having a gunshot
2 wound.
3 Q: Are you aware if it was a self inflicted
4 gunshot wound?
5 A: Yes, sir.
6 Q: Okay. Did you and Mr. Davenport go into the
7 patient's residence?
8 A: Yes, sir.
9 Q: Where was the patient transferred to?
10 A: He was transferred to AnMed.
11 Q: Okay. And who drove?
12 A: Mr. Davenport.
13 Q: Okay. All right. Moving on.
14 **MR. WICEVIC:** Your Honor, the Department would like
15 to admit Exhibit 11e.
16 **THE COURT:** Mr. Rothstein?
17 **MR. ROTHSTEIN:** Just my prior objection, Your Honor.
18 **THE COURT:** Okay. Thanks. The exhibit is now
19 admitted.
20 **(Petitioner's Exhibit Number 11e was admitted into**
21 **evidence.)**
22 **MR. WICEVIC:** Thank you, Your Honor.
23 Q: Ms. Aiken, let's turn to Exhibit 11b please.
24 Can you identify this please?
25 A: It's another patient care report.

1 Q: And when is this one dated?
2 A: March the 19th, 2016.
3 Q: Do you have the time of that patient care
4 report?
5 A: The dispatch time was 2112.01.
6 Q: So that's 9:12?
7 A: Uh-huh.
8 Q: Okay.
9 A: Yes, sir.
10 Q: Did dispatch inform you of the reason for the
11 call?
12 A: Yes, sir.
13 Q: Okay. And what was the reason for the call?
14 A: It was told that for us to go with the Iva
15 Police Department down there for a traumatic
16 injury for a self inflicted stab wound.
17 Q: You're saying, we were dispatched. Who was the
18 other person on this call?
19 A: Me and Mr. Davenport.
20 Q: Before arriving were you aware that law
21 enforcement was on the scene?
22 A: Yes, sir.
23 Q: Who was present on the scene when you arrived?
24 A: The two officers, T.J. Boucher and Eric Aiken.
25 Q: Okay. Of course reference -- what's your

1 relationship to Eric Aiken?
2 A: He's my husband.
3 Q: Okay. Were family members present at the scene
4 of the incident?
5 A: His wife was. The patient's wife was.
6 Q: Thank you. Upon arriving what did you do?
7 A: Just got ready, I mean, got our gloves set out,
8 stuff like that, prepared mentally to what we
9 was going into.
10 Q: Okay. Did you have any knowledge of the
11 suspected size of the knife?
12 A: No, sir.
13 Q: Okay. Regardless, where was the knife placed?
14 A: We didn't know en route. We didn't know until
15 we got there and actually got inside the
16 residence anything about it. We just knew it
17 was self inflicted. We had no idea where.
18 Q: Where was the wound located?
19 A: It was in his, I believe it was his upper left
20 abdominal plain.
21 Q: Right. And you can refer to the patient care
22 report.
23 A: Okay.
24 Q: I believe that as information.
25 **MR. WICEVIC:** And before I forget, Your Honor, can I

1 admit 11b into evidence?
2 **MR. ROTHSTEIN:** No objection to that one.
3 **THE COURT:** Okay. It's admitted.
4 **(Petitioner's Exhibit Number 11b was admitted into**
5 **evidence.)**
6 A: It was his upper left.
7 Q: Okay. And was the knife impaled?
8 A: Yes, sir.
9 Q: Was there a way to actually determine with
10 certainty the size of the knife?
11 A: No, sir.
12 Q: Okay. Did the patient inform you of the size?
13 A: Yes, sir.
14 Q: What did he say?
15 A: He said about six or seven inches.
16 Q: Did you perform an assessment of the patient at
17 the residence?
18 A: Just looking at him. Mr. Davenport was
19 actually bent down talking to him. His wife
20 who has also a lot of health problems, I spent
21 a little bit of time talking to her, trying to
22 get her to calm down because she has an
23 extensive history with breathing problems, and
24 she was wheezing and breathing hard. So I
25 tried to calm her down while James was

1 assessing his patient.
2 Q: Okay. Well let's get to Mr. Davenport, your
3 observations about Mr. Davenport. Upon
4 arriving what did he do?
5 A: When we first got onto the scene T.J. Boucher
6 was one of the officers on the scene came to
7 the door, and he's like, hurry up come one. So
8 we went in. When we walked in the door I asked
9 the patient by name what he had done again.
10 And the patient stated that he was trying to
11 stab himself in the heart. Mr. Davenport did
12 call him an idiot, and Mr. Davenport started
13 getting his stuff to stabilize the knife.
14 Q: Okay. Well backing up a little bit, did you or
15 Mr. Davenport bring equipment into the house?
16 A: Yes, sir. We had what we call the red bag,
17 which is our bag that has most of our ALS
18 equipment in it.
19 Q: Okay. Who brought that in?
20 A: I believe Mr. Davenport did.
21 Q: Okay. Were there any carrying devices brought
22 in the house?
23 A: No, sir.
24 Q: Okay. So Mr. Davenport goes up to the patient.
25 Did he perform an assessment of the patient

1 inside the residence?
2 A: He did, like, a quick assessment over him as
3 far as looking at him, making sure the knife
4 was stabilized, stuff like that.
5 Q: Okay. What about a pulse? Did you observe Mr.
6 Davenport take the patient's pulse?
7 A: No, sir.
8 Q: Did Mr. Davenport take the patient's blood
9 pressure?
10 A: No, sir.
11 Q: Did Mr. Davenport take the patient's lung
12 sounds?
13 A: Not listening to them. No, sir.
14 Q: Did Mr. Davenport inform you of the results of
15 his assessment, visual assessment?
16 A: No, sir.
17 Q: After this, what happened? Was this when the
18 stabilization and bandaging of the knife
19 occurred?
20 A: Yes, sir.
21 Q: Okay. And can you explain that procedure?
22 A: He used some gauze that were in our red bag,
23 and he placed them on the side to stabilize the
24 knife. And then I handed him some tape and he
25 bandaged it around the knife to stabilize it.

1 Q: Then what was the next step in the treatment of
2 this patient?
3 A: To get the patient to the hospital.
4 Q: Were there carrying devices in the ambulance?
5 A: Yes, sir.
6 Q: What kinds?
7 A: Besides the stretcher we have back boards, we
8 have scoop stretchers, we have stair chairs.
9 Q: Were any of these carrying devices brought into
10 the home?
11 A: No, sir.
12 Q: Okay. After bandaging the wound and
13 stabilizing the knife, what course of treatment
14 was provided to this patient?
15 A: Mr. Davenport and one of the officers -- I'm
16 not sure what officer -- but one of the
17 officers assisted him, one on each side
18 assisted him down the stairs to our unit
19 outside.
20 Q: So, maybe I'm backing up a little bit. Where
21 was the patient located on initial arrival to
22 the scene?
23 A: He was sitting on the couch in his living room.
24 Q: Okay. And then y'all transferred him via
25 walking him?

1 A: Yes, sir.
2 Q: What type of assistance did Mr. Davenport and
3 the officer provide this patient?
4 A: One on each side of him.
5 Q: Were they holding his arms or shoulder?
6 A: I don't really remember.
7 Q: Okay. Did you have concerns or worries in
8 walking this patient?
9 A: Yes, sir.
10 Q: What were they?
11 A: That the knife might move.
12 Q: Did you observe any obstacles at the residence
13 that would prevent utilizing a carrying device?
14 A: Well there were stairs, but like I said, we had
15 a stair chair in the unit.
16 Q: Would stairs prevent use of a stretcher?
17 A: No, sir.
18 Q: Would stairs prevent usage of a back board or
19 a spine board?
20 A: No, sir.
21 Q: What about the narrowness of the door? Would
22 that prevent use of a stretcher?
23 A: I don't believe so, in this residence.
24 Q: What about the other carrying devices?
25 A: No, sir.

1 Q: Would it be feasible to utilize the back board
2 at this residence?
3 A: Yes, sir.
4 Q: All right. After Mr. Davenport and the officer
5 ambulated the patient to the ambulance, what
6 happened?
7 A: He was placed on the stretcher and they put him
8 in the unit. And while we were standing out
9 back of the unit, James looked at me and he
10 asked me he said, are you ready to go? And I
11 asked him I said, are you sure this is my call?
12 And he was like, yeah, it'll be fine. And so
13 I went around to the side door of our unit to
14 get in the unit. There were two officers
15 already in the unit taking still photos and
16 stuff, speaking with the patient about what had
17 happened, what was going on. And James came
18 around to the side again, and I asked him
19 again, are you sure. And he's like, you'll be
20 fine. And he went around to the driver's side.
21 I got in the compartment after the officers got
22 out.
23 Q: Okay. Well let's back up a little bit. Who
24 loaded the patient into the stretcher and then
25 onto the ambulance?

1 A: It was James and I believe one of the other
2 officers. By the end there was three or four
3 more officers that had got on scene by then.
4 Q: What were you doing during this time?
5 A: Just standing by.
6 Q: Okay. And you mentioned a discussion with Mr.
7 Davenport about who was riding in the patient
8 compartment. Can you explain to The Court your
9 feelings about riding this patient?
10 A: I felt like it was a trauma patient. It was an
11 impaled knife. I felt like it should have been
12 an ALS call. But at the time James was pretty
13 much my supervisor because he was my higher
14 certified on the truck and James is a good
15 paramedic and I trusted his opinion whenever he
16 told me that it would be fine.
17 Q: When Mr. Davenport asked you about riding this
18 call, what was your response?
19 A: I asked him was he sure?
20 Q: Okay. And what was his reply?
21 A: He said you'll be fine.
22 Q: Okay. Did you ride in the patient compartment?
23 A: Yes, sir.
24 Q: Where was this patient transported to?
25 A: To AnMed.

1 Q: During this transport what did you do?
2 A: I done his vital signs and his assessment
3 twice.
4 Q: Okay. Let's look at the patient care report.
5 Again, it's Exhibit 11b. Now, Ms. Aiken, the
6 first page about midway down there's vital
7 signs.
8 A: Okay.
9 Q: Were these the vital signs that you took?
10 A: Yes, sir.
11 Q: Okay. And do any of these particular vital
12 sign results look out of the ordinary?
13 A: No, sir.
14 Q: Okay. And am I correct that the times stamped
15 are the times you performed?
16 A: Yes, sir.
17 Q: Okay. Then below the vital signs are initial
18 assessment and an ongoing assessment. Did you
19 take both of these assessments?
20 A: Yes, sir.
21 Q: And what did you note the mental status of this
22 patient?
23 A: He's a psychiatric patient.
24 Q: And what was the wound that this patient
25 suffered?

1 A: A stab to the upper left quadrant.
2 Q: Is that left upper quadrant?
3 A: Yes.
4 Q: LUQ?
5 A: Yes, sir.
6 Q: And when was the initial assessment performed?
7 A: 2130, so 9:30.
8 Q: Okay. And then the ongoing assessment?
9 A: It was at 9:42.
10 Q: Okay. And can you explain to The Court how the
11 vital signs in the assessments relate?
12 A: Well I always ---
13 Q: Are they related?
14 A: Yes and no. 'Cause by touching a patient while
15 you're feeling their skin, you can take a pulse
16 then. So that can help you with that. Of
17 course we had a Life Pack 15 that was
18 constantly taking his pulse and blood pressure,
19 not monitoring his heart, but just his vital
20 signs.
21 Q: Okay. Can you explain what a LIFE Pack 15 is?
22 A: It's a heart monitor.
23 Q: Okay.
24 A: It also takes vitals. It'll take blood
25 pressure. It'll tell you what a person's

1 oxygen level is, what their pulse rate is.
2 Q: Is it also a cardiac monitor?
3 A: Yes, sir.
4 Q: But am I correct that as an EMT basic you
5 cannot read or interpret the cardiac monitor?
6 A: Correct. I could put him on it, but I can't
7 read it. So in this situation it wouldn't have
8 done any good.
9 Q: Okay. You mentioned the assessments were
10 performed by you. Was the patient stable
11 throughout the whole ride?
12 A: Yes, sir.
13 Q: Okay. Did you run into any issues during your
14 transport of the patient?
15 A: One time he kind of flailed his arms around a
16 little bit and he hit it, which made me
17 nervous. And I told him I was like, you're
18 going to have to be still or you're going to
19 end up getting tied down. 'Cause I was worried
20 about him moving it around inside of him 'cause
21 he does have a lot of mental issues. And
22 sometimes he does stuff and don't realize he's
23 doing it.
24 Q: Okay. So you're riding back to the -- you're
25 in the patient compartment in transport to

1 AnMed. Did you make a call to the Emergency
2 Department concerning this patient?
3 A: I thought I did, but after deposition, James is
4 the one that made the call.
5 Q: Okay. Let me pull up the audio file. Let's
6 see if we can play that. My Windows Media
7 Player might be frozen. Give me one moment
8 please.
9 **(Off the record from 2:19 p.m. until 2:27 p.m.)**
10 **THE COURT:** Mr. Wicevic.
11 **MR. WICEVIC:** Thank you, Your Honor.
12 Q: Ms. Aiken, I was having some technical
13 difficulties with the audio recording. Let me
14 play it for you, and see if you recognize the
15 voices in this call.
16 **(Audio Played)**
17 Q: All right, Ms. Aiken. Can you identify the
18 voices in that recording?
19 A: One of them was James and the other was Spencer
20 that works in the EMS room at AnMed.
21 Q: Okay. And was that the transmission or rather
22 a report of y'all's call prior to arriving at
23 the Emergency Department?
24 A: Yes, sir.
25 Q: Okay.

1 **MR. WICEVIC:** The Department would like to admit
2 Exhibit 3, the medic 61 AnMed ED report
3 recording.
4 **MR. ROTHSTEIN:** No objection.
5 **THE COURT:** It's admitted.
6 **(Petitioner's Exhibit Number 3 was admitted into**
7 **evidence.)**
8 Q: Okay. Ms. Aiken, now after arriving at AnMed,
9 what did you do?
10 A: We got the patient out of the unit, and we took
11 him into the critical room that they placed him
12 in. James helped me, along with nurses that
13 were in the ER helped us get him transferred
14 over to the ER bed. And then James took the
15 stretcher back outside to start cleaning our
16 unit up. And I gave my report to the RN that
17 was over his care. And she signed my report,
18 and then I went back out to the truck.
19 Q: Okay. So you returned back to the truck. Then
20 did you have a discussion with Mr. Davenport?
21 A: Once we were back in the truck leaving the ER,
22 James asked me if I was okay, and I said yeah,
23 and he said are you sure. And I told him I was
24 just worried about the call, about QA's and
25 stuff like that. And he explained to me why he

1 felt like it was a basic life support call
2 instead of an advanced. Saying to me
3 everything that I done for the patient was the
4 same thing he would have done for the patient.
5 And the only thing that he would even possibly
6 done different was to give him an IV, and he
7 only would have gave him that if he would have
8 been going to administer medication and that
9 the patient didn't need medication.
10 Q: You know from arriving at the scene of the
11 incident to dropping the patient off at AnMed,
12 did either you or Mr. Davenport ever call or
13 attempt to call an online Medical Control
14 Physician?
15 A: No, sir.
16 Q: Now, is Mr. Davenport a more experienced EMT
17 than you?
18 A: Yes, sir.
19 Q: Is he a higher certification than you?
20 A: Yes, sir.
21 Q: As the higher certification and more
22 experienced EMT, would you defer to his
23 judgement?
24 A: Yes, sir.
25 Q: Let's turn back to Exhibit 1, page 89 please.

1 Ms. Aiken, can you identify this document
2 please
3 A: Authority for patient management policy.
4 Q: Okay. And can you read the paragraph under
5 policy?
6 A: It is the policy of Anderson County EMS
7 provider that the authority for the patient
8 management of an out of hospital medical
9 emergency situation shall be the responsibility
10 of the individual first on the scene and in
11 attendance of the patient who is most
12 appropriately trained and knowledgeable in
13 providing pre-hospital emergency stabilization
14 and transport for the situation at hand.
15 Ideally the senior paramedic of the primary
16 responding agency will assume the
17 responsibility for the patient management.
18 Q: Okay. And then under procedure, could you read
19 the fourth paragraph down?
20 A: The most appropriately trained and
21 knowledgeable provider at the scene is
22 ultimately responsible for all the patient care
23 activities while he or she is present.
24 Q: Now was Mr. Davenport the most appropriately
25 trained and knowledgeable provider at the

1 scene?
2 A: Yes, sir.
3 Q: Okay. Were you concerned whether you had the
4 qualifications to meet the patient's immediate
5 needs or reasonably perceived needs?
6 A: Whether I did?
7 Q: Yes.
8 A: Yes, sir.
9 Q: Now, Ms. Aiken, getting back to Exhibit 11b the
10 patient care report, if you look on the third
11 page, can you explain why this states, the
12 patient care report states the level of service
13 is basic life support?
14 A: Because that's the only thing I can do for him.
15 I can't do ALS.
16 Q: Okay. Was this the first traumatic injury --
17 let me rephrase that. Was this the first time
18 you rode in the patient care compartment
19 without any paramedic partners for a traumatic
20 injury?
21 A: Like I stated before, traumatic injuries are a
22 lengthy thing. I mean it can be if grandma
23 fell out of the bed in the middle of the night
24 and her side's hurting or her knee's hurting.
25 That's considered a traumatic injury, and I've

1 rode stuff like that before.
2 Q: Okay.
3 A: Something as severe as a trauma alert having to
4 be called at the ER, I've never been the lead
5 in the patient care compartment, but I have
6 been there to assist a paramedic in the back of
7 the compartment.
8 Q: Are you aware if there was a trauma alert for
9 this particular patient?
10 A: I wasn't until we got there.
11 Q: Okay.
12 A: When we got to the ER.
13 Q: And what did you learn upon arrival?
14 A: They said, is this our trauma alert coming in,
15 whenever we came in.
16 Q: Was it?
17 A: Yes.
18 Q: Okay. At the time of the patient care
19 incident, were you aware that local law
20 enforcement officers were wearing a body cam
21 footage?
22 A: Yes, sir.
23 Q: Okay. Were you aware that Officer Boucher was
24 wearing a body cam?
25 A: Yes, sir.

1 Q: Okay.
2 **MR. WICEVIC:** Let me play another media.
3 **MR. ROTHSTEIN:** Your Honor, I do have an objection
4 to this. They don't have any way to lay a
5 foundation for this exhibit. Their witness
6 list does not include Officer Boucher, who is
7 the only one that could lay the foundation for
8 this video. So I would object on the grounds
9 that no foundation is laid.
10 **MR. WICEVIC:** And, Your Honor, we do have an
11 affidavit custodian from Iva Police Department,
12 and I'd be happy to submit that. I think this
13 could get into evidence based upon Ms. Aiken's
14 identification of the facts of the video. So
15 first of all I don't think establishing a chain
16 of custody is necessary for this. If there is
17 any concerns with alteration of this video, I
18 think that goes to the credibility, the
19 accuracy. However I submit to you that it's
20 time stamped and it's readily identifiable.
21 It's clear body cam footage. I believe Ms.
22 Aiken will be able to identify it, confirm that
23 it was the call in question. So I don't think
24 a strict chain of custody is necessary for this
25 particular admission. Again, there's case law

1 supporting this. I don't find much South
2 Carolina case law regarding this. I did find
3 some case law in Federal District Court that
4 said burden of proof, authentication, there
5 only need be a prima facie showing to The Court
6 of authenticity, not full argument on
7 admissibility. Once a prima facie case is
8 made, that evidence goes to the jury. It's the
9 jury who ultimately determines authenticity of
10 evidence, not The Court. Again, this isn't a
11 drug test, it's not drugs, it's not a lab test.
12 Parties can authenticate a video through
13 different types of evidence including that the
14 recording was accurate and the chain of custody
15 was materially maintained, or by testimony from
16 a witness that the footage is what they
17 observed. I think that's how we get it in.
18 Like I said, I do have an affidavit of
19 custodian from the Iva Police Department for
20 which this Police Officer worked for. I'd be
21 happy to submit that. Some other case law I
22 found, this is I believe from North Carolina.
23 Detailed chain of custody need be established
24 only when the evidence is not readily
25 identifiable or susceptible to alteration and

1 there's reason to believe that it may have been
2 altered sufficient for the party offering the
3 video tape simply satisfy to the trial court
4 the item is what it purports to be and has not
5 been altered. Any weak links in the chain of
6 custody relate only to the weight that's to be
7 given to the evidence, not to its
8 admissibility. Let me submit to you the
9 affidavit of the police department.
10 **MR. ROTHSTEIN:** And, Your Honor, I'm not contesting
11 the chain of custody. I'm contesting the
12 foundation for the evidence. Any photograph or
13 video evidence has to have a person to support
14 that document coming into evidence. And they
15 have to testify that it's a fair and accurate
16 representation of what it purports to be. This
17 body cam video is very limited in scope. It's,
18 I mean, most of the time you can't see the
19 patient or what's happening with the patient.
20 You can just see from like the head down or the
21 neck down. You can't tell what Mr. Davenport's
22 doing. There's a lot of stuff that's going on
23 at the scene that the audio and the video don't
24 capture. It's incredibly misleading. They've
25 had this -- I think the way the video was

1 originally brought to the attention of Mr.
2 Alier was directly through Scott Stoller, who
3 is the EMS Director. This wasn't obtained
4 through the Chief of Police at the Iva Police
5 Department, they didn't interview Mr. Boucher.
6 They didn't even know who actually took the
7 video until February of 2017 when they sent an
8 email to the Iva Police Department asking, you
9 know, who was the officer that shot this video.
10 It's their burden of proving this case. I
11 think this video is -- number one, there's no
12 foundation. Number two, it's grossly
13 misleading, Your Honor.
14 **MR. WICEVIC:** And, Your Honor, we did obtain the
15 video via subpoena from the Iva Police
16 Department. And let me -- may I approach the
17 bench?
18 **THE COURT:** Yes.
19 **MR. WICEVIC:** I'm handing you an affidavit from the
20 Iva Police Department documenting their
21 maintenance of the video confirming that it's
22 an accurate video. Again, it's our position
23 that a strict chain of custody is not required.
24 Ms. Aiken can identify the video. She was
25 aware that body cam footage -- officers having

1 body cam. She was on scene. She was a fact
2 witness of this matter. I think any kinds of
3 concerns with the accuracy of the video may
4 relate to chain of custody, can be taken in
5 your discretion. You can make the judgement on
6 that. I do not think it impacts the
7 admissibility of the body cam footage.
8 **THE COURT:** Now, Officer Boucher was the individual
9 that was wearing the body cam?
10 **MR. WICEVIC:** Yes, Your Honor.
11 **THE COURT:** Okay. And why isn't he here?
12 **MR. WICEVIC:** He, when we contacted him, I'll
13 represent to you that he didn't have much
14 recollection regarding this. I believe he
15 faxed me today an affidavit maintaining that
16 this is the body cam footage from the call in
17 question. I haven't been to the office this
18 morning. That being said, we obtained this
19 directly from Iva Police Department. There
20 were multiple other individuals on scene that
21 can testify to the veracity of the video. We
22 didn't call Officer Boucher because he
23 indicated he did not have memory concerning
24 this incident. He's a Police Officer, he works
25 night shifts. He's at a different police

1 department now. Again, it's our position that
2 Ms. Aiken can identify this. Mr. Davenport can
3 identify it. Any kinds of concerns with chain
4 of custody, I think are addressed by this
5 affidavit, and it's not -- testimony from
6 Officer Boucher is not a prerequisite to
7 getting this into evidence.
8 **MR. ROTHSTEIN:** Again, Your Honor, it's not a chain
9 of custody issue. But if you'll look at the
10 second, or the back of this affidavit from the
11 records custodian at Iva, they attached the
12 body worn camera policy for the Iva Police
13 Department. And under permitted use of
14 cameras, Your Honor, it says VWC or body warn
15 cameras shall only be used in conjunction with
16 official law enforcement duties. This is not
17 an official law enforcement duty. Officer
18 Boucher is the only person who can authenticate
19 or lay the proper foundation for this video
20 saying that it is a fair and accurate
21 representation of the events that occurred on
22 the night in question. Mr. Boucher has, you
23 know -- the fact that DHEC didn't get his, you
24 know -- didn't contact him or lay the
25 foundation or, you know, subpoena him to the

1 hearing today, that's DHEC's problem. That is
2 not our problem, Your Honor. And they don't
3 have anyone that can lay that requisite
4 foundation for the video.
5 **MR. WICEVIC:** And, Your Honor, the mention in the
6 policy is about official law enforcement usage.
7 Yes, this body cam footage was taken in
8 response to a 9-1-1 call. Officer Boucher was
9 using it to record that. He's required
10 pursuant to the policy to utilize it on that
11 scene. I think we're getting into this in
12 great detail, too in depth. If you look at
13 rule 901 regarding authentication, it
14 specifically says that -- it gives examples.
15 901-B, by way of illustration only, not by way
16 of limitation, the following examples for
17 authentication, identification conforming with
18 the requirements of this rule. First one,
19 testimony of witness with knowledge. Ms. Aiken
20 has knowledge regarding this footage. You
21 don't have to have the person that took the
22 photograph or took a video or set up
23 surveillance camera come to court to testify.
24 **THE COURT:** Okay.
25 **MR. WICEVIC:** And he's right. It doesn't catch

1 everything. I think that's undisputed. You
2 can't have a ever present body cam or camera
3 anywhere. So in that regard, I agree. But I
4 think the admissibility of this particular body
5 cam video, I think it is admissible pursuant to
6 the rules of evidence if she can identify it.
7 **THE COURT:** I am -- I'll be honest, I'm very
8 concerned that Officer Boucher is not here to
9 authenticate that at the time of the incident
10 he was wearing the body cam that the video was
11 -- even if he didn't have specific
12 recollections of what occurred, what was
13 occurring, he could still authenticate that he
14 was the individual that was there and that he
15 was wearing the body cam at that time, and that
16 this footage was shot during that time.
17 **MR. WICEVIC:** And, Your Honor, the affidavit does
18 indicate this was the body cam footage recorded
19 by Iva Police Officer T.J. Boucher on March
20 19th, 2016, from 9:14 p.m. to 9:30 p.m. at the
21 scene of the incident. Your Honor ---
22 **THE COURT:** Okay. I'm sorry.
23 **MR. WICEVIC:** --- I think if you see the video,
24 there's actually a mirror, so the body cam
25 actually records Officer Boucher. And I submit

1 to you that Ms. Aiken can identify Officer
2 Boucher. I think that the characteristics of
3 this video demonstrate that it is authentic,
4 that it's from him. It's not from some secret
5 DHEC agent or anything of that matter. The
6 characteristics of the video support its
7 admissibility.
8 **THE COURT:** Okay. Mr. Rothstein, I've heard your
9 objections but I'm going to go ahead and allow
10 the witness to -- Mr. Wicevic to play the
11 video. And I'm going to allow it into
12 evidence.
13 **(Petitioner's Exhibit Number 2 was admitted into**
14 **evidence.)**
15 **(Video Played)**
16 Q: Ms. Aiken, who was that that just entered the
17 video?
18 A: Eric Aiken.
19 Q: And, for the record, I'm at minute 1:45 of the
20 file.
21 **(Video Played)**
22 Q: Ms. Aiken, do you recognize that voice?
23 A: It was mine.
24 Q: Okay, and for the record, I'm at minute 2:24.
25 **(Video Played)**

1 Q: For the record, the person that just spoke was?
2 A: Mr. Davenport.
3 Q: And again, this was minute 2:43 of the video.
4 **(Video Played)**
5 Q: Ms. Aiken, the lady in the pink shirt, can you
6 identify her?
7 A: That's the patient's wife.
8 Q: And for the record, I'm referring to time stamp
9 4:40 of the video.
10 **(Video Played)**
11 Q: Ms. Aiken, can you identify this individual?
12 A: Mike Burns. He was another officer at the
13 time.
14 Q: And what was he doing in response to this call?
15 A: Most of the Iva Police Department ended up
16 showing on scene at the time. Like I said,
17 small town, something like that happens, they
18 all come out.
19 Q: And just for the record, I'm referring to 9:14
20 of the video.
21 **(Video Played)**
22 Q: Can you identify that individual at 11:20?
23 A: Jason Hawkins. He's the Chief of Police at
24 Iva.
25 **(Video Played)**

1 Q: All right, Ms. Aiken. Was that video that we
2 just reviewed a depiction of the care and
3 treatment that you and Mr. Davenport provided
4 on March 19th, 2016?
5 A: Yes, sir.
6 Q: Okay.
7 **MR. WICEVIC:** And, Your Honor, just to make sure,
8 did you admit that into evidence?
9 **THE COURT:** I'm sorry. I spoke prematurely.
10 **MR. WICEVIC:** The Department would like to introduce
11 that exhibit.
12 **THE COURT:** Okay.
13 **MR. ROTHSTEIN:** Same objection.
14 **THE COURT:** Okay. Thank you. But I think the
15 Department has established sufficient grounds
16 to have it admitted, and it is admitted.
17 **MR. WICEVIC:** Thank you, Your Honor.
18 Q: Now, Ms. Aiken, are you aware that the Iva
19 Police Department took photographs of the scene
20 of this accident and the patient?
21 A: Yes, sir.
22 Q: Okay. I've got a series of photographs, and
23 let's see if you can identify these please.
24 **MR. ROTHSTEIN:** Your Honor, you saw the video. The
25 photographs were taken after the ambulance left

1 the scene. There's no way that she's going to
2 be able to identify these photographs. They've
3 known who this Mr. Burns was, the officer.
4 They didn't bother to -- I actually got the
5 photographs from Iva about two days ago or
6 three days ago, Your Honor. Again, this goes
7 to the fact that there was no investigation
8 done by DHEC. There's no way that this witness
9 is going to be able to lay the foundation for
10 these photographs.
11 **MR. WICEVIC:** Your Honor, this is a de novo hearing.
12 If she can identify this it can go into
13 evidence. The fact that DHEC didn't obtain
14 this through our investigation isn't of
15 significance. It is relevant to this matter,
16 and I think it'd be helpful in your
17 determination of whether to uphold the
18 Department's findings and whether to revoke Mr.
19 Davenport's certificate.
20 **THE COURT:** Okay. Let's listen to the witness's
21 testimony relative to the photographs. Then
22 we'll make an evidentiary ruling.
23 Q: Okay. Ms. Aiken, can you identify this
24 photograph I just handed you?
25 A: No, sir.

1 Q: Okay. Let me hand you another one. What about
2 this one?
3 A: It looks like the cover on the couch that he
4 was sitting on.
5 Q: Okay.
6 A: I'm not positive.
7 Q: I've got another one that might be helpful in
8 that determination.
9 **MR. ROTHSTEIN:** Your Honor, I think the rules
10 require her to set a foundation, not for Mr.
11 Wicevic to lay a foundation. I mean he's
12 basically coaching this witness by saying, I
13 think there's another photograph that may help
14 you with that identification. I think that's
15 improper.
16 **THE COURT:** Your objection is noted, but it's
17 overruled. Go ahead, Mr. Wicevic.
18 Q: Ms. Aiken, can you identify the photograph I
19 just handed you?
20 A: This is the couch that is in the patient's
21 residence.
22 Q: Okay. This is the couch that the patient was
23 seated on arrival?
24 A: Yes, sir.
25 Q: Did you have observations, first hand

1 observations of this couch?
2 A: Yes, sir.
3 Q: Okay.
4 **MR. WICEVIC:** The Department would like to admit the
5 photograph of the couch, I guess that would be
6 Exhibit 16.
7 **THE COURT:** Mr. Rothstein?
8 **MR. ROTHSTEIN:** I do object to that, Your Honor. I
9 mean there's -- I think the Department has to
10 lay a foundation for this photograph. We have
11 no idea when this photograph was taken, they
12 don't have a witness that can authenticate when
13 it was taken. The fact that it looks like the
14 couch that was in the residence at some point
15 is not sufficient.
16 **THE COURT:** Mr. Wicevic?
17 **MR. WICEVIC:** Your Honor, for the same reason that
18 the video was properly admitted, Ms. Aiken can
19 identify this. She was on scene. Any kind of
20 issues with the credibility of the witness, he
21 can make that. But I think she can properly --
22 I mean, again looking at the rules of evidence,
23 rule 901, you can authenticate and lay a
24 foundation by identifying the substance of the
25 picture. Further, she -- there's video footage

1 of the officer taking photographs during the
2 video.
3 **MR. ROTHSTEIN:** He should be here. That's the
4 point.
5 **THE COURT:** Okay. So what your witness identified
6 this as being the sofa that was in the home at
7 the time of the incident or ...
8 Q: Is this the sofa -- does this photograph,
9 Exhibit 16 reflect the sofa that you observed
10 at the time of this incident?
11 A: Yes, sir.
12 **THE COURT:** This one I will admit. Now the other
13 two -- do we have other photographs that you're
14 ---
15 **(Petitioner's Exhibit Number 16 was admitted into**
16 **evidence.)**
17 **MR. WICEVIC:** Yes, Your Honor.
18 **THE COURT:** Okay.
19 Q: Ms. Aiken ---
20 **THE COURT:** I'm sorry, Mr. Wicevic. Have these been
21 pre-marked?
22 **MR. WICEVIC:** No, Your Honor.
23 **THE COURT:** Okay.
24 **MR. WICEVIC:** We just got them. We labeled the last
25 one as Exhibit 16, so we'll label this one as

1 Exhibit 17.
2 **(Petitioner's Exhibit Number 17 was marked for**
3 **identification purposes.)**
4 Q: Ms. Aiken, can you identify this photograph?
5 A: It's the couch at the residence of the patient.
6 Q: Is it in the state that you observed it on
7 March 19th, 2016?
8 A: Yes, sir.
9 Q: Okay.
10 **MR. WICEVIC:** The Department would like to admit
11 this as Exhibit 17.
12 **MR. ROTHSTEIN:** Same objection, lack of foundation,
13 Your Honor.
14 **THE COURT:** Okay. It's admitted.
15 **(Petitioner's Exhibit Number 17 was admitted into**
16 **evidence.)**
17 Q: Just a second. I've got another picture. Now,
18 Ms. Aiken, can you identify this photograph?
19 A: It looks like the door leading out to the front
20 door, leading out to the stairs.
21 Q: And it's the floor of what?
22 A: The patient's residence.
23 Q: Okay. And is that how you observed it on March
24 19th, 2016?
25 A: Yes, sir.

1 **MR. WICEVIC:** The Department would like to admit
2 this photograph as Exhibit 18, please.
3 **MR. ROTHSTEIN:** Same objection, Your Honor. She
4 said it looks like. She has to testify that
5 it's a fair and accurate depiction of what it
6 purports to be.
7 **THE COURT:** Right. And it's actually very similar
8 to the previous photograph that she could not
9 definitively recognize.
10 Q: Okay. Well do these newly admitted photographs
11 where you did identify to the couch, does that
12 refresh your memory of the floor?
13 A: The floor tiles actually looked familiar in the
14 first picture that you gave me, but I didn't
15 know what part of the floor it was.
16 Q: Okay.
17 A: But now that the front door is there I can tell
18 that that's where it is when you first come
19 into the trailer.
20 Q: You initially testified that this looks like
21 it. Is it the floor?
22 A: Yes.
23 Q: Okay.
24 **MR. WICEVIC:** The Department would like to admit
25 this photograph as Exhibit 18.

1 **MR. ROTHSTEIN:** Same objection, Your Honor.
2 **THE COURT:** Okay. And, my problem with this one is
3 that she's now saying she recognizes, but it
4 was after some coaching.
5 **MR. WICEVIC:** Your Honor, I mean I think she had her
6 memory refreshed by some evidence she was able
7 to recognize. I'm not sure that's improper.
8 I mean we're talking about a floor here. She
9 wasn't focusing on the floor during her patient
10 care. Instead she would be focusing on the
11 scene of the accident.
12 **THE COURT:** Okay. I'm not going to allow that one.
13 **MR. WICEVIC:** Okay.
14 **THE COURT:** The objection is sustained relative to
15 this photograph.
16 Q: We'll skip over the next floor ones, floor
17 photographs. Now, Ms. Aiken, is this -- can
18 you identify this document?
19 A: It's the front door of the patient's trailer.
20 Q: Okay. And what's the address?
21 A: 9 Park Drive.
22 Q: Okay.
23 A: Well actually it's 101 Park Drive, Lot 9.
24 Q: Is that indicated in your patient care report?
25 A: It should be.

1 Q: Exhibit 11b?
2 A: Yes, sir. It is.
3 Q: Okay. Does this photograph appear to be the
4 door as it was on March 19th, 2016?
5 A: Yes, sir.
6 Q: Okay.
7 **MR. WICEVIC:** All right. The Department would like
8 to admit this as Exhibit 18.
9 **MR. ROTHSTEIN:** Your Honor, in addition to the
10 foundation problem, I don't see the relevance
11 of this particular photograph. So I'd object
12 to that as well as the foundation, Your Honor.
13 **MR. WICEVIC:** The relevance is there's been some
14 discussion, arguments that there were obstacles
15 to getting carrying devices into the residence,
16 into and out the residence. So I think this
17 reflects on that particular argument.
18 **THE COURT:** Okay.
19 **MR. ROTHSTEIN:** But, Your Honor, it doesn't show the
20 railing which is a problem. It doesn't show
21 how wide the door swings. Again, I think he's
22 asking a lot of speculation from this
23 photograph. All this photograph shows is the
24 top half of the door.
25 **THE COURT:** And you'll be able to cross-examine her

1 on those matters. But I'm admitting the
2 photograph. Is this Exhibit 19?
3 **MR. WICEVIC:** I believe it's 18, Your Honor.
4 **THE COURT:** 18.
5 **MR. ROTHSTEIN:** I think it's 19. 18 was not
6 allowed.
7 **MR. WICEVIC:** Okay. Exhibit 19.
8 **(Petitioner's Exhibit Number 19 was marked for**
9 **identification purposes.)**
10 **THE COURT:** They haven't been marked or identified
11 beforehand, so this would be Exhibit -- did we
12 do 18?
13 **MS. HAZEL:** We didn't admit it, but you called it
14 18, but it's not admitted.
15 **THE COURT:** It's not admitted? Okay.
16 **MR. WICEVIC:** So we're referring to this particular
17 photograph with the door as 19?
18 **THE COURT:** Yes.
19 **(Petitioner's Exhibit Number 19 was admitted into**
20 **evidence.)**
21 **MR. WICEVIC:** Thank you, Your Honor. I have just a
22 few more photographs.
23 Q: Ms. Aiken, can you identify this photograph?
24 A: It's a picture of the patient's trailer.
25 Q: Okay. What part of the trailer?

1 A: The front door.
2 Q: Okay. Is it in the condition you observed it
3 on March 19th, 2016?
4 A: Yes, sir.
5 Q: Okay.
6 **MR. WICEVIC:** The Department would like to admit
7 this as Exhibit 20.
8 **(Petitioner's Exhibit Number 20 was marked for**
9 **identification purposes.)**
10 **MR. ROTHSTEIN:** Same foundation objection, Your
11 Honor.
12 **THE COURT:** Okay. The photograph is admitted.
13 **(Petitioner's Exhibit Number 20 was admitted into**
14 **evidence.)**
15 Q: Ms. Aiken, can you identify this document?
16 A: The patient in the back of our unit.
17 Q: Okay. This is the patient concerning this
18 March 19th, 2016 call?
19 A: Yes, sir.
20 Q: Okay. Suffered the same injury that you
21 observed on March 19th, 2016?
22 A: Yes, sir.
23 Q: Okay.
24 **MR. WICEVIC:** The Department would like to admit
25 this as Exhibit 21, please.

1 **(Petitioner's Exhibit Number 21 was marked for**
2 **identification purposes.)**
3 **MR. ROTHSTEIN:** All the phonographs have the same
4 foundation problem. If I could just have a
5 continuing objection to that, that would be
6 fine.
7 **THE COURT:** Yes. Okay. And this will be admitted
8 as Exhibit 21?
9 **(Petitioner's Exhibit Number 21 was admitted into**
10 **evidence.)**
11 **MR. WICEVIC:** Yes, Your Honor.
12 Q: All right, Ms. Aiken, I just handed you another
13 photograph. Can you identify this photograph?
14 A: The patient again.
15 Q: Okay. And where is he located?
16 A: In the back of our unit.
17 **MR. WICEVIC:** All right, the Department would like
18 to admit this as Exhibit 22.
19 **(Petitioner's Exhibit Number 22 was marked for**
20 **identification purposes.)**
21 **THE COURT:** Now how many additional photographs do
22 you have, Mr. Wicevic?
23 **MR. WICEVIC:** I have three more after this one.
24 **MR. ROTHSTEIN:** They seem to be getting a little
25 cumulative.

1 **THE COURT:** Yeah, they are getting cumulative.
2 That's why I was asking. Okay. You've got
3 three additional?
4 **MR. WICEVIC:** Yes, Your Honor.
5 **THE COURT:** Okay.
6 **MR. WICEVIC:** I just want you to have a full record
7 that's relevant to this matter.
8 **THE COURT:** Okay. It's admitted. Subject to the
9 objection by respondent's council.
10 **(Petitioner's Exhibit Number 22 was admitted into**
11 **evidence.)**
12 Q: All right, Ms. Aiken, can you identify the
13 photograph I just handed you?
14 A: It's the knife in the patient.
15 Q: Okay. And where is this patient located?
16 A: In the back of our unit.
17 Q: Okay.
18 **MR. WICEVIC:** All right, the Department would like
19 to admit this photograph as Exhibit 23.
20 **(Petitioner's Exhibit Number 23 was marked for**
21 **identification purposes.)**
22 **THE COURT:** Okay. And Mr. Rothstein has an ongoing
23 objection.
24 **(Petitioner's Exhibit Number 23 was admitted into**
25 **evidence.)**

1 Q: Ms. Aiken, can you identify this photograph?
2 A: It's the knife in the patient. He's in the
3 back of our unit again.
4 Q: Okay.
5 **MR. WICEVIC:** The Department would like to admit
6 this as Exhibit 24.
7 **(Petitioner's Exhibit Number 24 was marked for**
8 **identification purposes.)**
9 **THE COURT:** And you've got one additional ---
10 **MR. WICEVIC:** Yes, Your Honor.
11 **THE COURT:** --- photograph? Okay. If you would let
12 her identify that one, we'll just get it all
13 taken care of at one time.
14 Q: Ms. Aiken, final picture.
15 A: Our patient in the back of the unit.
16 **MR. WICEVIC:** The Department would like to offer
17 this as Exhibit 25.
18 **(Petitioner's Exhibit Number 25 was marked for**
19 **identification purposes.)**
20 **THE COURT:** Okay. They are rather cumulative, but
21 I'm going to go ahead and admit them as Exhibit
22 24 and 25 subject to Mr. Rothstein's objection.
23 **(Petitioner's Exhibit Number 24 was admitted into**
24 **evidence.)**
25 **(Petitioner's Exhibit Number 25 was admitted into**

1 **evidence.)**
2 **MR. ROTHSTEIN:** Thank you, Your Honor.
3 Q: All right, Ms. Aiken. After the call in
4 question, did you write a statement for
5 Anderson County or Iva Rescue Squad?
6 A: Yes, sir.
7 Q: Turn to DHEC Exhibit 4 please. Can you
8 identify this document please?
9 A: This is my statement to Anderson County.
10 Q: Okay. And who asked you to complete this
11 statement?
12 A: My chief and assistant chief at Iva Rescue
13 Squad.
14 Q: Do you recall when you were asked to complete
15 this statement?
16 A: It was a few days after the incident.
17 Q: Who's your chief at Iva Rescue Squad?
18 A: Sandy Sutherland.
19 Q: I understand there's kind of peculiar
20 circumstances behind your completing this
21 statement. Can you explain that to The Court?
22 A: Well after I completed my statement that I
23 wrote down, I turned my statement over to Amy
24 Evans, which is a member of our Rescue Squad.
25 She's a voluntary member but she's a member of

1 our Rescue Squad. She's also a school teacher.
2 And I turned it over to her. She helped as far
3 as punctuation, things that I needed to make
4 look official as far as I put T.J., and she
5 explained to me you need to put Officer T.J.
6 Boucher, so anybody reading your statement
7 knows what they're talking about. She also at
8 the very beginning, she told me that I needed
9 to put that I was giving my statement freely.
10 I had no idea that I needed to put that. So
11 she revised the copy of what I wrote and
12 emailed it back to me so I could print it off
13 and read it and make sure it was exactly how it
14 was supposed to be, and I signed it and turned
15 it into my chief.
16 Q: Okay. I'll let you read over it briefly to
17 yourself.
18 A: Okay.
19 Q: Ms. Aiken, does your statement remain an
20 accurate reflection of your observations on
21 that March 19th, 2016 call?
22 A: Yes, sir.
23 Q: All right.
24 **MR. WICEVIC:** The Department would like to admit
25 Exhibit 4 into evidence.

1 **MR. ROTHSTEIN:** I don't have any objection to
2 Exhibit 4, Your Honor.
3 **THE COURT:** Okay. It's admitted.
4 **(Petitioner's Exhibit Number 4 was admitted into**
5 **evidence.)**
6 **MR. WICEVIC:** Beg The Court's indulgence.
7 Q: Okay, Ms. Aiken, that's all the questions I
8 have for you. Please answer any questions that
9 The Court or Mr. Rothstein has for you.
10 A: Thank you.
11 **THE COURT:** Mr. Rothstein.
12 **MS. AIKEN - CROSS-EXAMINATION BY MR. ROTHSTEIN:**
13 Q: Ms. Aiken, Amy Evans was more than just a
14 member of the Rescue Squad and a teacher,
15 right?
16 A: Yes, sir. She's the girlfriend of my assistant
17 chief.
18 Q: Okay. You left that part out, didn't you?
19 A: Not on purpose. I mean, I gave you her
20 professionalism, not her dating.
21 Q: Was she involved in the care of this patient in
22 any way?
23 A: No, sir.
24 Q: I think I heard you testify earlier, kind of
25 early in your testimony, that you, I think you

1 said you did not see Mr. Davenport take a pulse
2 of this patient. Was that your testimony
3 earlier?
4 A: I'm not -- I mean I don't know if he took one.
5 I didn't personally see him take one, but that
6 don't mean that while he was touching him and
7 palpating his stomach that he didn't take one.
8 Q: Okay. Do you remember when your deposition was
9 taken by Mr. Wicevic on June 19th of this year?
10 A: Yes, sir.
11 Q: Okay. That was a little more than a month ago,
12 right?
13 A: Yes, sir.
14 Q: Okay. I'm going to hand you a copy of your
15 deposition. And do you recall before your
16 deposition started, you were sworn to tell the
17 truth, the whole truth, and nothing but the
18 truth so help you God?
19 A: Yes, sir.
20 Q: And I'm going to ask you, if you would, to turn
21 to page 28 of that deposition. I think there's
22 a little yellow tab on it actually for your
23 convenience. All right. I'm going to direct
24 you to line 11. I'm going to read it out loud,
25 and I want you to read along silently with me

1 to make sure I'm doing this correctly, okay?
2 A: Okay.
3 Q: Question -- and this was Mr. Wicevic asking the
4 questions. You recall that?
5 A: Yes, sir.
6 Q: And he said, all right, did you see the
7 patient's pulse being taken? Your answer was
8 yes, isn't that right?
9 A: Yes, sir.
10 Q: Okay. And then Mr. Wicevic said again, you
11 did? And your answer again was yes, right?
12 A: Yes, sir.
13 Q: So you did see Mr. Davenport take a pulse of
14 the patient, isn't that right?
15 A: I saw Mr. Davenport do a trauma -- a quick
16 trauma assessment, which meant he felt the
17 temperature of the patient's skin, and when he
18 reached down it was possibly a pulse that he
19 took.
20 Q: And Mr. Davenport's assessment of the patient
21 was that the patient was stable at the time,
22 isn't that right?
23 A: He never replied that to me, but I'm sure if it
24 wouldn't have been stable, we would have been
25 in more of a hurry than we were.

1 Q: Was this the first stabbing call you've ever
2 run in your career where the knife was actually
3 impaled in the patient?
4 A: Yes, sir.
5 Q: Okay. You know how many impaled objects Mr.
6 Davenport's handled in his career?
7 A: Probably multiples.
8 Q: Okay. In the video that we saw earlier, did
9 Mr. Davenport appear calm, cool, and collected
10 throughout the call?
11 A: Yes, sir.
12 Q: Okay. You think that was reassuring to the
13 patient?
14 A: I'm not sure if the patient even -- he's really
15 unstable. I don't think he really thinks that
16 much about it.
17 Q: Now I think you testified earlier also that you
18 prepared the actual run report in this case,
19 and I think it's in that exhibit notebook. I
20 think that was Exhibit 11b. Do you have that
21 in front of you?
22 A: Yes, sir.
23 Q: And when you fill out the patient reports, you
24 do this at the time of the events or near the
25 time the events are occurring, isn't that

1 right?
2 A: Yes, sir.
3 Q: It's very important to you to get down
4 everything as accurately and truthfully as you
5 can in completing that report, isn't that
6 right?
7 A: Yes, sir.
8 Q: Okay. And when you were completing the patient
9 care report for this particular patient on the
10 stabbing incident, I'll direct your attention
11 to the upper right hand corner of that report.
12 There's a block that's patient's level of
13 distress. You see where I'm indicating?
14 A: Yes, sir.
15 Q: And you put mild, you see that?
16 A: Yes, sir.
17 Q: Was that an accurate description of the
18 patient's distress level, was mild?
19 A: I believe so.
20 Q: Okay. And you also took the patient's vital
21 signs during the run on two separate occasions,
22 right?
23 A: Yes, sir.
24 Q: And let's just look at the blood pressure
25 first. Is the blood pressure that you took at

1 9:27, was that within the normal range of a
2 blood pressure?
3 A: It's a little elevated, but it's still within
4 normal range.
5 Q: And how about the pulse and the respiratory
6 rate, are those within the normal range?
7 A: Pulse rate's a little elevated, but it's not
8 extremely high.
9 Q: And then after RR which is respiratory rate,
10 there's a column called SPO2. Can you explain
11 to The Court what SPO2 is?
12 A: That's like his trauma score ---
13 Q: And before you get into that, isn't that the
14 oxygen saturation level? SPO2?
15 A: SPO2, yes. I'm sorry. That is his oxygen
16 level.
17 Q: Okay. And what is an SPO2 rating of 98 or 99
18 percent indicate?
19 A: That the air that he's getting in is good
20 quality.
21 Q: Okay. In the video, Mr. Doe -- I guess we'll
22 use John Doe to protect his identity, he didn't
23 seem to be having any difficulty breathing or
24 speaking during that episode, would you agree
25 with that?

1 A: Yes, sir.
2 Q: Did he seem to you to be in any kind of
3 respiratory distress?
4 A: No, sir.
5 Q: And you didn't put any type of supplemental
6 oxygen on the patient ---
7 A: No, sir.
8 Q: --- on the way to the hospital, right? As an
9 EMT basic, you're authorized or trained and
10 allowed under protocols to administer oxygen to
11 patients. Isn't that right?
12 A: Yes, sir.
13 Q: Okay. And then a little further to the right,
14 there's a column for pain. And what is a pain
15 level of four mean?
16 A: That's what he gives me.
17 Q: Okay. And is that out of a scale of one to
18 ten?
19 A: Yes, sir.
20 Q: Okay. So that's a little on the low side of
21 the pain score, isn't it?
22 A: Yes, sir. But the patient in question, his
23 pain tolerance is a little different.
24 Q: Okay. And over there to the right, a GCS, I
25 think that's what you were telling earlier, the

1 ---
2 A: Yes, sir.
3 Q: --- Glasgow Coma Score? Tell me what that
4 indicates.
5 A: That the patient's verbal. If I speak to him
6 he can speak back to me. His pressure's within
7 normal range, his pulse rate's normal range, he
8 is conscious, he's alert to people being around
9 him.
10 Q: Okay. So the score of 15 is the highest you
11 can give a patient?
12 A: Yes, sir.
13 Q: And then, over there, RTS of 12. What does RTS
14 stand for?
15 A: That's his reverse trauma score. And he got as
16 high as you can get on it also.
17 Q: And I think you testified a few minutes ago
18 that you observed Mr. Davenport palpating the
19 patient's stomach while he was putting the
20 bandages and the tape on the patient's stomach.
21 Did you also palpate or feel the patient's
22 stomach?
23 A: Once in the back of the unit, yes, sir.
24 Q: Okay. And you found that his abdomen was soft
25 and non-guarded, is that right?

1 A: Yes, sir.
2 Q: Okay. And on the route to the hospital, the
3 patient had no other complaints he expressed to
4 you, is that right?
5 A: Correct.
6 Q: So, if I understand correctly, no ALS level
7 care was provided to this patient from the time
8 that EMS arrived until he was delivered to the
9 Emergency Department, is that right?
10 A: That's right.
11 Q: Okay. Now, I recall listening to the video,
12 Mr. Davenport saying to you, it's your call as
13 to whether you want to ride in the back of the
14 truck or not. Do you recall listening to that
15 part of the video?
16 A: I remember him telling me, it's your call, as
17 far as that means I was getting in the back of
18 the truck.
19 Q: Not that it's your decision ---
20 A: Not that it's my decision, no.
21 Q: Did you object to Mr. Davenport saying, I don't
22 think this is my call. I mean, did you raise
23 an objection to him?
24 A: I mean, I never said, I don't think this is my
25 call. I questioned him, do you think this is

1 okay.
2 Q: Okay. And Mr. Davenport's response was, I'm
3 not providing any ALS -- I'm paraphrasing, but
4 he said, I'm not providing any care that you
5 couldn't provide to this patient?
6 A: He told me he wasn't doing anything for the
7 patient more than I could.
8 Q: Okay. No IV had been started?
9 A: No, sir.
10 Q: No heart monitor had been started?
11 A: No, sir.
12 Q: And no medications were provided for this
13 patient, right?
14 A: No, sir.
15 Q: Okay. In terms of oxygen, if this patient
16 needed oxygen, I think we established that you
17 could have provided the oxygen.
18 A: Yes, sir.
19 Q: Okay. Was the patient's skin color,
20 temperature, and tone appropriate, I mean,
21 warm, pink, and dry to indicate he was stable?
22 A: Yes, sir.
23 Q: And back on that call, I think you -- page
24 three of the call you indicated this was a BLS
25 level service call, isn't that right?

1 A: Because that's all I can offer.
2 Q: Okay. And that's all that was actually offered
3 to the -- or provided to the patient was BLS?
4 A: Correct.
5 Q: And that's something you're perfectly capable
6 of providing, BLS care?
7 A: Yes, sir.
8 Q: Okay. And under response urgency, page 3, kind
9 of the upper, about half way down on the right
10 side under response urgency, you put non-
11 immediate? Was that accurate?
12 A: No. That's not.
13 Q: Okay. Why did you put that it was not
14 immediate?
15 A: I must have tapped the wrong button because we
16 went code to it so ...
17 Q: Your testimony is you went lights and sirens on
18 this call?
19 A: We did.
20 Q: You're sure about that? Are you talking about
21 to the call or ---
22 A: To the call.
23 Q: Okay.
24 A: Receiving the call we went lights and siren.
25 Q: Okay. But once you go the patient in the back

1 of the ambulance in terms of getting him ---
2 A: We didn't go lights and siren.
3 Q: I'm sorry?
4 A: We did not go lights and siren.
5 Q: Okay.
6 A: So, response urgency would have been immediate,
7 yes. But leaving the scene, non-immediate.
8 Q: Okay. I apologize. So the response is, from
9 your station or where ever you are in the field
10 to the actual patient, rather than taking the
11 patient from the scene to the hospital?
12 A: Yes, sir.
13 Q: Okay. I think you also testified that Mr.
14 Boucher came to the door and said, y'all hurry
15 up and get in here. Do you recall testifying
16 about that?
17 A: I testified that it was Boucher that came to
18 the door and was like this (indicating). But
19 it wasn't Boucher, so it had to be Eric.
20 Q: Okay. That wasn't depicted on the video of
21 anyone saying, hey y'all, hurry up and get in
22 here, was it?
23 A: No, sir.
24 Q: Okay. And the photographs that Mr. Wicevic was
25 showing you that were purporting to be the

1 floor and the couch, you see any significant
2 blood on the floor or the couch?
3 A: No. I was actually surprised at the little
4 amount of blood that was on scene.
5 Q: And when you palpated the patient's stomach, if
6 there was internal bleeding into the peritoneal
7 cavity, what affect would that have on how the
8 stomach felt when you palpated it?
9 A: Hard, rigid.
10 Q: Okay. And when you felt it in the truck, it
11 was not hard or rigid, right?
12 A: No, sir.
13 Q: Okay. Do you know how long the particular
14 patient stayed in the hospital?
15 A: Not this time. No, sir.
16 Q: Okay. You know if there were any adverse
17 outcomes to this patient based on the care that
18 you and Mr. Davenport rendered at the scene?
19 A: Not that I'm aware of.
20 Q: Now I think you testified earlier that you had
21 some prior disciplinary actions at the Iva
22 Rescue Squad for riding in calls that were
23 deemed above the basic level, ALS level calls.
24 Is that right?
25 A: Yes, sir.

1 Q: And Mr. Stoller actually chewed you out pretty
2 good, didn't he, for riding calls that you
3 weren't authorized or qualified to ride, isn't
4 that right?
5 A: Yes, sir.
6 Q: Okay. How long before this particular incident
7 did you get chewed out by the EMS Director
8 about riding calls that you shouldn't be
9 riding?
10 A: I'm not exactly sure how long ago it had been.
11 Q: Okay. The paramedic that you were working with
12 at the time that allowed you to ride those
13 calls in, was he disciplined at Iva?
14 A: He was, but not only for that situation. There
15 were other situations involved in it.
16 Q: Okay. Do you know if he was allowed to
17 continue to work within Anderson County after
18 he was terminated from Iva?
19 A: Yes, sir.
20 Q: Okay. So Dr. Kickham, who's the emergency
21 control physician for that particular paramedic
22 allowed that paramedic to continue to operate
23 as a paramedic?
24 **MR. WICEVIC:** Your Honor, I'm going to object. This
25 is getting to the area where we talked about in

1 pre-hearing motions. Past disciplinary actions
2 within the Iva Anderson County system are not
3 relevant to DHEC's enforcement. Whether Iva or
4 Anderson County wants to suspend or terminate
5 medical control for her partner on a previous
6 call is not of significance to us. I don't see
7 where this going. It's a fine line, and I just
8 don't see how this testimony is helpful to The
9 Court in making it's determination in this
10 matter.
11 **THE COURT:** Mr. Rothstein.
12 **MR. ROTHSTEIN:** Your Honor, she testified that the
13 patient -- or the paramedic that she was riding
14 with on a couple of occasions -- I mean there
15 was no report made to DHEC, that paramedic was
16 allowed to continue to operate under Dr.
17 Kickham, the same emergency medical control.
18 I think this goes to the point that there's
19 something more to Mr. Davenport's case than
20 merely allowing an EMT basic to ride a stable
21 call in.
22 **THE COURT:** Okay. Mr. Rothstein, I'm going to allow
23 you to explore that avenue of questioning to a
24 certain extent. But, let's keep it narrowly
25 tailor to what the issue is in this case.

1 Q: Now the Exhibit 11e, that was the call from
2 September of 2015. I wanted to make sure we're
3 clear that the patient had called about
4 coughing up blood several days before he called
5 you all, is that right? I mean when you got to
6 the scene the patient was not actively coughing
7 up blood?
8 A: No. It had been going on prior to calling us.
9 Q: And you rode that call in the back of the
10 truck, isn't that right?
11 A: Yes, sir.
12 Q: Okay. And no QA officer ever complained about
13 you riding in that call, is that right?
14 A: No, sir.
15 Q: Okay. Now I think you mentioned something
16 called a stair chair. How many times have you
17 used a stair chair to move a patient out of a
18 home or up or down stairs?
19 A: Multiples.
20 Q: Okay. And does a stair chair, are you required
21 to strap the patient in on a stair chair?
22 A: Yes, sir.
23 Q: The one that you use at the Iva Rescue Squad,
24 does that have straps that go criss-cross
25 across the patient ---

1 A: Yes, sir.
2 Q: --- or does it have the straps across the body?
3 A: It goes criss-cross.
4 Q: Okay. So if you had strapped this patient in
5 a stair chair, that would probably potentially
6 interfere with the position of the knife, isn't
7 that right?
8 A: It could have.
9 Q: Okay. And to make sure the patient's strapped
10 in and doesn't move while you're bumping them
11 down the stairs, you have to kind of crank down
12 on those straps, isn't that right?
13 A: Yes, sir.
14 Q: Okay. And that could have caused further
15 injury to the patient by compressing on where
16 the knife was impaled, isn't that right?
17 A: Yes, sir.
18 Q: Now Mr. Wicevic had you read a couple different
19 policies from Exhibit 1. I just want to
20 continue on where you stopped off reading the
21 first time. If you'll look at page 89 of the
22 Exhibit 1, which is the clinical policy 07, you
23 see that?
24 A: Yes, sir.
25 Q: Okay. And I think you stopped reading -- and

1 we're looking at the fourth paragraph under
2 procedure, you stopped reading after that first
3 sentence, right? The first sentence reads, the
4 most appropriately trained and knowledgeable
5 provider at the scene is ultimately responsible
6 for all patient care activities while he or she
7 is present?
8 A: Yes, sir.
9 Q: Okay. I'm going to continue on. It says, he
10 or she, meaning the paramedic, may delegate all
11 or part of the patient management and
12 transportation to others who are qualified to
13 meet the patient's immediate needs or
14 reasonably perceived needs; however he or she,
15 meaning the paramedic, must intervene and take
16 control anytime management of the patient
17 becomes unacceptable. Did I read that
18 correctly?
19 A: Yes, sir.
20 Q: Okay. When you were riding in the back of the
21 stabbing patient's truck, was there ever a time
22 when your control of that patient became
23 unacceptable?
24 A: No, sir.
25 Q: And while you've got that book out, if you'll

1 turn to page 125 of Exhibit 1. Do you
2 recognize this, policy number 26. That'd be
3 the non-paramedic transport of patients policy
4 for Anderson County?
5 A: Yes, sir.
6 Q: And under policy I'm gonna go down to the forth
7 bullet. Second sentence says, if the
8 technician determines that the patient is
9 stable and all patient care needs can be
10 managed by the lower level provider, patient
11 care can be transferred to a technician of
12 lower certification for care while en route to
13 the hospital. Did I read that correctly?
14 A: Yes, sir.
15 Q: And that's exactly what happened in this case,
16 right? Mr. Davenport determined that this was
17 a BLS level call and he delegated the task to
18 you to ride that call in, isn't that right?
19 A: Yes, sir.
20 Q: And that's specifically authorized by this
21 policy 26, isn't it?
22 A: Yes, sir.
23 Q: Okay. And I'm going to have you look down
24 seventh bullet after the following patients can
25 be transferred to a lower level certification.

1 See the bullet that starts, the paramedic?
2 A: Yes, sir.
3 Q: I'm going to read that. It says, the paramedic
4 must accompany the patient to the hospital if
5 the BLS crew and or crew member expressed any
6 discomfort with assuming the care for the
7 patient. This is regardless of whether the
8 paramedic believes any ALS procedures are
9 warranted. It says, however it is the
10 obligation of the BLS crew and or crew member
11 to state if they are not comfortable with
12 managing the patient. Right?
13 A: Yes, sir.
14 Q: So it's your obligation to tell the paramedic,
15 I'm not going to take this call. This is an
16 ALS level call, right?
17 A: Correct.
18 Q: In fact you got in trouble for not doing that
19 on at least one other occasion in the County,
20 right?
21 A: Yes, sir.
22 Q: Mr. Stoller jumped on you, and actually made
23 you ride with a preceptor EMT for a couple of
24 shifts, isn't that right?
25 A: Yes, sir.

1 Q: So after you ran this stabbing call, you were
2 concerned that somebody in the QA office was
3 going to say, hey this is an advanced level
4 call. Maybe you shouldn't have ridden this one
5 in. Isn't that what your concern was?
6 A: Yes, sir.
7 Q: Okay. And so you and your husband took it upon
8 yourselves to sort of preemptively head that
9 off, right?
10 A: No, sir.
11 Q: Okay. Your husband didn't go to the Chief of
12 Police and say, I don't think Kim should have
13 ridden this call in?
14 A: That's not what I was told. No, sir.
15 Q: He didn't tell the Chief of Police at Iva that
16 he was trained that all calls are ALS calls
17 unless proven otherwise?
18 A: I have no idea if he said that or not.
19 Q: But he could have said that, right?
20 A: I guess he could have. I wasn't on scene
21 whenever that conversation took place.
22 **MR. ROTHSTEIN:** I don't have any further questions,
23 Your Honor.
24 **THE COURT:** Anything on re-direct?
25 **MR. WICEVIC:** Yes, Your Honor. Just a few minor

1 items.

2 **MS. AIKEN - RE-DIRECT EXAMINATION BY MR. WICEVIC:**

3 Q: Ms. Aiken, let's turn to Exhibit 11b please.
4 I forgot to ask you this. The very last page,
5 I think it's page 6, can you explain this page
6 of the patient care report?
7 A: What page is it?
8 Q: The very last page, page 6 of 11b.
9 A: Signature pages.
10 Q: Okay. And can you identify the signatures?
11 A: The first one is Gee-gee Derm. She is the RN
12 that I gave my report to at the ER. The lead
13 provider would be me. That's my signature.
14 The other provider would be James's signature.
15 Q: Okay. In completing this, do both EMT's
16 consult before filling in various fields in
17 this patient care report?
18 A: I mean, my report is always open to whoever the
19 other provider is with me. Anything that I can
20 see whoever is on the call with me, if they're
21 name's on it they can see too.
22 Q: When you sign off on the report, are you
23 attesting to it?
24 A: Yes, sir.
25 Q: Okay. Are both EMT's allowed to supplement or

1 amend?
2 A: I'm not sure. After it's locked -- before it's
3 locked you can.
4 Q: When is it locked in relation to the
5 signatures?
6 A: The signatures have to be in there before it's
7 locked.
8 Q: Okay.
9 A: It won't let you lock it without a signature.
10 Q: Okay. Going to the September 19th call,
11 Exhibit 11e, was that a basic life support call
12 or an advanced life support call?
13 A: A basic life support. He wasn't actually
14 hemorrhaging at the time that the call went
15 out.
16 Q: Is that the type of call you can run?
17 A: Yes, sir.
18 Q: Okay. There's some discussion in the cross-
19 examination about stair chairs. Are there
20 other appropriate carrying devices?
21 A: Yes, sir. We talked about spine boards, scoop
22 stretchers, a regular stretcher. There was
23 enough people on scene.
24 Q: Okay. Now policy 7 in Exhibit 1.
25 A: What page is that?

1 Q: That's page 89, I'm sorry. There was some
2 discussion regarding the last sentence or
3 clause in the last sentence of paragraph four.
4 Was your concern that you were not qualified to
5 meet the patient's immediate needs or
6 reasonably perceived needs?
7 A: Yes, sir.
8 Q: Okay. And then in your discussions with Mr.
9 Davenport after the patient was loaded, did you
10 express any discomfort?
11 A: Well like I said, whenever I got in the truck,
12 he must have could tell something was on my
13 mind because he asked me a couple of times.
14 And that's when I told him that I was concerned
15 about this call. And he assured me that there
16 was nothing more that he was going to do for
17 the patient that what I had already done.
18 Q: It looked like you might have done some
19 gestures. Do you recall what you did when he
20 asked you your comfort level?
21 A: He just told me he wasn't going to do anything
22 more for him
23 Q: Okay.
24 A: He went ahead and took off his gloves and was
25 ready to go.

1 Q: All right. That's all the questions I have.
2 Thank you, Ms. Aiken.
3 A: Thank you.
4 **THE COURT:** Thank you, Ms. Aiken. I have no
5 questions for you.
6 **MS. AIKEN:** Thank you.
7 **MR. WICEVIC:** Can Ms. Aiken be dismissed? She's
8 under subpoena.
9 **THE COURT:** Mr. Rothstein do you ---
10 **MR. ROTHSTEIN:** Fine with me.
11 **THE COURT:** Thank you for coming, Ms. Aiken. You're
12 dismissed.
13 **MS. AIKEN:** Thank you.
14 **MR. WICEVIC:** Okay. The Department's next witness
15 is Mr. Davenport.
16 **THE COURT:** Mr. Davenport, before taking your seat,
17 if you'll face the court reporter, raise your
18 right hand, and he'll swear you.
19 **JAMES DAVENPORT**, having been duly sworn, testifies as
20 follows:
21 **MR. DAVENPORT - CROSS-EXAMINATION BY MR. WICEVIC:**
22 Q: All right. Good afternoon, Mr. Davenport.
23 We've met several times. My name's Vito
24 Wicevic from DHEC. If you have any questions,
25 if you don't understand any of my questions

1 please ask me to repeat. Let's begin with some
2 background concerning yourself. Is it correct
3 you received your GED?
4 A: That's correct.
5 Q: Okay. And you began your college career at
6 Columbia College. You were studying emergency
7 management, but at this point you still haven't
8 graduated. I think you said you just have a
9 couple hours left?
10 A: Yes. That's correct.
11 Q: Okay. EMT training, you received your EMT
12 training at Greenville Technical College and
13 you completed that around '93, '94ish?
14 A: That's correct.
15 Q: Okay. It looks like you came back maybe a year
16 or so later and received paramedic training at
17 the Upstate EMS counsel, and you completed that
18 '95, '96ish?
19 A: Correct.
20 Q: Okay. And you underwent the national registry
21 of EMT's examination as part of being certified
22 as a EMT and a paramedic?
23 A: That's correct.
24 Q: Okay. Job experience, you practiced as an EMT
25 or paramedic from about '93, '94 all the way to

1 2002 in various licensed ambulance services, is
2 that correct?
3 A: That's correct.
4 Q: You did some med tech work at a hospital during
5 that time period?
6 A: Correct.
7 Q: Okay. Then in 2002, that's when you joined the
8 U.S. Army, correct?
9 A: That's correct.
10 Q: Is it correct you allowed the South Carolina
11 paramedic certificate to lapse when you joined
12 the Army?
13 A: That's correct.
14 Q: Okay.
15 A: It was unmanageable in the middle of all the
16 rest of the training requirements.
17 Q: That makes sense. And you were in the Army
18 until about 2015?
19 A: That's correct.
20 Q: And as part of your service, your military
21 service, you became a Special Forces Medic?
22 A: That's correct.
23 Q: You go through extensive combat training to be
24 a part of the Special Forces?
25 A: That's correct.

1 Q: You go through extensive medical training to be
2 a Special Forces Medic?
3 A: That's correct.
4 Q: I think you said in your deposition, you were
5 deployed in South America, Macedonia, Iraq,
6 Afghanistan, some of those multiple times, is
7 that correct?
8 A: That's correct.
9 Q: Okay. You suffered some serious injuries, you
10 had a through the knee amputation, several soft
11 tissue injuries to the perineum and groin, for
12 pelvic fractures, a couple of herniated disks,
13 some nerve damage, and soft tissue injuries to
14 the left arm?
15 A: That's correct.
16 Q: Then after you returned to Anderson County in
17 about 2015 you began working part time at
18 Anderson County in kind of an administrative
19 capacity, is that correct?
20 A: That's correct, with exception that while I was
21 healing and between some of those surgeries at
22 the end while I was on administrative leave, I
23 was working a little part-time for Anderson
24 County EMS in the same capacity.
25 Q: Did you also renew your, I guess -- I'm not

1 sure if I'm using correct terminology, but you
2 got your paramedic certificate reissued around
3 2015?
4 A: 2012.
5 Q: 2012, okay. Did you have to do some kind of
6 refresher course?
7 A: Well as part of being an SF Medic or a Special
8 Operations Medic, our refresher training
9 satisfies the registry requirements, so I
10 didn't have to attend any extra training. It
11 was all done through the military ---
12 Q: Okay.
13 A: --- as part of my regular skills refresher.
14 Q: Okay. So, then you started picking up shifts
15 with Anderson County EMS service. And I think
16 you said you started providing patient care
17 around August 2015?
18 A: It was prior to that, but ---
19 Q: You have an idea of when?
20 A: It was 2014 at some point.
21 Q: Okay.
22 A: I don't recall.
23 Q: Okay. Let's turn to Exhibit 10 please. Mr.
24 Davenport, can you identify this document
25 please?

1 A: That would be the medical control agreement
2 that I signed probably when I started working
3 at Iva.
4 Q: Okay. I think that's where I was getting
5 confused. You were working with Anderson
6 County EMS before August 2015, and then you
7 signed this application and agreement. Then
8 application's the next page, is that correct?
9 A: Yes.
10 Q: Okay. So you were working with Anderson County
11 EMS in a patient care perspective role prior to
12 this Iva Rescue Squad?
13 A: That's correct.
14 Q: Okay. Can you read the last paragraph on page
15 1 of Exhibit 10?
16 A: Starting with I the above named?
17 Q: Yes, sir.
18 A: I the above named person attest that I've
19 completed the necessary requirements to become
20 a certified EMT at the indicated level. I
21 agree to abide by any and all policies,
22 procedures, and standing orders regarding
23 patient care issued by Anderson County's
24 Medical Control Physician. I understand that
25 a violation of these policies, procedures, and

1 or standing orders may result in my medical
2 control authorization being withdrawn for a
3 period specified by the Medical Control
4 Physician at the time of withdrawal. Failure
5 to maintain a relationship with an authorised
6 EMS provider for whom Anderson County provides
7 medical control will void this authorization.
8 Q: Okay. And then your signature's on the bottom
9 of page 1?
10 A: That is my signature.
11 Q: Okay. And can you explain to The Court why you
12 did not complete the second page?
13 A: I already had a medical control application
14 with the County since I was previously working
15 for the County. The application for Iva would
16 just supplement what was already in place, and
17 so they just needed a place marker to know that
18 I had medical control with the County as well
19 as with Iva Rescue Squad. I didn't need to
20 reapply for medical control. It was -- what's
21 the word I'm looking for? It's the same
22 Medical Control Physician and same standing
23 orders. So ---
24 Q: Right.
25 A: --- it's just a copy for my record, personnel

1 file.
2 Q: And the Anderson County EMS is a bit different
3 than maybe other regions in this State.
4 There's Anderson County EMS. Within the
5 umbrella of Anderson County EMS Med. Control
6 Physician, there are seven or eight rescue
7 squads, is that correct?
8 A: That's correct.
9 Q: And as you explained, they're all operating
10 under the Med. Control Physician's protocols
11 and orders?
12 A: That's correct.
13 Q: And the Med. Control Physician at the time of
14 this incident was Dr. Kickham, Tom Kickham?
15 A: That's correct.
16 Q: Okay.
17 **MR. WICEVIC:** The Department would like to admit
18 Exhibit 10, the med. control agreement of Mr.
19 Davenport's into evidence.
20 **MR. ROTHSTEIN:** No objection, Your Honor.
21 **THE COURT:** Okay. It's admitted.
22 **(Petitioner's Exhibit Number 10 was admitted into**
23 **evidence.)**
24 Q: Before running calls, were you required to take
25 a standing orders test?

1 A: I took one at some point. I don't recall
2 exactly when I took the first. But then you're
3 supposed to take one subsequently every year
4 thereafter. And it seems, to the best of my
5 recollection, that I took one about seven
6 months before the incident in question.
7 Q: Okay. And you told me you didn't even read the
8 standing orders prior to taking the test,
9 correct?
10 A: That's correct.
11 Q: Why'd you deem it not important?
12 A: Well I wanted to see if I could pass it
13 without, you know, without -- it was kind of a
14 running joke in the office at the time, so ...
15 Q: Okay. So going along with that, you began to
16 run calls for Iva Rescue Squad right around
17 this August 2015 period?
18 A: That's correct.
19 Q: Okay. So you practiced civilian EMT or
20 paramedic roughly 10, 11 years?
21 A: Math. Yeah, I guess in total. I mean, if you
22 include some of the civil-military stuff,
23 that'd be about right.
24 Q: Okay. And I think you indicated that you
25 didn't recall receiving civilian paramedic or

1 EMT awards, is that correct.
2 A: No.
3 Q: Okay.
4 A: The Anderson County's not real good about that
5 stuff.
6 Q: Okay. Practice as a Special Forces Medic, as
7 a Special Forces Medic you're responsible for
8 the care of the entire Special Forces Team
9 while deployed and during training evolutions,
10 is that correct?
11 A: That's correct.
12 Q: Is it correct that as a Special Forces Medic,
13 you use much more discretion in your provision
14 of care than a civilian paramedic?
15 A: I would say that due to our training and the
16 trust that is placed in us, that we are allowed
17 more latitude sometimes.
18 Q: Okay. So you would agree with my statement,
19 that there's more discretion afforded Special
20 Forces Medics?
21 A: Oh, I'm sorry. Yeah. Sorry. I misunderstood.
22 Q: And that makes sense. I mean, y'all are in a
23 combat environment. I'm sure it's kind of a no
24 holds barred situation where you can encounter
25 anything. That makes sense to me.

1 A: I'm sorry. If I may?
2 Q: Sure.
3 A: It not only applies in combat, but I mean
4 training here in the U.S. or other, you know,
5 military actions that aren't involved in
6 warfare as well, but it's just a different --
7 it's much more akin to being a probably a
8 physician's assistant or a physician than it is
9 to being a medic.
10 Q: Okay. I think you indicated to me that as a
11 Special Forces Medic, do no harm is a standing
12 order, protocol that you follow. Is that
13 correct?
14 A: That's correct.
15 Q: That is based upon -- the care you provide to
16 the patient based upon patient's injuries, your
17 training, and the particular situation?
18 A: That's correct.
19 Q: Okay. Now Special Forces Medicine and civilian
20 EMT practice is quite different, correct?
21 A: I wouldn't say that they're quite different.
22 I would say that in Special Operations,
23 medicine is strictly based on science and
24 evidence vice tradition and a more controlling,
25 you know -- in civilian EMS the Medical Control

1 Physician has to take into account the least
2 experienced and the most experienced, and try
3 to build a box where both of those can work
4 within, vice an SF or Special Operations
5 medicine where we're all expected to practice
6 at the same level. You know, guys that doesn't
7 cut the mustard, they don't stay around long,
8 so ...
9 Q: So would you agree with the statement that they
10 are different, significantly different?
11 A: I wouldn't agree that the practice is
12 different, just that the controls put in place
13 are.
14 Q: Okay. 'Cause, I mean, as a civilian paramedic,
15 you're operating under the supervision and
16 direction of the Medical Control Physician,
17 right?
18 A: That's correct. But so am I as an SF Medic.
19 Q: I thought the only protocol was do no harm?
20 A: It's the only protocol, but I still have a
21 physician's license I have to work under.
22 Q: Okay.
23 A: It's my group surgeon. We talked about that in
24 my deposition I believe.
25 Q: Are there not standing orders or protocols?

1 A: No. Not to the degree that we have them at
2 EMS.
3 Q: Civilian EMS?
4 A: I'm sorry. Yes, civilian EMS.
5 Q: So that aspect, it is significantly different?
6 A: Indeed.
7 Q: Okay. And as a civilian paramedic, you're
8 expected to comply with these protocols and
9 standing orders, right?
10 A: Unless you deem that a deviation is necessary.
11 I mean protocols are -- there's a difference
12 between a protocol and a standing order.
13 Q: Right.
14 A: A standing order is a physician's order. A
15 protocol is a set of guidelines to assist you
16 in making determinations about a diagnosis or
17 a differential diagnosis, or used to rule out
18 injury or illness more so than it is a hard and
19 fast rule. Whereas a standing order, that's --
20 or a physician's order, it's the same thing.
21 Q: Okay. And we'll get to the deviations and what
22 not. But you're still supposed to comply with
23 the orders and the protocols, correct?
24 A: The orders, yes.
25 Q: Protocols you can disregard?

1 A: I didn't say I could disregard them. I said
2 that they're a set of guidelines. They can't
3 be inclusive of every patient encounter you
4 could possibly have.
5 Q: Okay.
6 A: So, I mean, the policy manual would be as tall
7 as this building if you tried to include every
8 possible patient scenario in one of those
9 situations. And so it is, at the end of the
10 day when it's you and the patient, you are left
11 to doing what's best for the patient's well
12 being, and that's the guide.
13 Q: Okay. General rule is follow with those
14 protocols?
15 A: Yes. As much as possible.
16 Q: Okay. And that's explained to you during your
17 education as an EMT?
18 A: Yes.
19 Q: And that's explained by Anderson County and the
20 various rescue squads, correct?
21 A: That's correct.
22 Q: Okay. I think you acknowledged it's been
23 quote, a challenge, transitioning from Special
24 Forces Medicine to civilian paramedicine,
25 paramedic practice. Is that correct?

1 A: That's a correct statement.
2 Q: Do you know, I think you even mentioned it
3 earlier, as a Special Forces Medic, you were
4 generally left to yourself?
5 A: That's correct.
6 Q: I think you said during your deposition, when
7 transitioning back to civilian paramedicine you
8 weren't accustomed to marching to the beat of
9 somebody else's drum. Is that correct?
10 A: To a degree, yes.
11 Q: I mean, when you say marching to somebody
12 else's drum, are you referring to the Med.
13 Control Physician's orders and protocols?
14 A: It's more that -- in short, yes. But again in
15 soft medicine, if I do something wrong I still
16 have to answer for doing wrong. You know, if
17 I mistreat a patient, maltreat a patient, I'm
18 still held accountable by my group surgeon or
19 battalion surgeon or whoever is providing me
20 medical control at the time as a soft guy. But
21 I'm not accustomed to having to document the
22 why's that I don't perform something as opposed
23 to just writing down pertinent positives and
24 moving on, if that makes sense to The Court.
25 Q: And when you say soft medicine ---

1 A: I'm sorry. Special Operations. I'll try to
2 curb the acronyms. I'm very aware that I speak
3 in a foreign language.
4 Q: Right. So you've had difficulty ratcheting
5 back the decision making specifically in the
6 trauma context I suppose?
7 A: I wouldn't say that I have a trouble ratcheting
8 back decision making. What the patient needs
9 is still what the patient needs without regard
10 to anything else. The patient's condition
11 dictate the needs of that patient in that
12 situation. So with regards to that, just like
13 I told the patient, you know, if we were in
14 Afghanistan I would have anesthetized him and
15 take the knife out. And then he'd stay in my
16 clinic a couple days and I'd release him the
17 same way they did in the hospital. But I can't
18 do that here. And so those are the differences
19 that I'm discussing. I can't readily, you
20 know, perform surgery on somebody that needs
21 surgery just because I deem that they're going
22 to need surgery.
23 Q: Right. This case, this matter, it's not about
24 exceeding the scope of a paramedic, correct?
25 A: That's correct.

1 Q: It's more about not providing care in
2 accordance with protocols and orders, correct?
3 A: No. It's about providing the care that patient
4 needs.
5 Q: Well, I'm talking about the Department's
6 allegations.
7 A: We're still back to what the patient needs.
8 Q: Okay. And giving up decision making authority,
9 has it been a struggle for you?
10 A: Giving up the decision making? You mean about
11 the patient?
12 Q: Patient care, treatment.
13 A: In so much that there are different procedures
14 and practices that we normally do that isn't as
15 widely accepted in civilian EMS because it's
16 more a lot of times things are done because
17 you're worried about, like Kim said, being
18 called into the office vice doing it because
19 it's what the patient needs. So in that
20 aspect, yes.
21 Q: It's been a struggle?
22 A: Yes.
23 Q: Okay. I think you also indicated in your
24 transcript, put a doctor on an ambulance and
25 give him the same restrictions, he'd be

1 similarly frustrated, correct?
2 A: Yes. I'm sorry. If I may?
3 Q: Sure.
4 A: Not that I equate myself with a physician. I
5 don't want to give off that. But you take
6 somebody that's accustomed to making complete
7 decisions about an individual's well being to
8 the point taking them to the OR and doing
9 surgery on them. And then regressing out of
10 the military into civilian life, and being
11 virtually whittled down to about 50 percent of
12 my skill set, or my abilities, or being told
13 that those experiences no longer matter is a
14 little hard to swallow sometimes. So, I don't
15 think it's a matter of disrespect or second
16 guessing, you know, physicians. I completely
17 understand why protocols exist. But there, you
18 know -- experience is experience at the end of
19 the day. And when you're a new paramedic or a
20 new EMT doesn't react the same way as an
21 experienced one. And whereas one will either
22 be upset or excited about certain calls, the
23 other one may not. This is a great example of
24 that.
25 Q: I think you mentioned something about strictly

1 complying with protocols and orders can result
2 in bad medicine.
3 A: Yes.
4 Q: You stated that sometimes what you consider a
5 fairly benign injury, a civilian paramedic or
6 EMT might consider grave.
7 A: Yes. Based on experiences. I mean the first
8 cardiac arrest a paramedic runs, they usually
9 don't run as smoothly as after a paramedic's
10 been doing it a while. The same thing applies
11 for a Special Operations Medic. You know,
12 first time you're in a gun fight and you're
13 trying to, you know, fix something on somebody,
14 things don't run as well in that scenario as
15 they will, you know, years down the road when
16 you have much more experience under your belt.
17 So, yeah.
18 Q: Okay. And I think you also explained that in
19 civilian paramedic pre-hospital care, there's a
20 lot of CYA, meaning there's a lot of erring on
21 the side of the patient, is that correct?
22 A: CYA is more erring on the side of not getting
23 in trouble, doing whatever the QA Officer needs
24 you to do so that you don't end up in his
25 office answering questions about why you did

1 this or didn't do that, or you know, used this
2 procedure instead of that one more than
3 anything else.
4 Q: And you'd rather give the patient care based
5 upon his or her needs, is that correct?
6 A: To the extent possible, yes.
7 Q: I think you referred to paramedic's compliance
8 with protocols and standing orders as being
9 akin to monkey medicine or cookbook medicine?
10 A: The rigid compliance, yes.
11 Q: And I think you compared protocols in this
12 regard, complying with protocols as monkey
13 medicine versus paramedics who can think.
14 A: Well, no. I think that's a little taken out of
15 context. So, if I may?
16 Q: Sure.
17 A: We're back to the experienced part. When
18 you're a new paramedic, it is -- you literally
19 start at the top and just go down a checklist.
20 You know, did I do this, did I do that, I gotta
21 do this, I gotta do that. You know. Once
22 you've seen a certain number of patients, a lot
23 of that stuff takes care of itself. You don't
24 have to go down that same mental checklist
25 according to the protocol because you know

1 certain things aren't an issue, and you can
2 completely move on to more important issues.
3 Q: Is that even if your Med. Control Physician
4 orders those certain things in the protocols or
5 orders?
6 A: There's a difference in an order and a
7 protocol.
8 Q: Okay. Well let's start with protocol. If
9 those things you mentioned are listed in the
10 protocol, and you have experience saying, no I
11 don't have to do that, do you still have to
12 comply with the protocol?
13 A: Well then that would be an order if he said you
14 have to do it, not a protocol.
15 Q: Okay. So protocols are not requirements?
16 A: Protocols, again, are a guideline. A protocol
17 isn't a, it has to go in this order the entire
18 time that you're with the patient. If that
19 were the case then there would be no way for
20 you to treat the patient according to the
21 situation they're in.
22 Q: But you understand the protocols give direction
23 for care, is that correct?
24 A: Yes.
25 Q: So, you can disregard that direction?

1 A: I think you're still confusing a protocol with
2 a standing order.
3 Q: Okay. Well let's look at standing orders. Can
4 you disregard standing orders?
5 A: Well a standing order would be like a drug
6 dose, or if a patient's having respiratory
7 difficulty, you will give him this much oxygen.
8 But a protocol is more, this is the way you
9 would treat the illness in whole, right? So
10 there's areas where you can deviate from a
11 protocol. The standing orders, no. A
12 physician says that I want, you know, that this
13 happens, then that's an order not a protocol.
14 Q: Okay.
15 A: There's deference given to, you know, your
16 ability to deviate from protocol when
17 necessary. It even says it in the protocols
18 that it's acceptable to deviate.
19 Q: Under certain circumstances, correct?
20 A: Yes.
21 Q: Okay.
22 A: I mean, that's not a, you know, just throw them
23 to the wind kind of thing. But again, you
24 couldn't -- there's no way possible to include,
25 be inclusive of every patient and every

1 situation that you could possibly find
2 yourself. So at some point the Medical Control
3 Physician has to rely on the paramedic or EMT
4 to make clinical decisions based on their
5 experience and training about what's best for
6 the patient. Not, you know, like cardiac
7 arrest. It says initiate CPR, but if you're in
8 the middle of the water, you can't do CPR in
9 the water. You got to get the patient out of
10 the water first. So doing CPR on a patient in
11 the water is not really going to get you
12 anywhere. So, you know, the idea that CPR
13 should be initiated immediately, we agree that
14 it should be initiated immediately but doing it
15 in the water is a futile effort. So you'd have
16 to get them out of the water. Well if you took
17 it directly by CPR will be initialed
18 immediately, you know, upon realizing the
19 patient's in cardiac arrest, then you stand in
20 the middle of a pool trying to do CPR with a
21 patient laying in the water.
22 Q: Yeah. I mean that would seem kind of absurd,
23 correct.
24 A: Yes.
25 Q: Performing CPR on water.

1 A: Well, I used it because it's, you know, an
2 easily understood analogy.
3 Q: Okay. Well let's turn to Exhibit 1 please.
4 A: All right.
5 Q: Specifically page 2 of Exhibit 1.
6 A: Bates page 2?
7 Q: Yes, sir. You there?
8 A: Yep. Sorry.
9 Q: And I'm reading from the introduction second
10 paragraph says, while treatment of transport
11 decisions in the field vary, these guidelines
12 can assist the pre-hospital provider by
13 standardizing procedures for the most common
14 and routine emergencies encountered, and will
15 be considered the minimum standards by Anderson
16 County EMS. Is that correct?
17 A: Uh-huh.
18 Q: Third paragraph last sentence, if any situation
19 arises in which the provider is unsure of the
20 most prudent treatment sequence, then that
21 provider should contact Med. Control for
22 guidance, correct?
23 A: Yes. That's assuming you don't know what the
24 most prudent thing to do is.
25 Q: Fifth paragraph ---

1 A: Yes, sir.
2 Q: --- last sentence, all providers are
3 responsible for their own individual actions
4 with regards to protocol compliance and any
5 deviation from the standards stated herein must
6 be documented and explained. Is that correct?
7 A: That's correct.
8 Q: Is it fair to say that as a civilian EMT it's
9 extremely important to know and understand
10 these protocols and standards of care?
11 A: Yes.
12 Q: All right. The incident in question. You were
13 present at the call involving the self
14 inflicted stab wound on March 19th?
15 A: Yes, sir.
16 Q: Okay. Ms. Aiken was your partner, correct?
17 A: Oh, I'm sorry. Yes, sir. My apologies.
18 Q: You cared for this patient on one other
19 occasion, correct? It was September 19th ---
20 A: Yes. That's correct.
21 Q: --- of 2015? I think you mentioned in other
22 contacts, the interview with DHEC the IRC, you
23 run this patient maybe five times?
24 A: I've seen him out an about.
25 Q: Okay.

1 A: Sorry for the confusion. Like Kim testified
2 to, Iva's a pretty small town in comparison,
3 and it's difficult to go out to eat. There's
4 only four restaurants in the entire town. So
5 you run into your patients while you're
6 refueling the truck or in a restaurant, in a
7 convenience store kind of thing. And, as Kim
8 pointed out, I mean two of the paramedics in
9 the Rescue Squad went to high school with him,
10 so he comes around the Squad as well.
11 Q: He was readily known amongst y'all, right, the
12 EMT's at Iva Rescue Squad?
13 A: That's correct.
14 Q: You might refer to him as a familiar face?
15 A: You could say that.
16 Q: Okay. However this March 19th, 2016 call was
17 the first time you've ever been in his
18 residence?
19 A: That's correct.
20 Q: Okay. Is it correct to describe this patient
21 as having extensive psycho-social history?
22 A: That's correct.
23 Q: And you were aware of this psycho-social
24 history prior to this call?
25 A: That's correct.

1 Q: Is it true that you aware he had a history of
2 suicide attempts?
3 A: Yes.
4 Q: I think you also indicated that he had a
5 pattern of attention seeking for certain -- a
6 means of either claiming to attempt suicide or
7 claiming he was going to attempt suicide, or
8 having done so in some form of fashion?
9 A: That's correct.
10 Q: Can you explain that?
11 A: Which part?
12 Q: His pattern of attention seeking.
13 A: Oh, just that he, just he made a lot of
14 threats. But he rarely conducted himself in a
15 manner that lent itself to actually committing
16 suicide.
17 Q: Uh-huh. When I asked you about the attempting
18 suicide, I think you indicated that based upon
19 your history with people, if they're really
20 serious about attempting suicide, they'll go
21 ahead and do it. Is that correct?
22 A: That was a bit of a flippant comment. But, I
23 mean, for the most part, most people that are
24 intent on committing suicide commit suicide.
25 Q: Okay.

1 A: I mean, 22 veterans kill themselves every day
2 without calling people asking for attention.
3 Q: Okay. Getting back to this March 19th, 2016
4 incident, you arrived right around 9:12 p.m.?
5 A: That sounds right.
6 Q: It's dark outside?
7 A: Yes, sir. I'm sorry.
8 Q: Officer Boucher and Eric Aiken were on the
9 scene?
10 A: That's correct.
11 Q: You grabbed your medication bag, go inside the
12 house?
13 A: That's correct.
14 Q: You did a visual assessment of the patient.
15 A: I did, I'm sorry. Go ahead.
16 Q: You didn't bring any kind of carrying device
17 inside the home?
18 A: I typically don't take a carrying device in the
19 house initially until what we discern what we
20 have. It prevents us from having to take one
21 device back outside and having to bring another
22 one in on occasion. So it's just generally
23 easier to leave the carrying device outside
24 until we realize exactly what we have with the
25 situation and then return to the truck for the

1 carrying device or send somebody for it.
2 Q: Okay. So on this encounter you didn't
3 introduce yourself to the patient, did you?
4 A: I did not. I had seen him before, had seen him
5 in town. I felt that he recognized me since he
6 walked up to me in other places and talked to
7 me readily. You know, introducing myself by
8 name was not really -- it's not like I was
9 meeting him for the first time kind of
10 situation. If it was under different
11 circumstances I may have.
12 Q: Your verbal interaction with this patient --
13 throughout the course of the call you said,
14 ever been told you're an idiot? You're being
15 told that right now. Is that correct?
16 A: I said those words.
17 Q: After the patient complained of pain, I think
18 you said, yeah well that's what the fuck
19 happens when you stab yourself in the belly
20 with a knife?
21 A: Yes.
22 Q: And you said, you stabbed yourself in the wrong
23 spot. That's not where your heart is?
24 A: Yes.
25 Q: You asked, why are you trying to kill yourself.

1 And then you responded, I don't want to hear
2 that. I stepped on a goddamned IED and blew my
3 nuts off. Is that a yes?
4 A: Oh, I'm sorry. Yes.
5 Q: You said, don't be stupid?
6 A: I think I said, let's just don't be -- yeah.
7 Don't do stupid stuff or something to that
8 effect.
9 Q: You said, you've got it so bad?
10 A: Yeah.
11 Q: Okay. Then with the ambulance door still open,
12 you said, fucking stupid people. Is that
13 correct?
14 A: That's correct.
15 Q: So you think these interactions with the
16 patient were not intimidating?
17 A: So, while I was in the Army, there near the end
18 of my career, I worked for the Seventh Group
19 Force Preservation Director. And, if I may
20 have some latitude. And as a part of that job
21 was taking care of wounded soldiers, physically
22 and psychologically. We went through a fair
23 amount of training about how to deal with those
24 'cause unfortunately Special Operations
25 soldiers are under a lot of stress, and a lot

1 of guys were committing suicide due to their
2 not being able to deal with their injuries when
3 they get home. And so that training CISM, or
4 critical incident stress management, a few
5 other things, told us that it was better to
6 talk right at the problem rather than handle.
7 That's not going to get you anywhere except for
8 further down the hole because then patients
9 think you're being patronizing. So I may have
10 used some wording that I otherwise could have
11 used differently. But again, you know, talking
12 around the problem or coddling and demeaning
13 the individual wasn't the way we were trained
14 to handle people with suicide ideations or
15 inclinations.
16 Q: So it's your position you weren't intimidating?
17 A: No. I mean I was trying to put him at ease.
18 You know, the stupid comment was kind of a
19 flippant comment like, you know, if the
20 paramedic comes in making jokes about it, it
21 can't be that bad. You know? I agree that I
22 probably should have chose different wording,
23 but again, he wasn't -- I mean, I can't tell
24 you that he was or wasn't. I haven't talked to
25 him since that night. But ...

1 Q: I think you characterized your verbal
2 interactions with the patient as being terse.
3 Is that correct?
4 A: Yes, sir.
5 Q: And matter of fact?
6 A: Yes, sir.
7 Q: And you characterized your behavior as joking
8 with the patient.
9 A: Well I mean, yes. Initially I was just trying
10 to get his mind off of going on.
11 Q: Right. This was a form of sarcasm?
12 A: You could probably -- that's a fair assumption.
13 Q: And I think you said ---
14 A: Or assertion.
15 Q: I'm sorry. And I think you characterized this
16 as gallows humor?
17 A: Well the part in the back of the ambulance is
18 more the gallows humor part, you know.
19 Q: Is that when you spoke with the Officer outside
20 of the presence of the patient. Said something
21 like, fortunately it missed his aorta?
22 A: Yes, sir.
23 Q: Okay. I think you also indicated that
24 sometimes you come off as gruff. Is that
25 correct?

1 A: That's correct.
2 Q: And you didn't see your comments as being
3 derogatory to this patient?
4 A: They weren't intended to be derogatory. That
5 wasn't the light in which I made -- I mean, in
6 the video you can see me smiling in the mirror,
7 you know. It's hard to be too serious when
8 you're smiling at the patient.
9 Q: Okay. I think you also acknowledged having
10 some people problems?
11 A: I don't have people problems. I am in pain a
12 lot, and when I don't have a smile on my face,
13 you now, it's -- I don't remember the word I
14 used.
15 Q: Terse?
16 A: No, no. Not the terse word. I just look mad.
17 But ---
18 Q: Mean mug?
19 A: Mean mug. There we go. That's a good word.
20 Q: Speaking of pain, with your injuries, you're in
21 significant pain.
22 A: Some days, yes.
23 Q: I think the patient had a pain level of four
24 out of ten. Is that correct?
25 A: Yes.

1 Q: And I think in the deposition, you said you
2 walk around every day with pain greater than
3 that.
4 A: Well I was just trying to use it as an example
5 of about where a four is on a scale. I mean
6 it's hard to -- different people have different
7 pain indexes, you know? Asking me what my pain
8 level is on a one to ten scale is going to be
9 different than what your scale is, different
10 than, Your Honor, what yours may be, or anybody
11 else's. And so strictly using a one to ten
12 scale doesn't really -- it gives you a good
13 baseline to start with, but it shouldn't be the
14 basis of treatment.
15 Q: But you're saying yours is greater than four on
16 a regular basis?
17 A: Yes.
18 Q: And part of that, I mean while you're on the
19 job, you can't use your pain medications,
20 correct?
21 A: No. I can't.
22 Q: Okay. All right. So you walked into the
23 house, you do a visual of the patient and watch
24 him breath for a couple seconds?
25 A: Yes, sir.

1 Q: You're looking at his breathing to see if the
2 knife perforated his diaphragm?
3 A: Well, after I made the comment, you know, I
4 just kind of stood back for a second and
5 watched the patient's facial expression,
6 watched him breath, you know, as I said in my
7 deposition, I wanted to ensure that as the
8 patient breathed, if the knife handle had moved
9 with is respirations it would be indicative of
10 it possibly perforating the diaphragm. Or if
11 it had a tick to it, like it was resting
12 against the aorta. But that wasn't as much of
13 a concern due to the position of the knife in
14 the body.
15 Q: Uh-huh. So you did that, then you walk in and
16 you bandage the knife in place?
17 A: Yes.
18 Q: And there wasn't much bleeding, correct?
19 A: No. There wasn't.
20 Q: And bandaging it in place, you're stabilizing
21 the knife, correct?
22 A: That's correct.
23 Q: Now when you bandaged the wound and stabilized
24 the knife, the patient guarded his wound, the
25 impalement, is that correct?

1 A: So, there's two types of guarding. There's
2 voluntary and involuntary. So one is an
3 autonomic response of the body to fluid in the
4 abdomen, or your body tensing itself against
5 injury. Like if you broke an arm, the muscles
6 in the area tense to stabilize it to prevent
7 further injury. So there's a difference
8 between, you know, like a Heisman Trophy pose
9 guarding, you know, or trying to keep
10 somebody's hand off of something, than the
11 abdominal cavity being rigid because of fluid
12 ---
13 Q: Uh-huh.
14 A: --- in the peritoneal cavity.
15 Q: But when you bandaged the knife, did he guard
16 his abdomen?
17 A: He guarded around the knife with his hands, you
18 know, out of fear that it might be touched, but
19 that's completely different than abdominal
20 guarding.
21 Q: Right. Well I'm just asking you if he guarded
22 ---
23 A: Yes, sir. I'm just trying to clarify for The
24 Court.
25 Q: The patient guarded his abdomen when you stood

1 him up, correct?
2 A: He didn't guard his abdomen when you stood him
3 up. We had to hold both of his hands. I think
4 you're confusing being defensive with guarding.
5 Q: Did he guard his abdomen when you laid him
6 down?
7 A: No.
8 Q: All right. You also indicated that you had a
9 verbal interaction with the patient so you
10 could assess his mental state?
11 A: Yes.
12 Q: So you're telling The Court your conversation
13 with this patient was aimed at assessing his
14 mental status?
15 A: Some of it was. Some of the rest of it was
16 just trying to get his mind off of what was
17 going on.
18 Q: Okay.
19 A: I mean he carried on a fairly, you know, normal
20 conversation for that patient. There wasn't a
21 lot of assessing of his mental status that was
22 necessary outside of, you know, the
23 conversation that he was currently having. He
24 knew what he had done and he explained, you
25 know, what he was trying to do. I mean, so

1 he's alert and oriented.
2 Q: Did you acknowledge he's a psychiatric patient?
3 A: He has a psycho-social history, yes.
4 Q: You indicated that you took the patient's
5 dorsal pedal pulse?
6 A: His pedal pulse, yes.
7 Q: And that's, for The Court's ---
8 A: The foot.
9 Q: It's the foot. Did you mark that?
10 A: Did I mark it?
11 Q: Yeah.
12 A: No.
13 Q: Okay. You indicated that you took the
14 patient's radial pulse when he stood up. And
15 the radial pulse is ---
16 A: On the wrist.
17 Q: On the wrist. And just for clarification,
18 dorsal pedal pulse was while he was sitting?
19 A: Was while he was sitting, yes.
20 Q: Okay. Now during your deposition, you couldn't
21 pinpoint where in the footage when you did
22 either of those, is that correct?
23 A: I couldn't what?
24 Q: Pinpoint exactly where in the body cam footage.
25 A: Well you can't see the patient from about

1 midchest down in most of that video.
2 Q: But you couldn't pinpoint it regardless?
3 A: Not from a video that can't show the rest of
4 the patient.
5 Q: Okay. Now you didn't write down or otherwise
6 document any of the results of your assessment?
7 A: I rarely do on assessments like that.
8 Q: When would you?
9 A: When there was a pertinent negative finding.
10 Q: Okay.
11 A: Like the patient didn't have a pulse or it was
12 rapid, his skin was cold and clammy, something
13 that I needed to convey something to my partner
14 so that she knew that the condition of the
15 patient wasn't acceptable.
16 Q: Right. So I mean, that was my next question.
17 You don't go into defining negatives, is that
18 correct?
19 A: As a general rule, no. It's just out of habit,
20 you know?
21 Q: And negatives would be if there was something
22 wrong or positives would be if there's
23 something wrong?
24 A: I'm sorry. Rephrase your question.
25 Q: I'm sorry. I think I was confused. So you

1 indicated that you don't go into defining
2 negatives.
3 A: Negatives with the patient.
4 Q: And negatives would be everything's normal
5 within the accepted range?
6 A: That's right.
7 Q: Okay.
8 A: Something bad would be a negative finding.
9 Q: Okay.
10 A: Well it depends on how you refer to negative
11 findings. I mean, if you were looking for
12 something positive and it wasn't there, then
13 that would be different, but ...
14 Q: Right. When you're referring to negatives,
15 you're talking about ---
16 A: Yeah. I was referring to something that is out
17 of the abnormal -- or something that is
18 abnormal, that's out of the normal.
19 Q: Okay.
20 **THE COURT:** Mr. Wicevic, I'm going to allow you to
21 finish your direct of this witness today, but
22 at this time let's take a ten minute break.
23 **MR. WICEVIC:** Sure.
24 **THE COURT:** Okay. We've been sitting a long time.
25 **(Off the record from 4:38 p.m. until 4:50 p.m.)**

1 **THE COURT:** Mr. Wicevic, if you're ready to continue
2 with your direct.
3 Q: You ready, Mr. Davenport? All right. So we
4 left off I think with the documentation
5 discussion. You don't go into defining
6 negatives. So if assessment results are normal
7 you don't document?
8 A: As a general rule, yes.
9 Q: Okay. Have you heard the old medical adage, if
10 you don't document it it didn't happen?
11 A: That's correct.
12 Q: Okay. Now based upon your assessment, you
13 determined that there wasn't any urgency to
14 transport, this patient did not have any life
15 threatening conditions, is that correct?
16 A: That's correct. All of -- he was in short
17 hemodynamically stable. Didn't have any
18 respiratory problems. I mean his heart was
19 beating, his blood was moving around his body
20 at a normal rate, and his skin was warm and
21 dry.
22 Q: Now he did have a knife impaled in his stomach,
23 right?
24 A: That's correct.
25 Q: Would you agree that he had the potential to

1 decompensate?
2 A: I would agree that had the knife been located
3 over something vital, that it may have been
4 there.
5 Q: So it wasn't located over something vital?
6 A: It wasn't over his aorta or his heart.
7 Q: But there's other organs under there, correct?
8 A: Yes, but none of them are going to cause him to
9 rapidly decompensate.
10 Q: Okay.
11 A: None of the ones that are underlying where the
12 knife was. Excuse me. I mean there's other
13 organs in the left upper quadrant that could,
14 but they weren't in the immediate area around
15 the knife.
16 Q: Okay. We did acknowledge that the patient
17 would need to get operated on, is that correct?
18 A: Yes.
19 Q: And that was to have surgery for removal of the
20 knife?
21 A: That's correct.
22 Q: You didn't ask the medications about his
23 medications, correct?
24 A: No. I didn't.
25 Q: Did you ask the patient if he was under the

1 influence of any drugs or alcohol?
2 A: No, I didn't.
3 Q: Now drugs and alcohol, can that impact your
4 pulse?
5 A: To a degree, yes.
6 Q: What about medications? Can they impact your
7 pulse?
8 A: Yes.
9 Q: And you were aware that the patient had a
10 history of overdoses?
11 A: Yes.
12 Q: Did you take the patient's lungs, lung sounds?
13 A: Did I what?
14 Q: You didn't take the patient's lung sounds?
15 A: There was no immediate need.
16 Q: Okay. What about bowel sounds? Is that
17 something you can take?
18 A: I could have, but again, trying to listen to
19 bowel sounds with everything else going on
20 around in that house would have been akin to
21 percussing the chest or percussing the abdomen.
22 Picking up on subtle differences are -- you
23 know, people talking around you, it's very
24 difficult.
25 Q: And you don't remember ever communicating the

1 results of your assessment to Ms. Aiken,
2 correct?
3 A: That's correct.
4 Q: You acknowledge that you don't always
5 communicate the results of your ---
6 A: Well ---
7 Q: --- assessments?
8 A: --- again, if the patient was in a poor
9 condition, there would have been certain things
10 that, you know -- I would have been moving with
11 more urgency. But as a general rule, I mean if
12 the patient's breathing, I'm not going to turn
13 and look at my partner and go, he's breathing,
14 he has a pulse, you know, he's alert and
15 oriented. It's not part of my -- the way I
16 normally conduct medicine.
17 Q: What about when you know you're not going to be
18 riding the call? Isn't communication of those
19 results particularly important?
20 A: So, if I was -- for her to be riding in the
21 call means that the patient is stable and is
22 non-critical to begin with. So the very fact
23 that I let -- that I chose to delegate that
24 patient care to her is indicates that the
25 patient is stable.

1 Q: Okay. But you never communicated anything to
2 her?
3 A: No. I mean we ran a broken leg together
4 sometime earlier, and I didn't, you know, I
5 mean you get into a rhythm, and I just find
6 that me and my partner don't talk a whole lot
7 when we're, you know, talking about doing
8 patient care.
9 Q: Well you'd agree team work is necessary for
10 EMT's, right?
11 A: Yes.
12 Q: You'd also agree that a broken leg's not the
13 same as an impaled penetrating object in your
14 stomach?
15 A: Yes. But the issue at hand is that's not a
16 critical injury.
17 Q: Okay. Well that was your determination,
18 correct?
19 A: Yes.
20 Q: And getting to the knife, I mean there's no way
21 with certainty for you to know the length of
22 the knife, correct?
23 A: With any certainty other than it was a steak
24 knife. I mean, a steak knife generally don't
25 come in a foot long variety. I mean, if there

1 is one, I haven't seen it.
2 Q: And it's your position that you proceeded with
3 caution in this case?
4 A: Yes.
5 Q: Now did you assume that the knife was of a
6 length that could cause life threatening
7 injuries?
8 A: For that knife in that position to cause a life
9 threatening injury, based on the position the
10 knife was in in the body, would have had to
11 been substantially long given the patient's
12 adipose tissue.
13 Q: So you did not assume that it could cause ---
14 A: I don't ---
15 Q: --- life threatening injuries?
16 A: I don't understand your question.
17 Q: When you were approaching this care of ---
18 A: Yes.
19 Q: --- this patient, did you assume that the
20 length of the knife was a length that could
21 cause a life threatening injury?
22 A: I assumed that the knife had not penetrated
23 anything that was causing a life threatening
24 injury due to the patient's condition and the
25 assessment that I made ---

1 Q: Okay
2 A: --- based on the number of impaled objects that
3 I've treated in the past.
4 Q: Okay. So then you proceeded to walk the
5 patient from his couch to the ambulance, right?
6 A: That's correct.
7 Q: One of the Officers at the patient's left
8 forearm, and you at the other, patient's right
9 forearm, is that correct?
10 A: That's correct.
11 Q: And together, y'all assisted the patient to the
12 ambulance?
13 A: That's correct.
14 Q: I think you indicated the patient's stairs were
15 rickety, is that correct?
16 A: They're uneven. I mean the stairs are made out
17 of substantial material, but they rock back and
18 forth side to side a little bit.
19 Q: Okay. You indicated the doorway was narrow, is
20 that correct?
21 A: Well, I mean, you have a rail on one side, the
22 door opens opposite which creates kind of a
23 channel that you have to step out of. And so
24 the door opening one way and the railing being
25 all on the same side, you know, it's almost

1 like you walk out into a semi, like hallway
2 kind of, like when you walk out onto the
3 landing, you're still enclosed between the door
4 and the railing.
5 Q: Okay. You can still fit a spine board through
6 there, correct?
7 A: Yes.
8 Q: You could still fit the stair chair through
9 there, correct?
10 A: Yes.
11 Q: Could you fit the stretcher through there?
12 A: I mean, with some effort. I mean I'd have to
13 measure between the two, but I wouldn't
14 normally take the stretcher up there like that,
15 but ...
16 Q: Can't you kind of manipulate the stretcher to
17 go up inclines like a stair?
18 A: You can pick it up and carry it if that's what
19 you're referring to.
20 Q: Well I thought you could lift it up some, the
21 head of the stretcher, along with I guess the
22 wheels.
23 A: Well the wheels aren't, I mean the steps are
24 larger than the wheels are. You can't like
25 just lift the end of it and push it up the

1 stairs, if that's what you're getting at.
2 Q: Okay.
3 A: I mean, it's going to bump going up ---
4 Q: Uh-huh.
5 A: --- the stairs.
6 Q: All right. So the patient did complain of pain
7 when you stood him up, correct?
8 A: Yes, sir.
9 Q: The patient complained of pain when you moved
10 him to the stretcher, correct?
11 A: Yes.
12 Q: Now while loading the patient into stretcher,
13 I think it was Mr. Aiken, he asked the patient
14 if he wanted to stay in a sitting position.
15 Then you indicated, no he was going to lay
16 down. Is that right?
17 A: Yes.
18 Q: Okay. You felt like restraints on this patient
19 were unnecessary?
20 A: I wouldn't say that I felt restraints were
21 unnecessary. My position on restraining that
22 patient is that he's got a knife in his
23 stomach. In the past he has become violent and
24 fought getting off the stretcher a little bit.
25 Getting into a physical altercation with a guy

1 with a knife sticking out of his stomach is not
2 a good position to be in. I mean there's no
3 going back once that started.
4 Q: Well -- I'm sorry.
5 A: I was just going to say the risk to further
6 harming that patient through trying to
7 physically restrain him was -- I did not deem
8 it worth the -- it would do more harm than good
9 in the end.
10 Q: Okay. You mentioned in the past, this
11 particular patient has been combative. But
12 this was your first call with this patient,
13 correct? Second?
14 A: Second.
15 Q: He became combative the last -- the September
16 19 ---
17 A: I didn't say he became combative with me. I
18 said he'd been combative in the past with other
19 crews.
20 Q: Okay.
21 A: I mean I know about his psycho-social history
22 because it's been passed in the Squad. While
23 those conversations go on as well, we talk
24 about, you know, issues that arise with, you
25 know, patients like that. So that when EMT's

1 or paramedics go out to a house, you're not
2 surprised all of a sudden with an unmanageable
3 situation, if you will.
4 Q: Okay. All right. So, after loading the
5 patient into the ambulance, you had a
6 discussion with Ms. Aiken. You asked her if
7 she was comfortable to ride the call or if she
8 wanted to ride it, is that correct?
9 A: That's correct.
10 Q: Then I believe Ms. Aiken shrugged kind of. Do
11 you recall?
12 A: I don't recall her shrugging.
13 Q: Okay. Well what do you recall?
14 A: I recall us having a conversation about it, but
15 Ms. Aiken had had her backside chewed into
16 pretty heavily by Mr. Stoller in the past, and
17 she wished for that not to happen again. So I
18 was trying to ensure her that that was not
19 going to be an issue, you know, that the
20 patient's needs had been met, and that she
21 would be perfectly fine riding it, riding in
22 the back on the way to the hospital that is.
23 Q: And then after, I guess, her reply you said
24 something along the lines, because I'm not
25 doing anything for him, it's up to you. Is

1 that correct?
2 A: So, meaning there's not any ALS procedures that
3 I'm going to start on that patient.
4 Q: That's what you intended?
5 A: Yes.
6 Q: Okay.
7 A: And I believe Ms. Aiken said during her
8 deposition that that's what she realized I
9 meant, that ---
10 Q: Now ---
11 A: --- it wasn't that I wasn't going to care for
12 the patient, just that the patient didn't need
13 any ALS care.
14 Q: Okay. After that discussion, then you got into
15 the driver's seat of the ambulance, is that
16 correct?
17 A: Yes. A few minutes thereafter.
18 Q: Ms. Aiken got in the patient compartment, and
19 y'all drove off to AnMed?
20 A: That's correct.
21 Q: You made the call into AnMed?
22 A: That's correct.
23 Q: I believe you said that the rational was you
24 didn't want the patient hearing the discussion
25 about his psycho-social history. Thought that

1 might upset him, is that correct?
2 A: That's correct.
3 Q: So on this call, neither you or Ms. Aiken
4 administered oxygen to the patient, is that
5 correct?
6 A: That's correct.
7 Q: You never attempted to establish an IV ---
8 A: That's correct.
9 Q: --- intravenous access? You never performed a
10 cardiac monitor?
11 A: That's correct.
12 Q: You acknowledge that you never contacted Dr.
13 Kickham or any Medical Control Physician during
14 this patient's injuries?
15 A: That's correct.
16 Q: You'd agree that all the assessment and vital
17 signs documented on Exhibit 11c, you can look
18 at it, concern assessments and vital signs
19 taken by Ms. Aiken?
20 A: Yes. I so stipulate.
21 Q: You'd also agree that you were the most
22 appropriately trained EMT on this call?
23 A: Well, every trauma call that I show up on, if
24 we're going to go down that road, I'd end up
25 riding ---

1 Q: Well ---
2 A: --- by virtue of my training.
3 Q: --- I'm just asking if you're the most
4 appropriately trained.
5 A: So, I'm the most trained, but there was no need
6 that patient had that went unmet.
7 Q: Okay. So you're not the most appropriately
8 trained?
9 A: I just said I am the most trained.
10 Q: Okay. You'd also agree that on this particular
11 call, you were the only paramedic on the scene?
12 A: Yes.
13 Q: You'd agree that you were the lead EMT as far
14 as patient management?
15 A: Yes.
16 Q: Now you determined that Ms. Aiken, an EMT
17 basic, was qualified to meet the immediate
18 needs or reasonably perceived needs of this
19 patient?
20 A: Yes.
21 Q: You acknowledge that you knew this patient
22 suffered a traumatic injury that required
23 surgery?
24 A: Oh, I'm sorry. Yes. My apologies.
25 Q: It's fine. Now after dropping the patient off

1 at AnMed, you indicated to Ms. Aiken that the
2 only thing you would have done for the patient
3 was establish an IV, but you were not going to
4 give him any kinds of drugs or medications. Is
5 that correct?
6 A: No. That is not correct. So we had a
7 conversation when she got in the ambulance, and
8 aside from her being visibly concerned that she
9 was going to be QA'd for the call, we discussed
10 a number of things, one being hypotensive,
11 permissive hypotension. My comment was that
12 the only thing, if I was going to do anything,
13 would have been to establish an INT or a
14 hepwell where you just start an IV but don't
15 give any fluids. It keeps the vein accessible
16 if you needed it, but it keeps you from, you
17 know, over hydrating the patient or giving them
18 too much fluid by accident.
19 Q: Now wouldn't that be appropriate?
20 A: For what?
21 Q: For this particular patient?
22 A: Why?
23 Q: Because of the potential to decompensate.
24 A: We just covered the fact that the knife didn't
25 underlay -- there was nothing underlaying the

1 knife that would cause that patient to
2 decompensate.
3 Q: Well you don't know because you don't know
4 where the knife was, correct?
5 A: I know where the knife is in the stomach, and
6 I'm very familiar with the organs inside of the
7 abdomen.
8 Q: But you don't know how long the knife is, is
9 that correct?
10 A: Well, regardless of how long the knife was, the
11 only thing that it was going to hit other than
12 his stomach, his transverse colon, or his
13 mesentery. If it had perforated through all of
14 that would have been into the muscle into his
15 back.
16 Q: So you're saying perforating any of those
17 mentioned organs ---
18 A: Was not going to cause him to decompensate in
19 the near term.
20 Q: What about the long term?
21 A: I can't do anything about the long term.
22 Q: Okay.
23 A: No more so than giving antibiotics for sepsis.
24 At the time that wasn't an option.
25 Q: So getting back to my initial question, did you

1 indicate to Ms. Aiken that the only thing you
2 would have done was established an IV
3 understanding you weren't going to administer
4 any fluids? Is that what you told her after --
5 -
6 A: I told her that if anything, that would have
7 been the only thing to be done.
8 Q: Okay.
9 A: But that doesn't indicate that that's what the
10 patient needed.
11 Q: Okay. And that was my next question. You
12 indicated that you won't start IV's on peoples
13 who don't have an immediate need for the IV, is
14 that correct?
15 A: Yes.
16 Q: Now you knew the patient was going to the
17 Operating Room and would get an IV, is that
18 correct?
19 A: That's correct.
20 Q: During your deposition I think I asked you if
21 you would have done some things differently
22 during this call. I think you mentioned you
23 could have moved, and this might have been
24 general. You mentioned you could have moved
25 the patient a little bit faster at certain

1 points, you could have moved him a little bit
2 slower at points, is that correct?
3 A: Yes.
4 Q: You would not have been so terse with the
5 patient, is that correct?
6 A: I would have chose my words differently.
7 Q: I think you also acknowledged that you've
8 talked worse to patients who have done similar
9 kind of silly acts?
10 A: Team guys, yes.
11 Q: Team guys, so not ---
12 A: SF guys. Not civilian patients.
13 Q: You also indicated a distinction between erring
14 on the side CYA, meaning strict compliance with
15 protocols, versus giving the patient what he or
16 she needs. Is that a distinction you made?
17 A: I'm sorry. I didn't hear a question in there.
18 Q: So, I'm trying to understand. You indicated
19 that there is a distinction between CYA,
20 meaning strict compliance with the protocols
21 and orders, versus giving the patient what he
22 needs.
23 A: Yes. There is a difference.
24 Q: And in your practice, you're going to give a
25 patient what he needs versus strict compliance

1 with orders and protocols.
2 A: No. Those two things can line up. But just
3 because, you know, I mean like trauma for
4 instance. That's a big word. Like Kim stated,
5 you know it could mean a little old lady falls
6 out of her recliner and needs help put back in
7 her recliner verse somebody in a really bad car
8 accident who has multiple fractures. It's an
9 all encompassing word for an injury to the
10 body. So there's some people that need things
11 and other people that don't. Somebody with --
12 and I'm using extremes here so that we don't
13 kind of mince words. But, you know, a patient
14 that is completely stable, starting IV's on
15 those patients for the sake of starting IV's is
16 bad medicine. The same way it would be if you
17 went to the hospital and had one injury and
18 ended up getting a whole bunch of other
19 procedures started on you that had nothing to
20 do with what you needed at the time. Aside
21 from that being Medicare and Medicaid for all
22 -- it's poor medicine, not being able to
23 distinguish that the patient needs an IV
24 because they're in shock or they're
25 decompensating and are going to be in shock by

1 starting the IV so that you can start the IV so
2 that you don't have to answer questions to the
3 QA guy about why you didn't start an IV.
4 That's the distinction I'm trying to draw is
5 between being able to discern what the patient
6 needs and giving them what they need, and then
7 just going down the cookbook and go well I'll
8 just do all this stuff so that I don't end up
9 having to answer questions about why I didn't
10 do that stuff.
11 Q: So you acknowledge that your practice of not
12 rotely following protocols, you're going to
13 have to answer to QI and a Medical Control
14 Physician ---
15 A: Uh-huh.
16 Q: --- but you'll be able to explain yourself
17 later, is that correct?
18 A: Well, this isn't like an everyday occurrence
19 kind of thing. I mean, or, you know, this
20 would have happened sooner. This is a patient
21 that had a problem that didn't -- and we're
22 here because of, you know, my boss having an
23 axe to grind. But we'll get to that later.
24 But the patient was hemodynamically stable. He
25 didn't have a respiratory complaint. The

1 American Heart Association previously issued
2 numerous papers stating that if the O2 stat is
3 greater than 94 percent that they don't need
4 oxygen, that it does more harm than good, and
5 some of the same people that issued papers that
6 state, you know, that pre-hospital IV's don't
7 make a hill of beans difference in the vast
8 majority of trauma cases. Especially those
9 that you're not starting the IV to give the
10 patient something.
11 Q: Okay. Well I'm sure your expert will get into
12 these medical determinations. Let's go to
13 protocols and standing orders, and, Mr.
14 Davenport, I'm referring to ---
15 A: Yes, sir.
16 Q: --- Exhibit 1.
17 A: Yes, sir.
18 Q: GP-16 patient safety protocol, that's on Bates
19 page 14.
20 A: Okay.
21 Q: Now you'd agree that's applicable in all
22 patient encounters?
23 A: Yes, sir.
24 Q: Okay. GP-18, it's the following page,
25 universal patient care protocol. That's also

1 applicable to all patient encounters?
2 A: Yes, sir.
3 Q: M-9, this is page 31.
4 A: Excuse me.
5 Q: Sure. The psychiatric emergencies protocol.
6 A: Yes, sir. You said page 31, Vito?
7 Q: Yes, sir.
8 A: Or, Mr. Wicevic. Okay.
9 Q: Again, that's this particular protocol,
10 psychiatric emergency is applicable to this
11 patient?
12 A: Yes, sir.
13 Q: I'm sorry we're flipping back so much. GP-19,
14 that's page 16, the adult assessment protocol.
15 A: Yes.
16 Q: That's another one that's applicable to this
17 particular patient?
18 A: Yes.
19 Q: Now the only critical intervention that you
20 determined was necessary for this patient was
21 that he needed the knife stabilized in his
22 abdomen and you needed to control any
23 hemorrhaging, is that correct?
24 A: That's correct.
25 Q: Let's turn to page 5. Okay. And, Mr.

1 Davenport, just for the record, you didn't
2 apply oxygen therapy to this patient because he
3 had warm pink dry skin, his skin was of no
4 concern, and his respiratory rate was normal,
5 is that correct?
6 A: That's correct.
7 Q: Okay. And because the patient's traumatic
8 injury did not involve his respiratory drive,
9 is that correct?
10 A: I'm sorry?
11 Q: You didn't administer oxygen therapy because
12 the patient's traumatic injury did not involve
13 his respiratory drive?
14 A: I didn't apply oxygen because the patient's
15 condition didn't warrant oxygen regardless of
16 the injury.
17 Q: Okay. So my understanding was that if he had
18 some traumatic injury in order to administer
19 oxygen, you'd need some kind of distress of the
20 respiratory drive. Is that your position?
21 A: Well that or being in shock and having an issue
22 moving, you know, getting oxygen to the cells
23 as a general rule.
24 Q: Right. I'm just trying to understand.
25 A: Yes, sir.

1 Q: And it's your position that the patient did not
2 have the potential for multiple system trauma?
3 A: No.
4 Q: And he did not have the potential for shock?
5 A: Huh-uh.
6 Q: No?
7 A: No. I'm sorry. My apologies. No. No he
8 didn't.
9 Q: T-1 requires crews to administer oxygen as soon
10 as possible for critical traumas, is that
11 correct?
12 A: Where's T-1?
13 Q: Page 42.
14 A: General trauma.
15 Q: And I think I'm referring to first paragraph
16 under critical trauma, about the middle of the
17 page.
18 A: That's not critical trauma.
19 Q: Okay. So it's your position this was not a
20 critical trauma?
21 A: No.
22 Q: Okay.
23 A: If I may?
24 Q: Well he can ask you.
25 A: Oh, okay. I was just going to explain. Okay.

1 That's fine.
2 **MR. ROTHSTEIN:** Your Honor, I think, if I could
3 explain---
4 **MR. WICEVIC:** Sure.
5 **MR. ROTHSTEIN:** I think Mr. Wicevic is sort of
6 cutting him off.
7 **MR. WICEVIC:** He can ...
8 A: So critical trauma is a -- a critical casualty
9 or a critical patient is somebody that I can't
10 meet their immediate needs. All right? So if
11 they're bleeding and I can't stop it, they have
12 an airway problem that I can't fix, or a
13 respiratory problem that I can't fix in the
14 immediate, all right, that is going to call
15 them to die that they need a surgeon for to fix
16 those problems. That is a critical casualty.
17 All right? So if this gentleman had stuck that
18 knife in his aorta, then that becomes a
19 critical casualty because I can't address that.
20 All right? He could have cut his entire leg
21 off and once a tourniquet is in place and the
22 bleeding has stopped, regardless of the
23 gruesomness of that injury, it is no longer a
24 critical injury. The limitation to the injury
25 is completely ceased. All right? So using the

1 word critical is kind of, I mean without being
2 able to define what it means, which these
3 protocols do not define what that word means,
4 is, I mean, in my medical training that's the
5 way I was taught to view critical trauma.
6 Somebody that has an issue that I can't
7 immediately fix, which would mean going to a
8 surgeon. All right? Now this patient, we
9 agreed is going to a surgeon, but it isn't to
10 fix an injury that is threatening his life. I
11 mean that knife could stay in place for the
12 next week and it's still not threatening his
13 life. It's not impeding his ability to
14 exchange oxygen, it's not impeding his ability
15 to move blood around, and it's not impeding the
16 cellular exchange of oxygen and carbon dioxide,
17 which is the definition of shock.
18 Q: And you know all that with certainty?
19 A: Based on my experience, yes.
20 Q: Okay. So, it's your position you had the
21 capability to meet the immediate needs of this
22 patient?
23 A: Kim had the immediate needs of that patient by
24 herself.
25 Q: So the EMT basic had the capability to meet the

1 immediate needs of this patient?
2 A: Yes.
3 Q: Okay.
4 A: The patient was delivered to the hospital in
5 the same condition we picked him up. If he had
6 immediate needs that were going unmet he would
7 have -- his situation would have degraded. His
8 pain would have increased, his respiratory rate
9 would have increased, his pulse would have
10 increased, or the rate of it would have
11 increased, the character would have decreased,
12 skin get cool and clammy which are all
13 indicative of the patient being in shock.
14 Q: Let me ask you this. Have you ever had a
15 patient out of no where just totally
16 decompensate suddenly?
17 A: Have I ever had a patient just suddenly
18 decompensate? Not from an injury that I
19 understood the etiology. No.
20 Q: And you understood the etiology of this
21 particular ---
22 A: What caused his injury? Yes.
23 Q: All right. Get back to oxygen. Page 43.
24 A: Yes, sir.
25 Q: T-3, the multiple trauma and shock protocol.

1 It requires the initiation of airway management
2 protocol, is that correct?
3 A: That's correct.
4 Q: All right. Now I think I understand this.
5 It's your position that the patient did not
6 have the potential for multiple system trauma?
7 A: That's correct.
8 Q: He didn't have the potential for shock,
9 correct?
10 A: Not given the injury that he had, no.
11 Q: Okay.
12 A: I mean, he had the potential to jump up off the
13 couch and do jumping jacks, but I mean that's
14 not the patient that I had in front of me. The
15 idea that you can treat a patient for one
16 thing, and then treat them all encompassing,
17 try to be a catch all is a little misleading.
18 The patient had an immediate need that I
19 believed to be stabilized. He needed to be
20 taken to the hospital so that a surgeon could
21 remove it. There were no other immediate needs
22 that the patient had. He knife was in his
23 abdomen, it had penetrated the skin, through a
24 good bit of adipose tissue, and ended up with
25 a half centimeter perforation of his peritoneal

1 cavity. But the organs underlaying that knife,
2 if he had after -- 20 minutes there would have
3 been signs of his abdomen showing rigidity and
4 guarding. Not this kind of guarding but like
5 the abdomen musculature getting tight to
6 protect itself because of the irritation of
7 blood inside the peritoneal cavity. Or
8 conversely, abdominal content spilled out into
9 the abdomen.
10 Q: Could that have been resulted in a significant
11 injury?
12 A: It could have resulted in an injury that
13 required more surgery, but nothing that was
14 threatening his life in the immediate sense.
15 Q: Okay. Well I mean you talked about potential.
16 There's potential for everything. I mean he
17 had the potential to be dead, correct?
18 A: Yes. I mean as soon as we got there, he could
19 have gone into cardiac arrest.
20 Q: Right.
21 A: I mean I can't immediately start treating him
22 for cardiac arrest without him being in cardiac
23 arrest.
24 Q: Well let me ask you this. Isn't one of the, I
25 guess, principles of pre-hospital care is to

1 prevent something before it happens, prevent,
2 you know, injury, prevent death, or I shouldn't
3 say death, prevent shock before it happens, be
4 ready for it if it does?
5 A: Yes.
6 Q: Okay. I mean you want to get ahead of the
7 eight ball. I mean you don't want to be behind
8 the eight ball, correct?
9 A: That's correct.
10 Q: Now do you think your care in this case you
11 were getting ahead of the eight ball?
12 A: So, we're back to giving the patient a bunch of
13 stuff the patient didn't need. I mean I could
14 have went ahead and intubated the patient
15 because he was going to the OR. He was going
16 to get intubated going in the OR.
17 Q: Do the protocols require that?
18 A: Protocols don't require him being on oxygen.
19 Q: Well that's your position.
20 A: No. That's the position of the protocols.
21 Q: Okay. Let's move to page 6 of Exhibit 1
22 please. GP 3, intravenous access protocol.
23 Now is it correct that your position is that
24 the need for an IV depends on whether or not
25 the patient is hemodynamically stable?

1 A: Or if he's going to get medication or, you
2 know, there's another condition that I'm
3 treating, but, as a general rule, yes.
4 Q: Okay.
5 A: It's not just the hemodynamically stable part,
6 it's the ability for that patient to
7 decompensate. So, again, if the knife was in
8 his aorta which given the position of the
9 knife, and knowing where the aorta runs in the
10 body, I mean, the likelihood of it being in the
11 aorta is the same as it being in the bladder.
12 I mean that's just not where the knife was. So
13 for the patient to decompensate, it would have
14 had to have struck something to cause him to
15 decompensate. All right? If the knife was in
16 him for a week, then he could go into septic
17 shock and be in shock without the knife being
18 in something that's causing bleeding, but that
19 is a completely different story and different
20 injury. So, but the idea that you just start
21 IV's for the sake of starting one is bad
22 medicine in my opinion and it's shared by a lot
23 of other people, and isn't supported in the
24 protocol.
25 Q: It's not supported by the protocols?

1 A: Starting IV's for the sake of starting an IV is
2 not supported in the protocol.
3 Q: Okay. All right. So you said whether to
4 initiate an IV depends on whether the patient's
5 hemodynamically stable, and whether the patient
6 needs medications?
7 A: Well, given different patients, yes. I mean,
8 I wasn't speaking specifically to this patient,
9 but more generally speaking of patients in
10 general. You know? Starting it just so you
11 can say I started an IV on the patient, it's
12 just not good medicine.
13 Q: Well this patient in question, he was going to
14 need medication, wouldn't he?
15 A: When he got to the OR.
16 Q: Okay. So he didn't have an immediate need for
17 medications? So that's the only time -- I mean
18 when you're talking about hemodynamically
19 stable and the need for medications, those are
20 the two triggers for whether to IV ---
21 A: Or if I think they're going to progress into
22 shock.
23 Q: Okay. So there's three circumstances?
24 A: Well the latter one overrides the other two.
25 Q: Okay. There might be overlap.

1 A: Yes.
2 Q: Okay. Getting back to this injury, I mean
3 there's no way for you to really know the angle
4 in which this knife went into this ---
5 A: The handle was at 90 degrees to the body. I
6 mean there's tissues underlying the knife. It
7 can't just go in and magically change
8 directions like a pendulum.
9 Q: So if it went in at a 45 degree angle it would
10 have been sticking out at a 45 degree angle.
11 A: Yes.
12 Q: Okay. Well just getting back to our discussion
13 ---
14 A: I mean, we're going down this would have,
15 should have, could have, road and ---
16 **THE COURT:** Mr. Davenport.
17 **MR. DAVENPORT:** Yes, ma'am?
18 **THE COURT:** If you would, just respond to the
19 question.
20 **MR. DAVENPORT:** Yes, ma'am.
21 **THE COURT:** And, I mean if it's necessary, we'll let
22 you elaborate.
23 **MR. DAVENPORT:** Yes, ma'am.
24 Q: Okay. And when you say hemodynamically stable
25 you mean that the patient has a stable heart

1 pump, good circulation of blood, is that
2 correct?
3 A: That's correct.
4 Q: Now GP-3, I think we're on that page, page 6.
5 It orders normal saline for unstable patients,
6 hypotensive patients, cardiac arrest, and
7 trauma patients, is that correct?
8 A: That's correct. But that's defining who gets
9 normal saline. Again, trauma's a big word. I
10 mean, respiratory illness isn't in there,
11 seizures not in there, but those get IV's
12 started on them if they have a need for one.
13 That's not a do this for these patients. It's
14 a if these patients need it, this is what they
15 get.
16 Q: Okay. I'm moving around again.
17 A: Okay.
18 Q: Page 42, T-1.
19 A: I'm sorry, Mr. Wicevic. What page is it again?
20 Q: 42.
21 A: Oh, T-1. Okay.
22 Q: Under critical trauma, and I understand you
23 don't consider this a critical trauma. It
24 says, the third bullet point, all IV's will be
25 established en route to the hospital unless the

1 patient's is trapped or the IV will delay
2 transport, is that correct?
3 A: That's correct.
4 Q: Next page, trauma transport protocol, T-2, page
5 43.
6 A: Yes.
7 Q: Amongst the traumatic injuries requiring trauma
8 transport is penetrating abdominal injury, is
9 that correct?
10 A: That's correct.
11 Q: Okay. Moving to the right of that page,
12 multiple trauma slash shock protocol. Under
13 the paramedic management it states, initiate
14 intravenous access protocol. Is that correct?
15 A: Yes.
16 Q: And the top of T-3, it says under general
17 information third bullet point down,
18 intravenous access is initiated en route to
19 medical facility unless extrication is
20 required.
21 A: That's correct.
22 Q: And you'll acknowledge that attempting and
23 establishing IV access is an ALS skill?
24 A: Yes
25 Q: And that means paramedics or intermediates,

1 advanced EMT's can perform it, right?
2 A: I agree with that.
3 Q: And basic EMT's cannot?
4 A: That's correct.
5 Q: Okay. Regarding the reassessment of the
6 patient, I think you indicated that there was
7 nothing you, a paramedic, could do than Ms.
8 Aiken, a basic EMT could not do. That's
9 correct?
10 A: Yes.
11 Q: Okay. You're both equally qualified and
12 experienced to reassess this patient?
13 A: Yes. Based on his injuries.
14 Q: That being said, you have significantly more
15 experience than Ms. Aiken, correct?
16 A: Yes. But if I rode every call based on
17 experience she'd never get any experience. And
18 I'd ride all the calls in Anderson County that
19 I arrive on. I mean ...
20 Q: Okay. Now, just regarding this matter, on
21 Tuesday, April 19th, 2016, about 10:00 a.m. you
22 were interviewed by various DHEC staff members
23 regarding this incident?
24 A: Uh-huh.
25 Q: Were you aware that the staff recorded the

1 interview?
2 A: Yes.
3 Q: Okay. Have you listened to the recording?
4 A: I have.
5 Q: Do you have any reason to question the accuracy
6 or authenticity of the video?
7 A: Of the video?
8 Q: Or excuse me, the audio.
9 A: I don't understand your question.
10 Q: Do you have any reason to question the accuracy
11 or authenticity of the recording?
12 A: You mean, am I questioning whether they
13 tampered with it?
14 Q: Yes, sir.
15 A: I don't suppose so.
16 Q: Okay. The IRC on Thursday, June 23rd, 2016
17 about 9:30 a.m. the IRC convened to review the
18 Department's investigation, is that correct?
19 A: They convened to do what?
20 Q: To review the investigation into the
21 allegations against you.
22 A: I was under the impression they were there to
23 ask me questions, but ...
24 Q: Right. They reviewed the Department's
25 investigation, and then if they have questions

1 for you they could ask you questions. Were you
2 present?
3 A: I was.
4 Q: Were you aware that the IRC was transcribed by
5 a court reporter?
6 A: Yes.
7 Q: Have you reviewed the transcript?
8 A: Yes.
9 Q: Are there any inaccuracies with any of the
10 statements in there?
11 A: Inaccuracies?
12 Q: Yeah, with your statements ---
13 A: I don't understand the question you're asking.
14 Q: Are there any inaccuracies with the statements
15 you made that are transcribed in the IRC
16 transcript?
17 A: Only to the extent that I was trying to be
18 short and brief, and didn't go into as much
19 detail as I probably should have on some of
20 them. But ...
21 Q: Sure. Exhibit 14, let's turn to Exhibit 14
22 please. And I'm almost done. Now this is an
23 email from you to Scott Stoller at 8:13 a.m. on
24 March 30th, 2016, correct?
25 A: Yep.

1 Q: And in the email you suggest that Dr. Kickham
2 only expressed that he'd prefer to see
3 different treatment from you, is that correct?
4 A: Yes. He did not point out by policy where I
5 did wrong. That was the point of the email.
6 Q: So your understanding was that they were just
7 preferences?
8 A: Well, that, again, he did not say, you should
9 have done this, you should have done that, you
10 shouldn't have done this, you should have done
11 that. We had a discussion. He asked me why I
12 did, you know, why I didn't start an IV, why we
13 walked the patient, and so forth. I explained
14 it and then at the end of it we adjourned, and
15 then Scott sent me an email a day or so later
16 telling me I had to take a protocol test.
17 Q: Okay. So leaving that meeting you thought Dr.
18 Kickham just had preferences that you provide
19 ---
20 A: Yes.
21 Q: --- care differently?
22 A: Yes.
23 Q: And similar to that, it was your understanding
24 that he didn't determine that you violated any
25 protocol?

1 A: He didn't point out any protocol that I
2 violated.
3 Q: Okay.
4 A: He didn't have any with him at the meeting.
5 Q: And then -- sorry.
6 A: Oh. I was just pointing out that Dr. Kickham
7 didn't bring protocols with him to the meeting
8 to point out where I did wrong. It was a
9 discussion about why I did what I did, you
10 know, like in the introduction where it says,
11 you know, explain deviations. And that's the
12 route I took.
13 Q: Did you document why you deviated?
14 A: I don't remember. I mean, that was the purpose
15 of the meeting, was for me to explain my
16 deviations. So after that I did not document
17 it, no.
18 Q: Well what were your deviations?
19 A: That I walked the patient and that I, yeah.
20 That I walked the patient.
21 Q: That was your only deviation?
22 A: Well, yeah. 'Cause no where else in the
23 protocol did it state what I had to do.
24 Q: Okay.
25 A: Other than what I did do.

1 Q: Okay. And then your signature line says, it's
2 better to die on your feet than live on your
3 knees.
4 A: Yes.
5 Q: Something I just wanted clarification about is
6 a statement made my Mr. Rothstein in his
7 opening argument. It's my understanding that
8 the Department made settlement offers in this
9 case to you, even before the IRC.
10 **MR. ROTHSTEIN:** Your Honor, I object to the
11 discussion of settlement offers. I think the
12 rule specifically prohibits discussion of
13 settlement offers.
14 **MR. WICEVIC:** The fact that an offer is made, I
15 think we're not talking about statements
16 concerning liability. We're talking about
17 whether a settlement offer was made. I believe
18 that's what the rule of evidence says.
19 Statements admitting to liability would be
20 inadmissable. The fact that settlement offers
21 were made is a different matter. He said
22 during his opening argument, the Department
23 want's revokation from the beginning. I do not
24 believe that was the case.
25 **THE COURT:** Okay. But is opening statement is not

1 evidence in this case. And the Department has
2 the burden of proof. So I don't see the
3 relevance of talking about settlement offers.
4 **MR. WICEVIC:** Fair enough.
5 **THE COURT:** Okay. Thank you.
6 **MR. WICEVIC:** Beg The Court's indulgence.
7 Q: I think that's all I have for you. Thank you,
8 Mr. Davenport.
9 **MR. ROTHSTEIN:** Your Honor, I would like to defer my
10 questioning of Mr. Davenport for my defense
11 case in Chief. I do want to raise a
12 housekeeping matter.
13 **THE COURT:** Okay.
14 **MR. ROTHSTEIN:** I know he's on the stand and under
15 oath. I feel like Mr. Wicevic called him when
16 he called him today for strategic purposes to
17 try and prevent me from consulting with my
18 client throughout the rest of the trial. I
19 mean, if I don't call Mr. Davenport until my
20 last witness in the case for example -- I mean
21 I need to have the ability to talk to him about
22 the strategies of the trial. And I want some
23 guidance from The Court. I don't want to go
24 run afoul. I certainly -- I think I'm entitled
25 to help further prepare Mr. Davenport for his

1 direct testimony in our case. I don't want to
2 run afoul of the rule of once he's under oath,
3 I can't talk with him.
4 **THE COURT:** Right.
5 **MR. ROTHSTEIN:** Understand?
6 **THE COURT:** Now when you're saying preparing him for
7 the rest of the trial and discussing the
8 strategy, are we talking about the additional
9 witnesses you're going to be calling, or
10 specifically talking about preparing him for
11 his cross-examination when he testifies?
12 **MR. ROTHSTEIN:** Well, Your Honor, we're planning to
13 meet with our expert witnesses further, say
14 like I think they're coming in Tuesday night --
15 -
16 **THE COURT:** Uh-huh.
17 **MR. ROTHSTEIN:** --- and I think it's important for
18 Mr. Davenport to be part of that discussion.
19 And I don't want to run afoul of any rule that
20 says, you know, once he's under oath and
21 testified that I can't further discuss his
22 testimony. I mean the fact that Mr. Wicevic
23 chose to call Mr. Davenport sort of as an
24 adverse witness shouldn't preclude me from
25 preparing the rest of the case with Mr.

1 Davenport's input.
2 **THE COURT:** I understand, and I think that would --
3 Mr. Wicevic, do you have any comment?
4 **MR. WICEVIC:** Your Honor, I think this is a fine
5 line too because Mr. Davenport, I'm sure, has
6 some points to make with the experts and their
7 testimony. We just ask that the substance of
8 the discussions try to avoid his testimony that
9 was offered during direct. Other than that, I
10 understand Mr. Rothstein's dilemma.
11 **THE COURT:** Mr. Rothstein, you appear to be a very
12 ethical attorney, so I'm sure that you would
13 not get into Mr. Davenport's testimony today.
14 But just prepare for your case going forward
15 without extensively -- getting extensively into
16 his testimony here.
17 **MR. ROTHSTEIN:** I think I can do that, Your Honor.
18 It's a little tricky.
19 **THE COURT:** I know that's going to be tricky. I
20 know that. I know. Mr. Wicevic ---
21 **MR. WICEVIC:** I understand.
22 **THE COURT:** --- you've given us a little dilemma
23 here. But, Mr. Rothstein, I think you're very
24 well familiar with the rules and whatnot, and
25 what's allowed and what is not. And like I

said, you appear to be an ethical lawyer, so ...

MR. ROTHSTEIN: I appreciate that, Your Honor.

THE COURT: So I'm not going to prohibit Mr. Davenport from participating in any discussions about your strategies.

MR. ROTHSTEIN: Thank you very much.

THE COURT: Okay. Thank you. Okay. And I am going to adjourn the hearing for today. And we will reconvene at 10:00 o'clock tomorrow morning.

(Whereupon, the hearing adjourned at 5:41 p.m. and was reconvened on Tuesday, July, 25, 2017 at 12:57 p.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

****

Tuesday, July 25, 2017
12:57 p.m. - 6:15 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 25th day of July, 2017 before Travis McLeod, Court Reporter and Notary Public in and for the State of South Carolina.

APPEARANCES

Vito M. Wicevic, Esquire
DHEC Office of General Counsel
2600 Bull Street
Columbia, South Carolina 29201
Attorney for the Petitioner

Ashley C. Biggers, Esquire
DHEC Chief Counsel for Health Regulation
2600 Bull Street
Columbia, South Carolina 29201
Attorney for the Petitioner

David E. Rothstein, Esquire
Rothstein Law Firm, P.A.
1312 Augusta Street
Greenville, South Carolina 29605
Attorney for the Respondent

Also Present:
Tia Hazel, Law Clerk

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EXHIBITS

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

(No Exhibits Were Marked or Admitted During the Hearing.)

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.

1 **THE COURT:** Okay. If we're ready, we can start.
2 Mr. Wicevic, you can call your next witness.
3 **MR. WICEVIC:** Yes, Your Honor. The Department would
4 like to call Keith Eudy.
5 **THE COURT:** What's that last name?
6 **MR. WICEVIC:** Eudy.
7 **THE COURT:** Eudy?
8 **MR. WICEVIC:** Yes.
9 **THE COURT:** Okay. Mr. Eudy, if you'll face the
10 court reporter, raise your right hand, he will
11 swear you.
12 **WAYNE KEITH EUDY**, having been duly sworn, testifies
13 as follows:
14 **MR. EUDY - DIRECT EXAMINATION BY MR. WICEVIC:**
15 Q: All right. Good afternoon, Mr. Eudy. We've
16 spoken over the phone once or twice. My name's
17 Vito Wicevic. I represent DHEC in this
18 contested case hearing. Can you please state
19 your full name for the record please?
20 A: Wayne Keith Eudy.
21 Q: And is Eudy an unusual spelling?
22 A: E-U-D-Y.
23 Q: Okay. Let's start off with some background.
24 Education, when did you graduate from high
25 school?

1 A: In '87.
2 Q: Okay. Where at?
3 A: From Hillcrest High School ---
4 Q: Okay.
5 A: --- in Simpsonville.
6 Q: And from there what did you do as far as
7 education?
8 A: I went to Greenville Tech and went through the
9 paramedic program there.
10 Q: Okay. Did you work your way up beginning with
11 EMT?
12 A: Uh-huh. Started off as a basic EMT.
13 Q: When did you get your EMT certificate or
14 graduate from Greenville Tech?
15 A: I never did fully graduate from Greenville
16 Tech. I got married before I finished up the
17 degree program. But I did earn my certificate,
18 I think in 1991. '91, '92.
19 Q: Was that your paramedic?
20 A: My paramedic, uh-huh.
21 Q: Speaking toward the EMT, the basic, when did
22 you get that certificate?
23 A: Would probably have been around '88, '89.
24 Q: Okay. Did you go straight to paramedic from
25 your basic level?

1 A: Uh-huh. We do basic EMT, and then you do
2 classes for intermediate EMT. I think it's
3 called advanced EMT now. And then you go into
4 your paramedic, and you increase in your skills
5 level and knowledge level and training.
6 Q: Okay. So basic '88, paramedic '93, when was
7 the intermediate?
8 A: It would have been around '90, '91.
9 Q: Okay. And you mentioned you worked on, is it
10 an associate's degree?
11 A: Uh-huh. I was in the associate degree program
12 at Greenville Tech.
13 Q: Okay. So never completed it.
14 A: I never did complete it, no.
15 Q: Okay. Well your experience in the EMS field,
16 can you, I guess explain from your initial
17 employment as an EMT?
18 A: I started off with Greenville County EMS. I
19 was a reserve EMT there as I got my EMT.
20 Q: What's a reserve EMT?
21 A: Reserve? You go through your skills and all
22 with a senior paramedic there, and you earn
23 your second man status. So you can actually
24 work. Back then it was kind of like a part
25 time but we didn't get paid. We were like a

1 reserve status, so we could ride as a second
2 person and fill in. I then went on, as I got
3 my intermediate, and became part time. Worked
4 part time as I went to school and did clinicals
5 and such through school.
6 Q: Is this still with Greenville County?
7 A: Still with Greenville County. Yes, sir.
8 Q: Okay. And then where did you go?
9 A: And stayed with Greenville County as I got my
10 paramedic and stayed part time. After I got my
11 paramedic certification I went full time with
12 the Greenville hospital system. They had a
13 full time opening there for a paramedic and I
14 went there. And that was a inner-facility, a
15 hospital based ambulance service.
16 Q: Okay.
17 A: And worked there.
18 Q: So was the ambulance service owned by the
19 hospital?
20 A: Correct.
21 Q: Okay. How long did you work there?
22 A: I worked there 10 or 11 years. With that I had
23 worked up, was a field medic, critical care
24 medic, and then went on and actually became a
25 supervisor, and was interim Director there for

1 a two years before I left.
2 Q: Did you have any other part time employments
3 during that time period?
4 A: About '95, '96 I went back to Greenville County
5 as a part time paramedic. Worked there for two
6 or three years, and then as I got the, I guess,
7 promotion I got put in as interim Director with
8 mobile care when the Director left. I did
9 that, I had to leave my employment with part
10 time Greenville County because my time needed
11 to be dedicated to mobile care, to that
12 service.
13 Q: Okay. And then from mobile care, did you --
14 where did you go from that?
15 A: From mobile care, I missed the patient care, so
16 I went back to the field. Actually was -- when
17 I left there I went to Medshore ambulance
18 service which is a private service in Anderson.
19 Was there for about years as their operations
20 manager for the Greenville Division. And
21 that's a private service that does inner-
22 facility transports and such, nursing home
23 contracts, and things of the non-emergent
24 nature. I was actually approached by the human
25 resources Director at Greenville County EMS

1 after about a year and a half, two years. I
2 had met up with her at a conference and she
3 asked me if I would like to come back to EMS,
4 and so I was still doing some patient care with
5 the private service with Med Shore, but not a
6 lot. So I looked into it and went back to
7 Greenville County and then I've been there ever
8 since.
9 Q: Okay. So what's your current role with
10 Greenville County?
11 A: My current role is I'm a shift supervisor with
12 Greenville County.
13 Q: Does that mean you're still in the field?
14 A: I do. I do run like, it's called back up, a
15 code 5. I do an ALS back up for crews. I do
16 first response if there's not an ambulance
17 that's close available. So I still do in the
18 field calls.
19 Q: Okay. Tell The Court your involvement with
20 Anderson County.
21 A: Anderson County, I am a part time paramedic
22 there. I had originally started, I was working
23 on the QRV's, or the single QRV when it started
24 out.
25 Q: Can you explain what QRV is?

1 A: I'm sorry. A quick response vehicle. It's a
2 one man vehicle that has your ALS gear on it,
3 that would run as a first response until the
4 ambulance could make it to the scene. It's to
5 help cut down on your response times to the
6 patients. So ...
7 Q: So you mean the QRV does not transport
8 patients?
9 A: It does not.
10 Q: Okay.
11 A: It would hand off patient care to the incoming
12 ambulance crew.
13 Q: Okay. Any other duties with Anderson County
14 EMS?
15 A: I did. I had originally helped do the QA, QI
16 process with the paperwork, where I would
17 review all the calls as the crews would write
18 them, check for documentation errors, make sure
19 everything was compliant, make sure things were
20 compliant with the protocols and such. And
21 there were like the rapid sequence innovation,
22 which is an advanced airway type procedure.
23 There was 100 percent QA that was performed on
24 those, so we would always have to QA those to
25 send into the Medical Control Physician. And

1 when they did the County wide QA meetings.
2 Q: Okay. We'll get into that some more. Can you
3 explain to The Court your relationship to Scott
4 Stoller?
5 A: Yes. Scott Stoller, he is the Director of
6 Anderson County EMS and Special Operations. He
7 is also a close friend. We've known each other
8 for, oh goodness, quite a long time. Probably
9 20, 25 years since he moved down. He
10 originally was working for Greenville County
11 EMS, so we were partners on occasions there.
12 And like I said he's a friend of the family.
13 Q: Okay. What about your relationship with Arnold
14 Alier?
15 A: Arnold is -- he worked for Greenville County
16 EMS. We were partners a couple times since I
17 was part time. He was also our training
18 Director for many years there at Greenville
19 County before he left and went to other
20 endeavors for him.
21 Q: Okay. Anything outside of work related ---
22 A: No. Nothing outside of work.
23 Q: What about Mr. Wronski, Rob Wronski?
24 A: I've met him a couple times at a seminar and at
25 a conference.

1 Q: Okay. What about Mr. Davenport?
2 A: I haven't met him before. I think we may have
3 possibly bumped into each other at the office
4 there at Anderson if I come down. But as far
5 as any personal relationship, I've never had
6 the opportunity to get to know him.
7 Q: Okay. And then finally, Mr. Dean Douglas. Do
8 you have any relationship with him?
9 A: Yes. Dean Douglas also worked for Greenville
10 County EMS. He actually was -- when I got into
11 EMS, he was on the volunteer fire department
12 that I was volunteering with, and we were doing
13 medical responses. At that point I had just
14 gotten my first responder, which is a
15 certification like a first aid certification
16 that's lower than what DHEC actually oversaw.
17 So we were doing patient care, and he put his
18 hand on my shoulder on a call and said, you'd
19 do pretty good as a paramedic. You ought to
20 think about going to school.
21 Q: Uh-huh.
22 A: And so did. I rode with him a couple of times
23 as a reservist. And as I was starting in the
24 EMT program, and like I said, I don't think we
25 were ever partners at EMS. He was a supervisor

1 at the time once I started working. So it was
2 the work relationship there.
3 Q: Did you have any idea that Mr. Douglas was
4 involved with this matter?
5 A: I didn't until he sat down beside me this
6 morning.
7 Q: Okay. All right. Well getting back to your QA
8 responsibilities with Anderson County, was this
9 like a part time or as needed, or was it a full
10 time QA?
11 A: Well the way we worked it is the call volume
12 was not a lot, so about every week or two I
13 would go and look at the calls and would QA
14 them, make sure everything was okay there. And
15 the only other thing that I did do was if there
16 was a concern or a complaint that was call
17 related, Scott would ask me to look into the
18 call, do a call review on it. Look and make
19 sure that it followed protocols, standard
20 practice, and also like the documentation was
21 good, if documentation was wrong or such.
22 Q: Now I understand that each of the individual
23 squads or services under the Anderson County
24 umbrella, they each have like QI or QA
25 officer.

1 A: Yes, sir. Each individual department has their
2 QA person that would look at things and such
3 for their department --
4 Q: Okay.
5 A: --- internally.
6 Q: Were you considered the QA officer for
7 Anderson?
8 A: I guess you could say.
9 Q: Yeah. Was there anybody else?
10 A: Every now and then if I couldn't get to
11 something, or if there was something that if I
12 was out of town or something, then Scott may
13 have another paramedic ---
14 Q: Okay.
15 A: --- perform something. But I don't recall.
16 Q: How would you review a case?
17 A: I would be sent the PCR, the documentation that
18 the paramedic or EMT fills out on the patient
19 care, it's a patient care report. I would be
20 sent a copy of it. If there were any crew
21 statements, then I would possibly get sent
22 those as well. What I would do is read the
23 report, look at the documentation, compare it
24 to our protocols, and see if anything deviated,
25 if anything was missed, if anything was done

1 incorrectly. Then I would just write up a
2 short summary, and then would send it back to
3 Scott.
4 Q: Okay. Did you have previous experience doing
5 these case reviews?
6 A: Yes. As part of my job, full time with
7 Greenville County EMS as a supervisor. I was
8 assistant supervisor prior to becoming the sift
9 supervisor for about eight or nine years. So
10 part of our job is doing complaint
11 investigations on our shift employees. So that
12 is something that I routinely would do as part
13 of my full time job is do case reviews and
14 complaints from either outside agencies, a
15 patient or a patient's family or such. And
16 then we were assigned those, would do the
17 complete call review and everything with that,
18 the whole investigation, submit our findings,
19 and recommendations to our supervisor who then
20 would overlook it and then send it up to the
21 complaint review board.
22 Q: All right. Well I have a document. I would
23 like you to take a look at it.
24 A: Okay.
25 **MR. WICEVIC:** Can we mark this? I guess this would

1 be Exhibit 26. And, Your Honor, this is in the
2 proposed exhibit binder, we have this marked as
3 Exhibit 4. But in the pre-hearing motion
4 argument, we talked about this case and this
5 particular exhibit. And had the last two chart
6 reviews redacted based upon our position that
7 they're irrelevant. And you asked that the
8 Department unredact those. Again, the
9 Department maintains that the latter two chart
10 reviews are not relevant to this proceeding.
11 We only plan to elicit testimony from Mr. Eudy
12 concerning chart one. Just mentioning that for
13 clarification on the record.
14 Q: Mr. Eudy, can you identify this document?
15 A: Yes. This is the summary that I performed on
16 the call review for that call.
17 Q: Okay. And is it the document you created?
18 A: Yes, it is.
19 Q: In response to what?
20 A: To the -- a complaint or a concern had come in
21 to Scott in regards to this call, and he had
22 asked me to do a case review on it, and submit
23 my findings to him.
24 Q: Do you recall when you created it, did your
25 review?

1 A: I'm sorry?
2 Q: Do you recall when you did your review?
3 A: I don't have the exact date that I dated the
4 review on, but I think it was a couple of days,
5 possibly maybe within that week of the actual
6 call. I don't recall.
7 Q: Okay. Fair enough. Focusing on chart one
8 regarding the 3/19/2016 stabbing injury.
9 A: Uh-huh.
10 Q: What information did you have to review this
11 particular call?
12 A: I know I would have had a PCR, the patient care
13 report. I'm not sure if there were a crew
14 statement provided to me or not.
15 Q: Well let me hand you the DHEC proposed trial
16 exhibit binder. And can you turn to tab 11b
17 please? B as in boy.
18 A: Okay.
19 Q: Was that the patient care report that you
20 reviewed?
21 A: Yes. It appears to be the chart.
22 Q: Okay. And you might want to -- they have
23 incident numbers ---
24 A: Yeah.
25 Q: --- at the top.

1 A: It correlates with what I have down as the
2 incident number.
3 Q: Okay. So your review consisted of this patient
4 care report ---
5 A: Yes.
6 Q: --- and you said perhaps other statements?
7 A: I don't recall if a crew statement was provided
8 to me or not.
9 Q: Can you turn to Exhibit 4 please?
10 A: Exhibit 4?
11 Q: Yes, sir. Do you recognize Exhibit 4?
12 A: I believe it was. Let me look at the PCR
13 narrative. Yes. I was. I did have that to
14 look at.
15 Q: Okay. Well what were the findings of your
16 review?
17 A: As I documented, my concerns with it were that
18 even though, in summary, even though the
19 patient appeared to be hemodynamically stable,
20 which the vital signs and such were within a
21 normal limit. The penetrating trauma that was
22 with the knife still being in place in the
23 patient's torso, with it secured and such,
24 we're taught to consider what's inside the
25 body, what vital organs are there. So with

1 that being in place in an area that you have
2 vital organs, great vessels, blood vessels and
3 such that could be damaged, with it in place
4 you have the luck that if there's any bleeding,
5 then it's going to kind of be tamponaded off
6 because it's not going to be removed to open up
7 that void that's been made by the knife
8 sticking in. So that's why, as it says in
9 here, she secured stabilized the knife end that
10 was sticking out. With that, also the patient
11 had been sitting, and as they -- you have to
12 worry about in a standing up procedure of
13 moving, that that's going to move around, and
14 you have the possibility of creating further
15 damage. So you have to very carful with that.
16 With the possibilities of that, it should
17 warrant advanced care, ALS. The only proper
18 and definitive treatment for best outcomes is
19 going to be surgery more than likely. So and
20 advanced paramedic should be riding with the
21 call. There should have been different things
22 with the IV. No IV was attempted, a heart
23 monitor was not placed. It was unclear based
24 on the documentation and the report, at what
25 angle and what manner, what type of force could

1 have been given to the injury as he attempted
2 to harm himself. So there could be cardiac
3 involvement with that. So the lung sounds, you
4 have your lungs there, they didn't appear to
5 have been assessed, so he could have possibly
6 had an airway issue there as well. So it was
7 evident to me in my training and experience
8 that this patient did warrant ALS procedures
9 and care, and it was given to a basic EMT, or
10 EMT. I'm not sure if she was a basic or
11 intermediate, but was given to a lower trained
12 person to provide the patient care.
13 Q: And you can check 11-b for her certification.
14 A: Yeah. EMT basic.
15 Q: Any other concerns about your review of this,
16 I think it's patient care report and statement?
17 A: The only thing that I see, and I do not see
18 that I mentioned it in the actual review, but
19 where the EMT asked him about running the call,
20 and I'm not sure if the call was for her, but
21 he thought that he should run it. And then he
22 stated that it was a basic life support call,
23 and it would be fine. So, she in that
24 evidently saw the need for ALS as well, and
25 mentioned it, but then Mr. Davenport told her

1 she would be fine, that the patient was stable
2 and she could run it.
3 Q: Okay. After you completed your review, what
4 did you do?
5 A: I typed up the review here and sent it to Mr.
6 Stoller.
7 Q: Okay. Any follow up involvement with this
8 matter?
9 A: Huh-uh.
10 Q: No?
11 A: No.
12 Q: That's all the questions I have for you.
13 Please answer any questions Mr. Rothstein has.
14 **THE COURT:** Mr. Rothstein.
15 **MR. EUDY - CROSS-EXAMINATION BY MR. ROTHSTEIN:**
16 Q: I'm a little confused, Mr. Eudy. I think you
17 testified and used the word she when you were
18 talking about who stabilized the knife. Is it
19 your impression that Ms. Aiken was the one that
20 taped the knife in place?
21 A: I would have to read and see exactly who had
22 performed that.
23 Q: Did I misunderstand your recent testimony. I
24 think you said she stabilized the knife.
25 A: I think I did say she, she stabilized it.

1 Q: So your understanding was that Ms. Aiken
2 stabilized the knife in place, is that right?
3 A: In her statement here, it states that Mr.
4 Davenport held the bandages to the knife and
5 she placed the tape around the bandages. So,
6 yes they both performed the stabilization of
7 the knife.
8 Q: Did you ever see the body camera video in this
9 -- for this patient care encounter?
10 A: I have not.
11 Q: Let me ask you to look at that Exhibit 26 that
12 Mr. Wicevic just handed you. The title of that
13 document, it says Chart Review PM Davenport Iva
14 Rescue Squad. You see that?
15 A: Huh-uh.
16 Q: Okay. In this particular chart review of the
17 call, the lead technician on that call, at
18 least according to the chart was Ms. Aiken,
19 isn't that right?
20 A: Yes.
21 Q: Okay. So why does the title of your chart
22 review of stabbing patient or chart review of
23 Kim Aiken?
24 A: The concern was that this should have been an
25 ALS call, and paramedic Davenport should have

1 been the primary care provider. So what I had
2 -- it's just something for me to be able to
3 recall who was involved and what service it was
4 involved with. I don't know very many with
5 Anderson County and any of the squads. And
6 that's part of the reason that Mr. Stoller has
7 asked me to do chart reviews is I'm a neutral
8 party, I don't know anyone, don't have
9 friendships with anyone down in that area that
10 would cause me to be biased one way or the
11 other. And being that it should have been ALS
12 and such, that's what I titled it with looking
13 at paramedic Davenport as being the paramedic
14 on the truck.
15 Q: Now, when was the first time you spoke to
16 anyone about DHEC about this particular chart
17 review that you did?
18 A: I would have to go back and look at an email.
19 It's been within probably the last couple of
20 weeks or so.
21 Q: Who at DHEC have you talked to about the chart
22 review?
23 A: Mr. Wicevic.
24 Q: The lawyer?
25 A: Yes, sir.

1 Q: Anyone else at DHEC ever talk to you about the
2 chart review?
3 A: Huh-uh.
4 Q: So you never talked to the Investigator Naugler
5 about the chart review?
6 A: No, I haven't.
7 Q: Never spoke with Mr. Wronski about the chart
8 review?
9 A: Huh-uh.
10 Q: You've never spoken to Dr. Alier about the
11 chart review?
12 A: Huh-uh.
13 Q: Had anyone from the investigative review
14 committee ever call you or ask you about the
15 chart review?
16 A: No, sir.
17 Q: When did Scott Stoller actually assign this
18 chart review to you?
19 A: I don't know. I don't have the actual date
20 that I performed the chart review on here.
21 Q: Okay. And tell me, if you can, what he said to
22 you when he said, hey I want you to do this
23 chart review on Mr. Davenport.
24 A: I don't recall the specific words used. I know
25 a lot of times he'll give me a call, and he'll

1 tell me, I'm going to email you a call. I need
2 you to look at it and do a review on it. And
3 that's usually it. And then I get the email
4 from him with the patient care report. And
5 then I perform the chart review.
6 Q: Okay. So when he gave you these three charts
7 to look at right, and said we have concern
8 about Mr. Davenport not recognizing when
9 something's an ALS call or a BLS call. Can you
10 review that for us?
11 A: Yes.
12 Q: Okay. So he told you what the concern was and
13 asked you to sort of validate that, is that
14 right?
15 A: Well, he had sent me the stabbing call first,
16 and he said -- I think he said there was
17 another call recently that had been concerned
18 that he wanted me to look to see if there was
19 a trend. But, like I said, I don't recall
20 exactly the words for it. And in the past
21 there has been some that I've reviewed that he
22 said, okay this is the last call that this
23 medic or this EMT has performed that had
24 concerned too. See if you see a trend.
25 Q: Okay. Be he only provided you three calls, he

1 cherry picked the three calls right, and
2 provided them to you. He didn't give you of
3 like a random sample of Mr. Davenport's calls
4 and say, can you discern a pattern from these
5 last three weeks of calls or something like
6 that.
7 A: I don't know how he chose them. He just gave
8 me those three. Those two were within a month
9 or so.
10 Q: Did he tell you there was some sort of urgency
11 in getting the chart review done?
12 A: Huh-uh.
13 Q: I noticed there's not date on the chart review.
14 Do you know how long it took you to complete
15 the chart review and send it back to Mr.
16 Stoller?
17 A: I don't. Usually chart reviews with looking at
18 things and based off of my personal schedule
19 and my work schedule, when I have time to
20 dedicate the time to them can be anywhere from
21 a couple hours to four, five, six hours.
22 Q: Can you tell the Judge what the normal purpose
23 of a QA or a chart review is in EMS? I know
24 you've been around EMS for a while. What's the
25 normal reason for doing a chart review or a QA

1 review?
2 A: QA review is for quality assurance and QI is
3 for quality improvement. You look at a call.
4 For my full time service we have corporals who
5 perform, they get a random selection based off
6 of our electronic patient care reporting
7 software. It can pull random calls for our
8 shift, and they'll go through and review the
9 call. Basically the same way that I perform a
10 case review. We look at the patient care, we
11 look at response times, we look at protocols,
12 their standard of care, and such. And if we
13 find any deviations or any concerns then we can
14 address it with the crew to educate them, help
15 them to learn. If there's any remediation that
16 needs to be involved or if it's something
17 that's significant then we can do corrective
18 measures, give them some extra training or help
19 to hopefully that it wouldn't happen again in
20 the future.
21 Q: Okay. To summarize, I think you used the
22 phrase educate the crew. One of the underlying
23 purposes of QA is to identify potential
24 problems and educate the crew on how to do
25 things better. Is that right?

1 A: Yes, sir.
2 Q: And typically that involves a regular meeting
3 of a QA committee, or in Anderson I think they
4 do -- I think they meet every other month to
5 talk about QA issues. Is that right?
6 A: I believe so.
7 Q: Okay. This wasn't part of that normal QA
8 process at Anderson County though, was it?
9 A: No, sir. This was a case review that was based
10 off of a complaint or a concern that come in
11 from an outside party to Mr. Stoller, I guess.
12 Q: And I noticed you didn't mention Dr. Kickham,
13 the Medical Control Physician at Anderson. You
14 never discussed this chart review with Dr.
15 Kickham did you?
16 A: No, sir.
17 Q: Okay. And if this were an educational purpose,
18 you never talked to Mr. Davenport or Ms. Aiken
19 about what your chart review findings were, did
20 you?
21 A: No, sir.
22 Q: Is it proper for an EMS Director to use a chart
23 review like this sort of as a hatchet job to
24 get rid of a paramedic or to discipline a
25 paramedic in your opinion?

1 A: No, sir.
2 **MR. WICEVIC:** Your Honor, I'm going to object. This
3 is getting to the employment issue that we
4 discussed at the pre-hearing -- the pre-motion
5 hearing, or the hearing motion, excuse me.
6 This doesn't relate to this matter. And it's
7 assuming facts that are not in evidence.
8 **THE COURT:** What's the purpose of the questions?
9 **MR. ROTHSTEIN:** My purpose is to show, Your Honor,
10 this is completely outside the normal QA
11 process at Anderson County. And I believe that
12 supports the theory that there's an underlying
13 improper purpose for the chart review.
14 **THE COURT:** I'm going to let him ask that question,
15 and let's see what his response is.
16 **MR. WICEVIC:** Yes, Your Honor.
17 **THE COURT:** And whether we're going to go down this
18 line of questioning.
19 Q: You agree this was not part of the normal
20 Anderson County QA process, isn't that right?
21 A: I'm not sure. The only thing that I would do,
22 like I said, I QA'd for the Anderson County
23 special operations, the QRV, and I submitted --
24 I have a form that I submitted with the types
25 of calls that we ran, the ALS, BLS, advanced

1 procedures and such. I would submit them to
2 Scott, and he would carry them to the monthly,
3 bi-monthly -- I don't know what actually the
4 schedule was. I thought it was monthly back
5 when I was ---
6 Q: Mr. Eudy, these three calls didn't involve the
7 QRV in Anderson County did they?
8 A: Correct. But what I'm saying is as part of my
9 job for Anderson County special operations, I
10 perform that QA. And as I mentioned a while
11 ago, whenever there is a concern that comes in,
12 Mr. Stoller's position is a liaison or a person
13 that has to oversee all of the squads within
14 Anderson County. There are nine different
15 squads ---
16 **MR. ROTHSTEIN:** Your Honor, I don't think this is a
17 response to my question. My question was, this
18 did not involve the Anderson County QRV where
19 he performs normal chart reviews.
20 A: But if I understand what he's trying to get at
21 as far as the QA process, it is because when
22 Mr. Stoller receives a complaint or a concern
23 that involves one of the other squads within
24 the County, then he has asked me, as I said, as
25 a neutral unbiased person, to perform a chart

1 review that I send to him that he uses within
2 his investigation and such with review with the
3 Med. Control Dr. Kickham. Then that's the
4 process that he follows there.
5 Q: Mr. Eudy, doesn't ---
6 **MR. WICEVIC:** Your Honor, can he finish his answer?
7 **THE COURT:** Yes. He can.
8 **MR. ROTHSTEIN:** I'm sorry.
9 A: So with that process, to my knowledge each
10 individual agency has their QI, QA person. And
11 they all come to a meeting with Mr. Kickham and
12 Mr. Stoller to give their information of how
13 many calls they run, QA'd problems that are
14 identified or such. That is the QA process as
15 in your basic quality assurance quality
16 improvement for the County. What I have
17 performed here is something -- I don't know how
18 to state it, but this is something that is more
19 of an investigative measure that he still has
20 the obligation to perform to be able to answer
21 up complaints and concerns that come from
22 outside agencies, whether it's a patient --
23 just like my full time job. If you have a
24 complaint or a concern that comes in, then that
25 is his process. He has to gather all

1 information to be able to put together to be
2 able to come to a conclusion of what has
3 happened and what would be the best outcome or
4 the following measures to take in regards to
5 that complaint. My part in that process is
6 basically he sends me the patient care report,
7 I review it and submit it back to him. And
8 then he does his investigation with them. I'm
9 just part of a piece -- a tool that he utilizes
10 when he has to look at the whole situation.
11 Q: So, you don't know what Mr. Stoller was
12 thinking when he sent you the chart review,
13 right?
14 A: No.
15 Q: Okay. And do you know who the QA or QI officer
16 for the Iva Rescue Squad has been for the last
17 maybe 12 or 15 years?
18 A: I don't.
19 Q: And you didn't speak to that person, Craig
20 Lawless?
21 A: No, sir.
22 Q: You know who Craig Lawless is?
23 A: I've heard the name. I believe he worked as a
24 dispatcher for us many many years ago at EMS.
25 Q: Okay. Did you ever see him at the bi-monthly

1 chart review meetings in Anderson County or QA
2 review meetings?
3 A: No. I only attended one of those, and that was
4 in the absence of Scott.
5 Q: How were you compensated to perform this chart
6 review that you did for Mr. Stoller?
7 **MR. WICEVIC:** Your Honor, I'm going to object. This
8 is getting way off the subject. His
9 compensation? I don't see how that relates to
10 the allegations of the Department.
11 **THE COURT:** I'm going to allow the question. Go on
12 Mr. Rothstein.
13 A: If he asked me to do a chart review or when I
14 do the monthly chart reviews, whatever time I
15 start and whatever time finish, I send it to
16 him with my time for that.
17 Q: Now are you actually on the payroll for
18 Anderson County?
19 A: Yeah, 'cause I get paid. I'm not salary or
20 anything. No, sir. I get paid by the hours
21 that I would actually work.
22 Q: Okay. So you actually submit the time sheet
23 for the hours you work and then your pay varies
24 from paycheck to paycheck or payroll period to
25 payroll period?

1 A: It would.
2 Q: You don't get a set amount of money from
3 Anderson County every two weeks?
4 A: No, sir.
5 Q: Okay. Now I noticed in your chart review, you
6 didn't site to any specific Anderson County
7 protocols that you alleged or you believe were
8 violated here. Did you actually go through the
9 Anderson County protocols as you were
10 evaluating these three charts?
11 A: Yes. I would have.
12 Q: Okay. Why didn't you say, you know, this is a
13 violation of protocol one or policy x, y, and
14 z? You don't identify a single protocol in
15 there, do you?
16 A: I do not. But it is -- I mean we use Anderson
17 County protocol is what he would have had to
18 have followed. So it's, I guess, assumed that
19 that's the protocol. All the protocols for
20 Anderson County would be what I base my
21 decisions off of when looking at the reviews.
22 I just didn't actually put in the actual
23 protocol numbers or each individual protocol
24 title with this.
25 Q: Are you familiar with the Anderson County

1 protocols that existed at the time of this
2 incident in March of 2016?
3 A: I was.
4 Q: Is that notebook up there?
5 A: This notebook?
6 Q: Yeah. That's it. If you'll look at Exhibit 1.
7 Let me ask you this. At the time you looked at
8 the chart review, did Anderson County have a
9 specific protocol for penetrating abdominal
10 trauma?
11 A: I don't recall right now. I'll have to look
12 through and see.
13 Q: Okay. Which protocol did you use in evaluating
14 the stabbing case?
15 A: Anything that would relate to trauma, advanced
16 procedures.
17 Q: You know which specific protocol you used in
18 this chart review?
19 A: Let me look and see.
20 Q: Mr. Eudy, did you actually have the book in
21 front of you, or did you go from your memory?
22 A: No. I have a copy of the protocols that I go
23 to. Just looking at it through here, transport
24 policy 21 I would probably have referenced that
25 to see about emergent or non-emergent

1 transport.
2 Q: I noticed in your writeup you indicated that
3 this patient was hemodynamically stable, right.
4 In your first paragraph?
5 A: Correct. I did.
6 Q: Okay. What does that mean, that he patient was
7 hemodynamically stable?
8 A: The patient's vital signs, your blood pressure,
9 your pulse rate, your respiratory rate, your
10 main things that we use as a tool to gage
11 severity of the patient, they were within a
12 stable range.
13 Q: Okay. Now one of the things you sort of dinged
14 Mr. Davenport in this case -- I'm going to
15 direct you to item three on the first page of
16 your chart review. You indicated that there
17 was a problem that Mr. Davenport did not -- it
18 says no oxygen is applied, is that right?
19 A: Correct.
20 Q: In fact you mention oxygen in every one of
21 these chart reviews, right?
22 A: Correct.
23 Q: Mr. Davenport did not administer oxygen. As a
24 paramedic, are you trained to recognize
25 respiratory distress in patients?

1 A: We are.
2 Q: Okay. What are the signs of respiratory
3 distress in your education, experience, and
4 training?
5 A: It can be anything from the patient telling you
6 they're short of breath, we have what's called
7 a pulse oximetry tool. It's a finger probe
8 that we can look and it does checks the
9 hemoglobin within the bloodstream, and can tell
10 the oxygen concentration. We have a number
11 range that's given out by that. Your patient's
12 skin, lung sounds, there are many things. The
13 patient, the way they're sitting, the way they
14 present, if they're anxious or such can give
15 you levels and degrees of a respiratory
16 problem.
17 Q: If a patient is not having respiratory
18 distress, do they need supplemental oxygen?
19 A: Not necessarily. But based off of what injury
20 or illness is occurring, then it may progress.
21 So any ALS call that we learn we do O2,
22 monitor, and IV. And it's something that we
23 want to have in place. With oxygen, it's also
24 a basic procedure, so doesn't have to
25 necessarily be a paramedic that would monitor

1 that.
2 Q: Okay. You used that phrase O2, IV, and
3 monitor. Is that sort of a mantra you learned
4 in paramedic school?
5 A: Uh-huh. They teach that.
6 Q: And that means that pretty much every patient
7 you respond on emergent calls should get
8 supplemental oxygen, should get an IV started,
9 and should be hooked up to a heart monitor, is
10 that right?
11 A: No. Not every patient. Your advanced
12 patients, your patients that would require
13 advanced procedures, ALS care.
14 Q: If a patient is hemodynamically stable, do they
15 need supplemental oxygen?
16 A: They may not at one point, but within your time
17 frame that you're with the patient they could.
18 Q: Okay. So you like to err on the side of
19 caution, sort of over treating the patient, is
20 that fair to say?
21 A: Correct, on the patient care side.
22 Q: Okay. Do you know what the O2 saturation for
23 the stabbing patient was during the -- or at
24 least as indicated in the patient care report?
25 A: It's documented here as 98 percent.

1 Q: That was the first reading. What was the
2 second reading?
3 A: Looks like it's 99.
4 Q: Okay. Are the respiratory rates within normal
5 limits on this patient?
6 A: Yes.
7 Q: Okay. So back to that oxygen saturation, what
8 do the guidelines in the protocols for when you
9 administer supplemental oxygen with a patient?
10 A: I'd have to look and see what the Anderson
11 County protocol would be. Personally, a
12 patient that has a penetrating trauma is an
13 advanced call, so that should warrant advanced
14 treatment, which should warrant supplemental
15 oxygen. The knife in itself where it was
16 penetrating in the upper abdomen torso area,
17 you have the possibility for the involvement of
18 your lungs. Now if it shows up immediately or
19 if is shows up later on, there's still going to
20 be damage to the lungs, so you would want to
21 have oxygen in place to assist with that.
22 Q: Okay. Oxygen's something the basic paramedic
23 could administer to the patient, right? That
24 doesn't make it an ALS call?
25 A: Correct.

1 Q: Okay. Are you aware that the Anderson County
2 protocols state that a patient with a pulse ox.
3 reading of between 95 and 99 percent is within
4 the normal limits?
5 A: I would have to look and see what the actual
6 numbers are to state for that.
7 Q: Okay. Sitting here today you don't recall
8 that?
9 A: No.
10 Q: Okay. The next thing I think you dinged Mr.
11 Davenport for on your chart review is no IV
12 catheter established, right?
13 A: Correct.
14 Q: And again, that's something that you listed in
15 common to all three of these patients that you
16 did chart reviews, right?
17 A: Chart three I don't have anything with the IV.
18 Chart two I do. Oh, sorry. I see on the next
19 page 3 was attempted but without success.
20 Q: And that gets back to the mantra of O2, IV,
21 monitor, right? You think this was an advanced
22 call, should have had an IV started?
23 A: Correct.
24 Q: So if you were running this call you would have
25 started an IV on all three of these patients?

1 A: Yes.
2 Q: And, lastly you stated that -- or not lastly,
3 but the fifth item there says, no heart monitor
4 was applied to the patient, right?
5 A: Yes, sir.
6 Q: Okay. What is the heart monitor going to show
7 you with a stabbing patient with a knife stuck
8 in his left upper quadrant?
9 A: You're going to have real time visualization of
10 the heart rate. One of the things with the
11 possibility with the stabbing is you're going
12 to have bleeding. As you bleed out you're
13 body's going to sense that, and you're heart
14 rate's going to increase trying to compensate
15 for the low blood volume. So it's going to try
16 to beat faster to get more blood out. With
17 that, you'll be able to see a heart rate
18 increase. Also if, like I said, being in the
19 general area, not knowing at what angle or
20 direction or force that the blade was stuck in,
21 you have the possibilities or concerns for
22 injuries to the heart. So you may have an
23 arrhythmia, which is the heart has a normal
24 pattern that it does, and then sometimes with
25 injury or damage to the heart it can give a

1 different look to the rhythm and image that
2 comes across our heart monitor. You would be
3 able to see that very quickly and be able to
4 start different care or more care to try to
5 stop anything from getting worse.
6 Q: Do you know how long the patient had been
7 sitting on the couch with a knife in his
8 abdomen before he called 9-1-1?
9 A: I do not, and I'm not sure if the report states
10 it.
11 Q: If that patient were bleeding profusely, would
12 you expect that to show up within 20 minutes of
13 the injury?
14 A: It all depends. The patient was seated on the
15 couch, so with that in place, if he had not
16 moved, there's great possibility with sitting
17 versus standing with compression and all of
18 your insides, your internal organs. So if he
19 had done it, performed it, while he was sitting
20 and then had sat there, then everything's going
21 to be kind of pushing on it, which is going to
22 be kind of direct pressure, which is actually
23 going to help with bleeding. But as you stand
24 up or straighten out you have the possibility
25 of that direct pressure lessening, so then you

1 would have the possibility starting to bleed
2 worse.
3 Q: Now, you keep using the possibility, but that
4 never happened with this patient, right?
5 A: I don't know. I don't know any outcome.
6 Q: If you look at the patient run report, the
7 blood pressure was within normal limits the
8 entire way to the hospital, is that right?
9 A: Of the two that was in here, yes.
10 Q: Okay. And the pulse rate was in normal limits,
11 right?
12 A: Yes.
13 Q: And I think you said a minute ago, if the
14 patient was losing a lot of blood, you would
15 expect the pulse to increase to compensate to
16 try to move more blood around the system,
17 right?
18 A: Yes, sir.
19 Q: Okay. But that didn't happen with this
20 particular patient, right?
21 A: Not according to the documentation.
22 Q: Now in your sort of narrative of the stabbing
23 patient, you state the knife was completely
24 within his abdominal cavity. What does that
25 mean?

1 A: That the knife blade -- the patient describes
2 the knife blade to be six inches in length, and
3 was complete within his abdominal cavity. The
4 handle was the only thing that was visible. So
5 basically if your knife blade was six inches
6 and then you had the handle that you grip, the
7 knife was into his abdominal and up to the skin
8 to where only the handle was visible.
9 Q: How do you know only the handle was visible?
10 A: It would have to have come either from the
11 chart or from Ms. Aiken's statement. It would
12 have been based off of information that I was
13 given there.
14 Q: Or it was something that Mr. Stoller told you,
15 right?
16 A: No.
17 Q: So you think it's somewhere in the either the
18 patient care report or Ms. Aiken's statement it
19 says that the only thing visible on the knife
20 was the handle?
21 A: In the documentation it states that the patient
22 sat there for about 20 minutes prior or before
23 he called us. The patient stated the blade was
24 about six inches long and the whole blade was
25 in him. So that's where I would have gotten

1 that information, out of the document.
2 Q: Is the phrase abdominal cavity the same as
3 peritoneal cavity? I'm not a medical person.
4 A: Your abdominal cavity would be your -- you have
5 your torso, which is basically the full body
6 here, not counting your limbs, your legs and
7 your arms. This would be considered your
8 torso. You have your chest cavity, which would
9 be from your diaphragm up. Your abdominal
10 cavity would have been from your diaphragm
11 down. So that was where the abdominal cavity,
12 it was within his ---
13 Q: What if it was just in a layer of fat? Is that
14 considered in the abdominal cavity?
15 A: Yes because the whole -- the abdominal cavity
16 is going to be anything underneath skin, around
17 the skin, within that area of the pelvis up to
18 the diaphragm.
19 Q: Okay. If the knife had actually penetrated the
20 peritoneum, you would expect the abdomen to
21 become rigid, wouldn't you?
22 A: It can.
23 Q: Now we hadn't talked much about it -- Mr.
24 Wicevic did not. Chart number two, that was
25 the second one you looked at when you were

1 reviewing Mr. Davenport? Is that right?
2 A: Yes.
3 Q: And that was an elderly gentleman at a nursing
4 facility ---
5 **MR. WICEVIC:** Your Honor, I'm going to make the same
6 objection. Chart review number two is not
7 relevant to the Department's action against Mr.
8 Davenport. So I'm unsure the relevance of
9 going into details about that particular
10 incident and chart review by Mr. Eudy.
11 **THE COURT:** What's the relevancy?
12 **MR. ROTHSTEIN:** Your Honor, again, this is the sort
13 of piling on of cases against Mr. Davenport.
14 And it gets to the motivation for Mr. Stoller
15 to send this outside the normal QA process to
16 sort of look for support or grounds to get rid
17 of Mr. Davenport. This is not an educational
18 QA chart review.
19 **THE COURT:** Okay. Mr. Rothstein, I'm going to allow
20 you some latitude, but it is limited ---
21 **MR. ROTHSTEIN:** Okay.
22 **THE COURT:** --- okay?
23 Q: Can you look at chart number two that you
24 looked at? And again, with this one, you only
25 looked at the chart that Mr. Stoller provided

1 you, is that right?
2 A: I'm assuming so. Do I have the chart
3 available?
4 **MR. ROTHSTEIN:** I'm going to skip those, Your Honor.
5 I'll move onto something else.
6 **THE COURT:** Okay.
7 Q: Do you understand the difference between a
8 physician order and a protocol?
9 A: I'm not sure that I understand your question.
10 Q: Okay. In your experience and training, do you
11 understand the difference between a physician
12 order and a protocol?
13 A: Okay. Protocol based off of our standing
14 orders, what the Med. Control Physician has
15 already stated and signed off that we can
16 perform without contacting him first versus
17 physician order as being a protocol that we
18 have to contact a Medical Control Physician
19 first to get authorization to perform.
20 Q: Let me ask you this way. You mentioned
21 standing orders. Do you see a distinction
22 between a standing order and a protocol?
23 A: Standing orders are protocols.
24 Q: All standing orders are protocols?
25 A: They're titles. You have protocols that you

1 follow. Your services have a Med. Control
2 Physician that oversees all procedures and
3 treatments for that agency. He signs off on
4 what can be performed without having to call
5 into ER and get orders to do, and then there
6 are some things that you actually have to call
7 the ER to give orders to perform or to
8 administer medications and such. So your
9 standing orders and protocols, in my mind, are
10 the same thing. Within those protocols you
11 have standing orders, which means this is what
12 is set for you to go ahead and perform and do
13 up to that point. Then if there is advanced
14 procedures that the Med. Control Physician has
15 stated that he wants you to contact the
16 physician to have a consult with to be able to
17 perform further, which are mostly with
18 medications some of your narcotics and things
19 for our side, different agencies. The State
20 gives the protocols that they allow for
21 agencies and paramedics to perform. The
22 individual agencies and their Med. Control can
23 utilize all of them, utilize part of them in
24 various forms based off of that Med. Control
25 Physician's -- whatever he deems would be

1 necessary and would be appropriate for that
2 level of that agency to perform.
3 Q: Well let me ask you this, have you ever heard
4 of protocols being referred to as guidelines or
5 like an algorithm or a flow chart for how you
6 proceed with certain patients that present with
7 certain conditions or injuries?
8 A: Yes. Different agencies have different ways
9 that they have those actually printed out and
10 done, and they can be called all those things.
11 Q: okay. So a protocol might say, for example,
12 you know, assess the patient's airway, right?
13 A: Uh-huh.
14 Q: And then you as the paramedic are not told what
15 to do other than see if the patient's breathing
16 okay in your protocol or your flow chart,
17 right?
18 A: Correct.
19 Q: And then, later on if the patient has a --
20 makes the decision to administer oxygen,
21 there's a standing order that says, if the
22 patient has this condition you should apply 10
23 liters of oxygen or whatever -- again, I'm not
24 an expert. So the order itself is telling you
25 specifically what to do if the protocol or flow

1 chart leads you to the order, is that right?
2 A: Yes. If you see any issues with the patient's
3 vital signs, you would go different routes to
4 treat those signs. Some protocols have things
5 listed out very detailed, some are generalized,
6 so it's -- I've seen protocols from agencies
7 all across the countries and such, and some are
8 very very detailed that actually do give
9 ranges, within this range you should perform
10 this, within this range, you should perform
11 that.
12 Q: Well let me ask you this, so the protocol gives
13 the paramedic or EMT some sort of decision
14 making authority about what to do next, right?
15 A: It does.
16 Q: But then once you get down to the bottom of the
17 protocol, there may be a standing order that
18 says administer this much medication or this
19 type of fluid for this patient, right?
20 A: Based off the protocol, it could be, yeah.
21 Q: Okay. So you have discretion, say with an IV,
22 you have the discretion whether or not to start
23 the IV, but if you do start the IV, say for a
24 critical trauma patient, you're supposed to do
25 two lines, one of them with blood -- that's the

1 order right? The specific thing about what you
2 need to do from the doctor?
3 A: It could have those, yes.
4 Q: Okay. Another type of order is what you refer
5 to as online Med. Control. So if you're not
6 sure what to do and you call up, you get a
7 doctor at the ER and he'll order you to do
8 something, right?
9 A: Uh-huh.
10 Q: Okay. And you're not allowed, as a paramedic
11 or EMT to disregard what the doctor has told
12 you to do, either in a standing order or in an
13 online Med. Control, right?
14 A: We can follow it as long as it is based off of
15 the State's protocols on what is allowed to be
16 performed by the paramedic and what's been
17 approved to be performed in the field pre-
18 hospital.
19 Q: Are there times when you can deviate from a
20 protocol?
21 A: No.
22 Q: You don't think so?
23 A: The protocols are there for the patient care,
24 and you may move from one protocol to another,
25 but you should never deviate from the

1 protocols.
2 Q: Let me ask you to look at that exhibit 1 in the
3 notebook there. And I'm going to turn to the
4 introductory page, page 1. Have you ever read
5 that before? You see that? You ever read the
6 introduction?
7 A: I'm sure I have when we received the protocols.
8 Q: Okay. I'm going to direct you to the second
9 paragraph. While treatment and transport
10 decisions in the field vary, these guidelines
11 can assist the pre-hospital provider by
12 standardizing procedures for most common and
13 routine emergencies encountered and will be
14 considered the minimum standard by Anderson
15 County EMS. Did I read that correctly?
16 A: Yes, sir.
17 Q: Okay. So it describes the protocols as
18 guidelines.
19 A: Yes, sir.
20 Q: Do you agree with that?
21 A: Uh-huh.
22 Q: A standing order is not a guideline, it's a
23 directive, isn't that right?
24 A: A standing order?
25 Q: Yes.

1 A: Say that again, I'm sorry. I was reading.
2 Q: A standing order is not a guideline, it's a
3 directive, right? If you get down the flow
4 chart and you're supposed to administer some
5 type of medication or perform some type of
6 procedure, the order tells you how to do it
7 properly, right?
8 A: Yes, sir.
9 Q: Okay. And going down to the forth paragraph of
10 the introduction, last sentence it says, all
11 providers are responsible for their own
12 individual actions with regard to protocol
13 compliance, and any deviation from the
14 standards stated herein must be documented and
15 explained, right?
16 A: Which paragraph? Okay. I see it now.
17 Q: I'll read it again. All providers are
18 responsible for their own individual actions
19 with regard to protocol compliance, and any
20 deviation from the standards stated herein must
21 be documented and explained, correct?
22 A: Yes.
23 Q: Okay. So that gives paramedics and EMT's in
24 their own experience the ability to deviate
25 from a protocol as long as they can explain it

1 and document it, isn't that right?
2 A: Correct.
3 Q: Okay. If you deviate from a standing order or
4 an online doctor's order, is that permissible?
5 Like if the doctor says, you need to give this
6 patient a certain amount of morphine for pain,
7 is morphine one of the things you've got to
8 call and get approval ahead of time to give?
9 A: Uh-huh.
10 Q: The doctor says, give ten milligrams of
11 morphine, and you say, I think this patient
12 needs 50 milligrams of morphine, that's a
13 violation of a doctor's order, isn't that
14 correct?
15 A: Correct.
16 Q: And, in your review did you ever see where Mr.
17 Davenport violated that type of an order by a
18 physician?
19 A: Of the ones that I reviewed, no.
20 Q: Now you described Mr. Stoller as a, I think I
21 wrote it down, a quote unquote close friend of
22 yours?
23 A: Yes.
24 Q: And I think Mr. Wicevic asked you to describe
25 your relationship. Now you didn't mention that

1 Mr. Stoller rents property from you, did you?
2 A: No. He does not rent property from me.
3 Q: I thought you or your mother owned the house
4 that Mr. Stoller lives in.
5 A: Probably 18, 20 years ago he rented a home from
6 my parents for a couple years while they were
7 in the process of finding a home.
8 Q: Okay. That's no longer the ---
9 A: No, sir.
10 Q: --- situation?
11 A: No.
12 Q: Finally you made some recommendations on your
13 chart review, I think it's the third page of
14 the document. Your recommendations state, have
15 paramedic Mr. Davenport review the protocols
16 and review his charts and calls for a period of
17 time to be determined. Also have him
18 remediated to the types of patients critical
19 versus stable, right?
20 A: Yes, sir.
21 Q: So you didn't recommend that Mr. Davenport have
22 his medical control revoked by Dr. Kickham, did
23 you?
24 A: No, sir.
25 Q: Okay. And you didn't recommend that Mr.

1 Davenport be sent back to ALS or advanced life
2 saving school or provided some sort of
3 technical training, did you?
4 A: No, sir.
5 Q: And you certainly didn't recommend that Mr.
6 Davenport be reported to DHEC to pull his
7 paramedic certificate, did you?
8 A: No, sir.
9 Q: Okay. These other reviews that you've done for
10 Mr. Stoller, you've had some paramedics that
11 have -- that you've recommended either revoking
12 their certif- -- or medical control, is that
13 right?
14 A: No.
15 Q: You've never done that?
16 A: I've never recommended, because that's out of
17 my realm. Only thing I would do is recommend
18 that they go through remediation or based off
19 of the service therewith, fall under their
20 disciplinary action policy.
21 Q: Some chart reviews you've done, the patients
22 have died as a result of the paramedic's
23 actions or inactions, isn't that right?
24 A: I would have to look back on all of them. I
25 don't recall.

1 Q: Okay. The remediation you mentioned for these
2 other chart reviews, was that more severe than
3 the remediation or the recommendations you
4 recommended for Mr. Davenport?
5 A: I don't know. Like I said, I would have to
6 look back at the ones that I've reviewed to
7 make a comparison.
8 Q: Okay. Some of them were tough, weren't they?
9 A: I don't know. When I review a chart and I send
10 it back, that's the only involvement I have in
11 it, so I don't keep any copies of anything and
12 I don't have any follow up, I'm not involved
13 with any follow up on the concern or the
14 complaint. So, I run many calls and do many
15 investigations, and so ---
16 Q: Thank you, sir. I don't have any further
17 questions.
18 A: Okay.
19 **THE COURT:** Mr. Wicevic?
20 **MR. EUDY - RE-DIRECT EXAMINATION BY MR. WICEVIC:**
21 **MR. WICEVIC:** Yes, Your Honor.
22 Q: Just a few questions, Mr. Eudy. There was some
23 discussion about the title of your chart
24 review. It's Exhibit 26. Can you explain what
25 types of chart reviews are performed commonly

1 amongst licensed emergency medical services?
2 A: In general or in relation to Anderson County?
3 Q: I mean, are there different types of QA
4 reviews?
5 A: You can do QA reviews for customer service, you
6 can do QA reviews for patient care. Those are
7 pretty well the two common things that I've had
8 to do investigations or reviews on.
9 Q: Is there a continuous QI review?
10 A: I could speak for our agency. If there is a
11 patient care issue that a crew member has been
12 involved with and they go through remediation,
13 then part of their performance improvement plan
14 is what we call it, states that you will have
15 -- we'll take for instance if it's a
16 respiratory call and they've done poorly on it,
17 then their respiratory calls will be pulled and
18 looked at for documentation, for protocol, and
19 such with that for 10, 15 calls or for a month.
20 That's something that our training department
21 does in with the remediation process. So ...
22 Q: What happens if there's a particular complaint
23 from the public or ---
24 A: The complaint from the public gets looked at --
25 -

1 **MR. ROTHSTEIN:** Your Honor, I'm going to object.
2 There's been no evidence that there's ever been
3 a complaint by the public against Mr.
4 Davenport. The question is irrelevant and it's
5 also not response to anything I brought up on
6 cross-examination.
7 **MR. WICEVIC:** Well he brought up various different
8 types of QI reviews and the QI process that Mr.
9 Eudy was involved with. I think this is within
10 the scope and it's relevant. It's making it
11 look like Mr. Eudy is somehow connected to Mr.
12 Stoller, and Mr. Stoller had some kind of bias
13 against Mr. Davenport.
14 **THE COURT:** I'm going to allow the question and the
15 objection is overruled.
16 Q: So, Mr. Eudy, are there some complaint QI's for
17 lack of a better word?
18 A: Yes. As I was telling him, whenever there's a
19 complaint or a concern that comes in from an
20 outside agency in regards to a call, then that
21 was where I was asked as a neutral and unbiased
22 person to perform a review on the call and give
23 my findings.
24 Q: How would you characterize your QI review of
25 this particular matter?

1 **MR. ROTHSTEIN:** Objection, Your Honor. That's
2 irrelevant. His opinion of his own review is,
3 I think is irrelevant. It's also improper.
4 Q: Well what was your review? What type of review
5 was this?
6 A: This was a review of the call that had come in
7 as a concern or complaint from an outside
8 agency in response to the treatment and such
9 that was rendered to this patient.
10 Q: Mr. Eudy, let's turn to Exhibit 1. And I
11 believe you were going to mention something
12 regarding policy 26. I think you were actually
13 interrupted. It's Bates page 125.
14 A: Uh-huh. I think the question was which
15 protocols I've looked at in regards to his
16 chart. I don't remember that night or day,
17 whenever I was performing it, but just to go
18 down what I normally would do is with the
19 situation, they type of call that having to
20 review, I would go through and look at the
21 policies and anything that would be a possible
22 involvement with it. Then I would pull that
23 up, reference it in review of the documentation
24 that I've been given. So, like I was saying,
25 policy 21 was transport, and then policy 26 is

1 a non-paramedic transport. Some of the concern
2 with this would have been that it was a trauma
3 patient should have been ALS. So those
4 possibly would have information that would be
5 relevant to the protocols or to the case in
6 review with the way it was documented.
7 Q: Does an advanced ALS provider meaning EMT
8 intermediate or paramedic have to ride all
9 trauma calls?
10 A: I would have to look and see what the protocol
11 states, but an ALS call trauma patient would,
12 based off of the mechanism of injury would
13 warrant an ALS provider attending the patient.
14 Q: Are you speaking specific to this call?
15 A: Yes.
16 Q: The March 19th, 2016?
17 A: Yes. The stabbing call.
18 Q: Okay. What was, I think you mentioned also
19 policy 21. What was the relevance to
20 mentioning policy 21?
21 A: Just by in the nature of the title, I would
22 have, probably would have referenced that.
23 I'll have to go and look at it and see if it
24 was relevant or such. But like I said, I don't
25 recall all the protocols that I looked at that

1 night.
2 Q: Okay. I was just curious.
3 A: Yeah.
4 Q: What level of certification -- what level of
5 certified EMT can establish an IV?
6 A: An advanced EMT can start an IV and paramedics
7 can start an IV.
8 Q: Did you mention something about performing pain
9 management?
10 A: I don't recall. I'll have to go look. I don't
11 believe so. There would not have been any
12 performed because the basic rode in with it.
13 But I don't see any mention of the need or that
14 it was determined if it would be or not.
15 Q: Okay. You mentioned that this patient required
16 advanced care ---
17 A: Uh-huh.
18 Q: --- or required advanced level care. What
19 other types of advanced level care in your
20 opinion based upon your review ---
21 **MR. ROTHSTEIN:** These are asked and answered. He
22 asked all this stuff on direct. He's not just
23 sort of trying to reemphasize what he's already
24 covered.
25 **MR. WICEVIC:** Your Honor, I think I'm trying to see

1 if there were any other items that we missed on
2 direct, so we don't misunderstand Mr. Eudy's
3 review of this particular chart.
4 **THE COURT:** Your objection's overruled.
5 A: Okay. So what was your question?
6 Q: Were there any other types of advanced level
7 services that were required for this March 19th
8 patient?
9 A: Nothing that would have been able to be
10 performed in the pre-hospital realm other than
11 what I've mentioned there. Your heart monitor,
12 IV, and O2. The IV and the heart monitor would
13 have been the ALS procedures that would have
14 been able to be performed.
15 Q: Was IV access required?
16 A: Based off the protocols with them being stable,
17 it did not warrant it at that time ---
18 Q: Okay.
19 A: --- but with the nature of the mechanism of
20 injury you have to be ready for the blood loss,
21 that you have with the possibilities of any
22 internal injuries. We don't have x-ray vision
23 and we don't have any way of determining what
24 could be involved inside. But with a knife to
25 the upper abdomen, that's going to be near

1 liver which is full of blood. It's going to be
2 near spleen that has a lot of blood. You have
3 your intestines, both small and large, which if
4 perforated could involve sepsis, which can kill
5 people very quickly as we see now a days. Your
6 great vessels that are right behind the -- in
7 line with the middle of your body, and such.
8 And also the simple fact that as the patient
9 was sitting as I described, you have that kind
10 of compression and such, which would be kind of
11 a direct pressure with the knife being in
12 there. And one of the things that we're always
13 taught in stabilizing it and with it being
14 penetrated, you never want to remove it because
15 if you've punctured in and made a hole, that's
16 still in the place of that hole, and it's
17 helping to keep the blood from coming out.
18 When you remove that, you make that hole open
19 and then you're going to bleed out. With that,
20 the movement, you have to be very careful in
21 how you move a patient and such with those,
22 stabilizing it as they did to make sure that
23 every opportunity is given to that patient for
24 survival and for the best outcome. And as I
25 described, as you're sitting that compression,

1 as you stand you have the possibility with
2 things stretching out, and that blade after
3 secured you can have the possibility of it
4 doing more damage by the stretching out of it
5 possibly pushing in. So, in situations like
6 this, you don't know the outcome, you don't
7 know what damage is inside, so you need to
8 treat for the worst possibility. And with
9 that, that should have been an advanced
10 procedures should have been initiated to
11 already have in place. Trauma patients,
12 there's a thing called the golden hour. You
13 need to have things and they need to be to
14 definitive surgery within an hour to have the
15 best outcomes. With that, if you already have
16 your IV's established and everything, then if
17 they were to start decompensating, then you
18 have a means with yourself to be able to give
19 IV fluids to help kind of replace some of the
20 blood loss that's out. Some services and some
21 of the air transport services can actually do
22 blood. So they would have that access there
23 that they would be able to give blood in that
24 situation. So the unknown of the mechanism of
25 injury is how I based with protocols and the

1 way we learn and the way we're taught to deal
2 with these situations to treat the patient for
3 the best outcome.
4 Q: Okay. Now, let's turn to GP 3, it's page 6 of
5 Exhibit 1.
6 A: Okay. What now?
7 Q: GP 3.
8 A: Which page did you say?
9 Q: It's Bates page 6.
10 A: Okay. Intravenous access protocol?
11 Q: Yes, sir.
12 A: Okay.
13 Q: And if you look at the management section ---
14 **MR. ROTHSTEIN:** Your Honor, I've got to object to
15 leading -- I mean he's now going to go through
16 and direct Mr. Eudy to every policy that DHEC
17 is contending was violated here. Mr. Eudy has
18 testified he doesn't recall which policies he
19 looked at. He also testified that he didn't
20 note any of the policies in his report. I
21 think this is -- Mr. Wicevic is testifying
22 here.
23 **MR. WICEVIC:** Well I can try to discontinue any kind
24 of leading, but I think this is appropriate.
25 He said his review was based upon compliance

1 with protocols and orders. I'm interested to
2 see what his take is on GP 3, whether it orders
3 intravenous access to be established for this
4 particular patient. I think that's relevant to
5 this matter.
6 **THE COURT:** But he's already expressed in his
7 testimony that that was the case from his
8 review of their protocol in composing his
9 review.
10 **MR. WICEVIC:** Well I was going to clarify whether he
11 believed that was an order or a protocol. That
12 seems to be at the heart of their case, a main
13 contention of their case. That this IV access
14 was not an order from the Med. Control
15 Physician. And I was going to ask what types
16 of patients does this particular GP 3 orders IV
17 access for.
18 **THE COURT:** Okay. Well let's limit it to that.
19 Okay
20 A: Okay. So what's exactly your question?
21 Q: What types of patients does GP 3 order IV
22 access for?
23 **MR. ROTHSTEIN:** Your Honor, again, this is leading.
24 I mean, Mr. Wicevic is pointing him to the
25 policy and asking him essentially to read it to

1 The Court. I mean that's an improper line of
2 questioning.
3 **THE COURT:** Could you rephrase your question?
4 **MR. WICEVIC:** Okay.
5 Q: Exhibit 1, could you point out the protocols
6 that you understand pertain to IV access?
7 A: It states here, IV access would be in any
8 patient specifically addressed in these
9 protocols if deemed necessary based on history,
10 examination, and or mechanism of injury. And
11 it also states with that, alternate IV sites
12 may be used for any life or limb threatened
13 situation when an upper extremity vein is
14 unaccessible being cardiac arrest, severe
15 trauma, shock, or hypotension, or severe burns.
16 Only paramedics are authorized to establish IV
17 access in an external jugular vein.
18 Q: What does this particular protocol state about
19 types of patients or types of injuries?
20 A: This would be a trauma patient, the mechanism
21 of injury would warrant the possibilities of
22 excessive blood loss and possible
23 decompensation. So you would want IV access
24 for that.
25 Q: Would that be an order?

1 A: It's a protocol, so that would be something
2 that the medical physician has agreed to have
3 in place in here that you would utilize it for.
4 Q: Okay. Now the choice of who rides the call,
5 what's that based upon?
6 A: It's based upon the type of call and the level
7 of care that's needed by the patient.
8 Q: Okay. And what level of care did this patient
9 require?
10 A: This patient required ALS advanced.
11 Q: And what would that mean as far as who rides
12 the call?
13 A: A paramedic would need to ride the call.
14 Q: That's all the questions I have for you. Thank
15 you, Mr. Eudy.
16 A: Okay.
17 **THE COURT:** Okay. Thank you, Mr. Eudy.
18 **MR. WICEVIC:** Your Honor, may Mr. Eudy be excused?
19 **THE COURT:** Mr. Rothstein, do you a ---
20 **MR. ROTHSTEIN:** I don't have any further ... Can we
21 take a brief restroom break?
22 **THE COURT:** I'm getting ready to do that. We're
23 going to take a ten minute break at this point
24 before you call your next witness.
25 **MR. ROTHSTEIN:** Thank you.

1 **MR. WICEVIC:** Thank you.
2 **(Off the record from 2:18 p.m until 2:34 p.m.)**
3 **THE COURT:** Mr. Wicevic, you can go ahead and call
4 your next witness.
5 **MR. WICEVIC:** Yes, Your Honor. The Department calls
6 Dr. Thomas Kickham.
7 **THE COURT:** Dr. Kickham, before you take your seat,
8 if you'll face the court reporter, raise your
9 right hand, he'll swear you in.
10 **THOMAS KICKHAM**, having been duly sworn, testifies as
11 follows:
12 **DR. KICKHAM - DIRECT EXAMINATION BY MR. WICEVIC:**
13 Q: All right. Dr. Kickham, good afternoon. My
14 names' Vito Wicevic. I represent DHEC. We've
15 met before. Could you please state your full
16 name for the record?
17 A: Thomas Charles Kickham.
18 Q: Okay. Just some background about yourself, and
19 you can refer to Exhibit 13.
20 A: Okay.
21 Q: It's tabbed out.
22 A: Okay.
23 Q: Can you identify Exhibit 13?
24 A: My curriculum vitae.
25 Q: Okay. And can you give us some details about

1 your education?
2 A: I attended Michigan State University for
3 undergrad, got a bachelor's of science degree
4 in biology and zoology. Finished in 1980. And
5 then I went to the University of Health
6 Sciences. The current name is Kansas City
7 University of Medicine and Biological Sciences
8 from '82 to '86 and got a degree in osteopathic
9 medicine. And I did a rotating internship at
10 Lancing General Hospital.
11 **MR. ROTHSTEIN:** Your Honor, can I -- I'm sorry to
12 interrupt. Can he speak into the microphone a
13 little bit? I'm having a little trouble
14 hearing.
15 **DR. KICKHAM:** Is that better?
16 **MR. ROTHSTEIN:** That's better. Thank you.
17 A: I did a rotating internship at Lancing General
18 Hospital, Lancing Michigan and a residency in
19 emergency medicine at Detroit Osteopathic
20 Hospital Bi County Hospital in Detroit
21 Michigan. Finished in 1989. Moved to
22 Anderson, South Carolina, started practicing
23 with Anderson Emergency Associates. 1989 I
24 worked with them until March of this year, so
25 27 and three quarters years worked on emergency

1 medicine in Anderson. Of that time I did about
2 24 years as the Medical Control Physician for
3 Anderson County EMS.
4 Q: Okay.
5 A: Currently I'm working for the Department of
6 Mental Health at Harris Psychiatric Hospital in
7 Anderson, South Carolina, full time primary
8 care physician for the inpatients.
9 Q: Okay. How long have you been licensed as a
10 South Carolina Physician?
11 A: Since 1989.
12 Q: And have you had any disciplinary action?
13 A: No, sir.
14 Q: Okay. Do you have any teaching
15 responsibilities?
16 A: We, as a clinical staff emergency physician, we
17 have medical students, pre-med students, and
18 family practice residents. Also did some
19 periodic training with EMT's and paramedics as
20 part of my job as Medical Control Physician.
21 Q: Okay. Now can you explain your role as the
22 Med. Control Physician?
23 A: Medical Control Physician's responsible for the
24 medical oversight of all the agencies under his
25 direction. In Anderson County there was

1 multiple rescue squads including one private
2 agency. Well they're all private agencies.
3 But there's nine agencies in Anderson County
4 that I was responsible for. In my role as the
5 Medical Control Physician of Anderson County
6 and those duties entail some education, some
7 training, writing and reviewing policies,
8 procedures, protocols, quality improvement
9 programs, as well as interacting with the EMS
10 commission, physicians.
11 Q: Okay. Can you explain to The Court of your
12 oversight over EMT's as the Med. Control
13 Physician?
14 A: The oversight is under the State law or statute
15 or whatever it's called, the EMT's, paramedics,
16 intermediates function under the Medical
17 Control Physician. So he has to sign off on
18 each EMT, intermediate, paramedic, and be
19 responsible for them. Does that answer your
20 question?
21 Q: Yeah. I mean how do you direct them to provide
22 care?
23 A: Well the direction is the policies and
24 procedures as written in the protocols and the
25 standards of care. And then ongoing education,

1 training, and quality improvement as need be.
2 Q: Okay. Can you identify Exhibit 1?
3 A: That's under tab one I guess?
4 Q: Yes, sir.
5 A: Okay. That's the Anderson County South
6 Carolina Standard of Care and Treatment
7 Protocols, 2013.
8 Q: Okay. Would that be the version in effect at
9 the time of March 19th, 2016?
10 A: Yes.
11 Q: Now, explain to The Court your involvement with
12 the development of these standards of care and
13 treatment protocols.
14 A: Well they evolved over the 24 years that I was
15 Medical Control Physician. So every few years
16 as need be we would revise them, add to them,
17 delete them, and try and edit them, and keep
18 them up with current standards of medical care.
19 Q: And I think you mentioned that as the Med.
20 Control Physician for Anderson County, you were
21 over a number of separately licensed services.
22 Was one of those services Iva Rescue Squad?
23 A: Correct.
24 Q: Okay. How are EMT's educated on this packet,
25 Exhibit 1 standards of care and treatment

1 protocols?
2 A: Each EMT and intermediate paramedic would get
3 a copy of them, and they were to study them.
4 They also had to take a test. Most of the
5 treatment protocols are fairly standard as
6 outlined in their classes they take when they
7 take advanced cardiac life support, basic life
8 support, trauma life support, pediatric life
9 support. So they also take those courses which
10 gives them background, and then they are to
11 study these protocols because these are the
12 ones that I signed off on allowing them to do
13 procedures under these standing orders. And
14 they were issued one of these and then they
15 were tested.
16 Q: Okay. Are copies of this available elsewhere?
17 A: There was a copy, I think, at Office Depot. So
18 if somebody wanted to make like a smaller
19 version or a ring binder, they could go to that
20 store and they could buy additional copies.
21 Q: Okay. Now explain to The Court the compliance
22 requirements of these standards of care as in
23 the protocols.
24 A: Well, as the name states, they're standards of
25 care and treatment protocols. So they're

1 standard policies and procedures that the
2 paramedics, intermediates, and basics, as well
3 as first responders can use them too, that
4 reenforces what they're taught in school, what
5 they're taught in ongoing education classes,
6 and then it's in written form, and I sign the
7 bottom that I agree that these are what I
8 approve as the standard of care and treatment
9 protocols that they're allowed to do under my
10 direction. So if they follow these they're
11 following the protocols and they're doing what
12 I'd approve. If they don't follow them, then
13 of course they're stepping outside what's
14 allowable under my license.
15 Q: Can you explain to The Court what's the
16 distinction between basic life support care and
17 advanced life support care?
18 A: The basic -- when I use that in terms of --
19 well basic life support is what's taught as a
20 basic knowledge for EMT's for example. Other
21 people can take those courses. You can take
22 them as a nurse's aid or an RN or an LPN.
23 Paramedics go beyond the basic life support
24 courses and take advanced life support courses,
25 which includes advanced airway skills as well

1 as administration of medications as well as
2 starting IV's and administering fluids. So
3 they're separate courses that are published by
4 and put on by American Heart Association for
5 example.
6 Q: Okay. And what about advanced life support?
7 A: Similar. The advanced life support includes
8 the advanced skills including IV's, IV
9 medications, PL medications, IV fluids, cardiac
10 defibrullation, advanced airway skills, those
11 are all advanced cardiac life support. And
12 that, again, is a course that the paramedics
13 take. You don't have to be a paramedic to take
14 the course. Nurses take it, LPN's take it,
15 RN's take it, doctors take it. And that course
16 gives them additional training skills, gives
17 them a card certifying that the attended and
18 passed a practical exam as well as a written
19 examination. And these policies and procedures
20 are written with those courses in mind.
21 Q: Does Exhibit 1 address the distinction between
22 ALS and BLS?
23 A: Yes. In each one of the protocols we have it
24 addressed for the basic EMT, the intermediate
25 EMT, and the advanced or paramedic EMT, as well

1 as the first responders.
2 Q: I think I understand what you're saying, but
3 maybe back up a little bit to the introduction.
4 Is there anything addressed in the protocols
5 regarding distinguishing the skills, the ALS
6 skills and the BLS skills?
7 A: Well, the skills follow what the State allows
8 at each level. So the basic skills are for the
9 basic EMT's, the intermediate skills are for
10 the intermediates, and the advanced skills for
11 the paramedics. So it follows what the State
12 allows each one of those certified providers,
13 what they allow them to do under the State
14 rules.
15 Q: Okay.
16 A: So we try and mirror what they have there as
17 best we can so we don't break any State rules.
18 Q: So can you explain what the State protocols
19 are?
20 A: Well the State writes their own protocols, and
21 each physician medical control person can use
22 the State protocols if they would like or they
23 can use their own protocols that they've
24 developed for their area, and then the
25 protocols are submitted to the State for

1 approval so that they mirror their protocols so
2 you don't put something in the protocols that's
3 not allowed by the State.
4 Q: Okay. Would you characterize the State
5 protocols as a ceiling or maybe a floor?
6 A: A ceiling.
7 Q: Let's turn to page 6 please.
8 A: When you say page 6 ---
9 Q: It's the Bates page on ---
10 A: The little numbers at the bottom?
11 Q: Yes, sir. Okay. GP-4. Can you explain what
12 this is for?
13 A: General Procedure 4 Adult Cardiac for basic
14 life support advanced life support skills, so
15 that delineates the skill levels for each level
16 of certification.
17 Q: What's this protocol have to say about standing
18 order skills and physician order skills?
19 A: Can you give me a hint, which paragraph it's
20 in?
21 Q: If you could look, it's the middle of the page.
22 A: I think what you're referring to is the
23 following tables that show -- with the x's that
24 show what's allowed under standing order
25 physician order, and what a first responders,

1 intermediates, and paramedics can perform.
2 Q: Right. I mean, can you explain what's ALS,
3 what's not, what's BLS, and so forth?
4 A: Well the -- I'm not sure if I explained that
5 properly or not. Well if you look under
6 certification level, Anderson County EMS
7 providers consist of four levels of
8 certification within the County. All personnel
9 require to follow the individual guidelines
10 appropriate for their level of certification.
11 So a basic EMT would follow the protocols based
12 on his level of certification as delineated in
13 each protocol what they can and can't do.
14 Q: Okay. And for the record I'm referring to when
15 I'm referencing these Bates pages, I'm
16 referencing Exhibit 1 in DHEC's exhibits. What
17 are the standing orders you have in place for
18 adult care?
19 A: Well we have -- there's dozens of them. Starts
20 out with airway and IV, there's medical
21 protocols, there's pediatric protocols, there's
22 trauma protocols.
23 Q: Okay. Well what are the ones applicable to
24 this matter?
25 A: Well how it started from the beginning of the

1 general procedure protocols -- let me read
2 through here a little bit. The airway oxygen
3 protocol, the IV fluid protocol, the universal
4 patient care protocol, the patient safety
5 protocol, and trauma protocol's under major
6 trauma. The trauma transport protocol would
7 apply too.
8 Q: Did you say protocols, trauma protocols plural?
9 A: Yes.
10 Q: Okay.
11 A: Particular, I think trauma protocol number one
12 and number two.
13 **THE COURT:** Dr. Kickham, what page of the protocols
14 are you referencing looking at Exhibit 1?
15 **DR. KICKHAM:** Okay. The way it's designed is like
16 the first section is GP, it starts off like GP-
17 1 and goes to like general protocols ---
18 **THE COURT:** Uh-huh.
19 **DR. KICKHAM:** And then the next section is cardiac
20 protocols. And then the next section I think
21 is there's pediatric and there's medical, and
22 then the last section is the trauma protocols.
23 **THE COURT:** Okay.
24 **DR. KICKHAM:** So if you look on the top, it'll say
25 like trauma protocol will be T-01, T-02. And

1 then the general procedure protocols start out
2 GP. So in the very beginning there's adult
3 airway protocol which is GP-1, and GP-2 is
4 pediatric which doesn't apply to this case.
5 And then GP-3 is intravenous access protocol.
6 And we were just talking about GP-4. So it's
7 kind of like four main sections, medical,
8 surgical, general, and pediatric.
9 Q: Okay. Well before we get into the whole
10 protocol, order, compliance, let's talk about
11 your review of this matter concerning Mr.
12 Davenport. Did you review the run involving
13 Iva Rescue Squad's paramedic James Davenport
14 and EMT Kimberly Aiken's care of this patient
15 on March 19th, 2016?
16 A: Yes, sir.
17 Q: What did the review consist of?
18 A: Well, Scott sent me -- Mr. Stoller sent me the
19 patient care reports and I reviewed them and
20 set up a date to meet with Mr. Davenport, and
21 Ms. Aiken, myself, and Scott Stoller. And then
22 so after I reviewed them myself, discussed them
23 briefly with Scott, and we met with Mr.
24 Davenport and discussed them further.
25 Q: Okay. Well let's start with the patient care

1 report. Can you turn to Exhibit 11c?
2 **MR. ROTHSTEIN:** I think it's b isn't it?
3 **MR. WICEVIC:** Is it b?
4 Q: I'm sorry. 11b.
5 A: Yes, sir.
6 Q: Can you identify this?
7 A: Let's see. It's blacked out. This is a
8 medical call overdose, toxic ingestions ---
9 Q: I'm sorry. You may be looking at 11c. I
10 misstated that. Are you looking at 11b?
11 A: That might be a, I'm sorry. Okay. Yeah, this
12 is the abdominal wound one. I'm sorry. I was
13 on a.
14 Q: Okay. And is that the one you reviewed? Is
15 this the patient care report 11b, that you
16 reviewed as part of your initial review of this
17 matter?
18 A: Yes, sir.
19 Q: Okay. You review any other documents?
20 A: We reviewed two other calls at that meeting.
21 I think they might be in here. One is a
22 pediatric seizure patient, and the other was a
23 hypotensive gentleman from a nursing center.
24 Q: Okay. Leaving that off the table, did you
25 obtain any statements from individuals involved

1 with the March 19th call?
2 A: We met with Ms. Aiken I believe before we met
3 with Mr. Davenport, and I believe she had a
4 written statement that she sent to Mr. Stoller,
5 and we also met with her and discussed the call
6 with her in person.
7 Q: Okay. Let's turn to Exhibit 4.
8 A: Yes, sir.
9 Q: Can you identify that?
10 A: That is her written statement.
11 Q: Ms. Aiken's?
12 A: Yes. I believe I had that before we met with
13 her and Mr. Davenport in person.
14 Q: Okay. And you referenced an interview with Mr.
15 Davenport, is that correct?
16 A: Correct.
17 Q: Who was involved with that interview?
18 A: It was myself, Mr. Stoller, and Mr. Davenport.
19 The QI officer Mr. Craig Lawless provided some
20 of the information, but it was just the three
21 of us at one time. Mr. Stoller, Mr. Davenport,
22 and myself. Prior to that there was the three
23 of us, Ms. Aiken, Mr. Stoller, and myself.
24 Q: Okay. At that time had you formulated findings
25 concerning this particular March 19th call?

1 A: After we met with the individuals involved,
2 yes.
3 Q: Well at the time of the meeting did you express
4 any concerns to Mr. Davenport about the patient
5 care he rendered?
6 A: Yes. We discussed that.
7 Q: Okay. What did you -- what were your concerns?
8 A: Well our conclusions were this patient had
9 major penetrating injury to the abdomen, and he
10 received basic emergency care. And it was of
11 my opinion and Mr. Stoller's opinion, and I
12 believe Mr. Davenport agreed with us, that this
13 was an advanced level call, which would require
14 advanced treatment by a paramedic.
15 Q: Okay. So, what was Mr. Davenport's response?
16 A: He indicated that he agreed, and he indicated
17 that he understood our opinion on it.
18 Q: Okay. At that time did you have the benefit of
19 having -- well let me back up a little bit.
20 Are you aware there was body cam footage?
21 A: No.
22 Q: You're not aware today?
23 A: Well I am today.
24 Q: Okay. At the time?
25 A: At the time of the meeting, no. I'm sorry.

1 Q: Okay. When did you review the body cam video?
2 A: It was I'm guessing about three days later
3 maybe, four days later. I'm not sure exactly.
4 Q: Okay. Who brought that to your attention?
5 A: Mr. Stoller.
6 Q: Okay. Can you explain the circumstances
7 through which that was brought to your
8 attention?
9 A: Yeah. I believe he called me early afternoon.
10 I was working a 3:00 p.m. shift. And he said
11 I have something to show you, and I said, well
12 just meet me at the hospital in the ER before
13 my shift, and he had the video on his
14 telephone. So we watched it on his little
15 pocket device, which is kind of a large iphone.
16 Q: Ipad?
17 A: It was smaller than an ipad, but larger than
18 the original iphones. A big iphone.
19 Q: Okay. Did your review consist of any other
20 pieces of evidence at that time?
21 A: No.
22 Q: Okay. Upon reviewing the video, what did you
23 recommend?
24 A: I reviewed the video and Scott suggested that
25 we forward this to DHEC and let them handle it

1 from there, and I agreed.
2 Q: Okay. All right. Well let's talk about
3 compliance with the various orders and
4 treatment protocols. I believe you mentioned
5 GP-16, patient safety was one of the applicable
6 protocols, procedures. Let's turn to pave 14
7 of Exhibit 1.
8 A: Page 14. There we go.
9 Q: Okay. Now, Dr. Kickham, who is -- what types
10 of patients is GP-16 applicable to?
11 A: All patients.
12 Q: Okay. Why?
13 A: Well it's the patient safety protocol, so it's
14 the summaries of do's and don't's of taking
15 care of patients in a safe manner.
16 Q: Okay. Well what are some of the requirements
17 that are relevant to this matter?
18 A: You're straining my eyeballs on this one, but
19 relevant to this matter, well under paramedic
20 follow universal patient care protocol, that's
21 another protocol in here. But if you follow it
22 down about half way, follow appropriate
23 treatment protocols, patient should not
24 ambulate to the ambulance is listed. Transport
25 all patients via appropriate carrying device is

1 right underneath there.
2 Q: Okay. Well let's talk about those two. Was
3 that one of your concerns?
4 A: Yes, sir.
5 Q: Okay. Please explain that concern.
6 A: Well initially when I reviewed the DHEC, it
7 didn't really dawn on me that they walked him
8 from inside the house to the ambulance, so I
9 didn't really understand that in our initial
10 meeting, Mr. Stoller, myself, and Mr.
11 Davenport. That piece of information came out
12 with the body cam, so that was a few days
13 later. So I didn't have that knowledge.
14 Q: What was the concern with ambulating the
15 patient?
16 A: Well the patient had a knife imbedded in the
17 abdomen, kind of left upper quadrant it
18 appeared to be on the video and in the
19 description of the patient care report. So the
20 concern is the knife, we don't know how long it
21 is, but in any case it doesn't matter how long
22 it is. If that knife were to move it could
23 potentially cause further injury and or death.
24 So that particular case, the safest thing for
25 the patient would be to place them on the

1 stretcher and transport them out of the house
2 in a manner that moves the patient the least
3 amount as possible.
4 Q: So would the only carrying device that would be
5 appropriate be the stretcher or are there
6 alternatives?
7 A: Well you could also use a back board. You
8 could slide the patient on a back board. There
9 are other devices you could improvise with if
10 need be. If you have plenty of help you could
11 actually just pick him up and put him on the
12 stretcher. You could try and get him to help
13 himself get on the stretcher as best as you
14 could. You wouldn't necessarily need a back
15 board device to move him from the position he
16 was in, which according to the video was he was
17 on a couch.
18 Q: How many people were on the scene?
19 A: On the video at least five ---
20 Q: Okay.
21 A: --- people minimum.
22 Q: Okay. You mentioned that this protocol GP-16
23 says follow appropriate treatment protocol.
24 What would be the appropriate treatment
25 protocol or protocols?

1 A: Well the initial general procedures one would
2 serve, airway oxygen, the IV protocol and IV
3 fluid administration protocol, the trauma
4 protocol one and two. I'd have to thumb
5 through here, but those are applicable. And
6 also the universal patient care protocol.
7 Q: Okay. Let's move to the universal patient care
8 protocol. That's the next page. Can you
9 explain to The Court what the universal patient
10 care protocol is for?
11 A: It lists things like, under paramedic a along,
12 it's like bring all equipment needed to
13 patient's side so you bring your jump bag, your
14 stretcher, any equipment that you think you
15 might need into the home or into wherever the
16 patient is so that you have that equipment with
17 you so you don't have to run back to the
18 ambulance to retrieve that equipment. And
19 under that it says demonstrate professionalism
20 and courtesy, personal protective equipment,
21 which is kind of off the subject here, but if
22 the patient's bleeding you'd want to wear
23 gloves, and then do your initial assessment
24 which is the adult assessment procedure. It
25 should be protocol, but it says procedure in

1 here. Then it says airway management, the
2 vital signs, and then it says vital
3 mobilization, KG cardiac monitoring, glucose
4 measurement, and then transport.
5 Q: Okay. Did you see any -- did you have any
6 concerns with the compliance with this GP-18
7 based upon your review?
8 A: Based on 18, as far as I know they didn't bring
9 the jump bag or their drug box or the stretcher
10 into the home, which is a concern. Based on
11 the video demonstrating professionalism and
12 courtesy did not occur. He did wear gloves
13 under personal protective equipment. Under
14 assessment I didn't see a complete set of vital
15 signs done at the scene, but it could have been
16 done in the ambulance and rightfully so.
17 Q: Can you explain why?
18 A: Well the patient had penetrating wound to the
19 abdomen, so he is a trauma alert patient, which
20 means transporting the patient as quickly as
21 possible is the primary concern. So the IV is
22 supposed to be one in the ambulance on the way
23 to the hospital. A complete set of vital
24 signs, additional history, whatever information
25 you need to obtain from the patient is

1 hopefully done in route to the emergency
2 department to try and save time.
3 Q: Okay. So as far as the assessment on scene,
4 are you saying that there's an expedited or
5 maybe you don't do the complete assessment on
6 scene?
7 A: Correct. You try and do it, at the time you're
8 trying to assess the patient's injuries and try
9 and transport them as soon as possible once you
10 realize this is a major trauma patient.
11 Q: For major trauma patients, what types of
12 assessments would need to be done on a primary
13 initial assessment?
14 A: Well you're first glace at the patient to see
15 how much distress he's having. You can check
16 their pulse, either radial or carotid pulse,
17 you can assess their breathing, work of
18 breathing or lack of work of breathing. And
19 then as you're assessing those things you could
20 start getting the patient ready for transport
21 on the stretcher and to the ambulance.
22 Q: Okay. Did you see any concerns with Mr.
23 Davenport's initial primary assessment?
24 A: Based on the video, his demeanor and rapport
25 with the patient. He stabilized the knife with

1 some bandages, and then they stood the patient
2 up and ambulated him out of the house down a
3 couple steps and to the stretcher that was
4 outside the ambulance doors. They put him on
5 the stretcher and then loaded him into the
6 ambulance. And then, after which, Mr.
7 Davenport rode in the truck, or drove while the
8 basic EMT rode with the patient.
9 Q: Okay. So you mentioned he did a visual
10 assessment at the scene of the injury. From
11 your review, did you observe any other kinds of
12 assessments vital signs taken by Mr. Davenport?
13 A: No, sir.
14 Q: Okay. Talked about the demonstrate
15 professionalism and courtesy. I think you
16 mentioned this in the previous protocol, GP-16,
17 it says go to appropriate treatment protocol.
18 So does universal patient care protocol and
19 patient safety protocol go hand in hand?
20 A: Yes, sir. They apply to all patients.
21 Q: Okay. Moving to the next page, page 16 of
22 Exhibit 1. What is GP-19?
23 A: Adult assessment protocol. It goes from the
24 history that the provider needs to obtain from
25 the patient. Pain assessment, there's a pain

1 scale, and then it goes down under EMT's and
2 intermediates as well as paramedics to size up
3 the scene, which means, you know, take
4 universal precautions if need be. Having
5 trouble with my vision here, but ascertain if
6 you need any additional resources, initial
7 assessment, the airway status, breathing,
8 circulation, mental status exam, general
9 impression, control major hemorrhage, assess
10 the need for any critical interventions,
11 anticipate the need for any additional
12 resources, complete any critical interventions,
13 which would mean critical would be more like if
14 they need an airway or they need a adult
15 decompression or IV, and then performing
16 secondary exam, and obtaining vital signs, and
17 then maintain ongoing assessment throughout
18 transport, which would be patient's responses
19 to interventions or complications interventions
20 needed for skilled interventions, and then
21 evolving patient complaints and condition
22 assessment.
23 Q: Okay. That last bullet point regarding
24 documentation ...
25 A: Oh, document the findings and information

1 associated with all the assessments, performed
2 procedures, and any medications administered in
3 the patient care report.
4 Q: How does GP-19 relate to GP-18?
5 A: Again, the adult assessment protocol goes with
6 all patients, adult patients, as does the
7 universal patient care protocol. But it also
8 goes into a little more detail about pain, a
9 little bit more detail about vital signs, more
10 detail about transportation, and then
11 reassessing the patient during transportation.
12 Q: Okay. What does a focus history and physical
13 based upon a patient's a Chief complaint
14 consist of?
15 A: The Chief complaint is what the patient
16 presents with either as they verbally complain
17 about what's bothering them or the initial
18 assessment from the provider. So then you
19 obtain a history based on what you're hearing
20 from the patient or what you're seeing when you
21 assess the patient. So you want to get a
22 history of -- in this case you want to get a
23 history of when it happened, how it happened,
24 why it happened. And then follow up with
25 assessment and took vital signs, and repeat

1 vital signs and repeat assessment to make sure
2 the condition doesn't change.
3 Q: Okay. When it first focused, is that referring
4 to looking at the particular injury and or
5 patient, particular patient that you've
6 encountered?
7 A: Yeah. It's kind of a general term, focused
8 exam. But you want to make history, focused
9 history, you want to take a history in
10 accordance with what you're presented with.
11 So, if it's a cardiac patient it's a different
12 history than if it's a respiratory patient,
13 different history than a trauma patient.
14 Q: Would you take a more comprehensive history
15 later on?
16 A: You could take additional history during
17 transport, but the primary concern is a load
18 and go scenario where you want to get the
19 patient and start going to the hospital with
20 penetrating wounds, penetrating wound to the
21 abdomen.
22 Q: From your review, do you have any concerns with
23 Mr. Davenport's compliance with GP-19?
24 A: Sorry. 19, oh, patient assessment. Yeah, the
25 initial assessment in terms of the vital signs,

1 maybe any additional history you might need,
2 how much pain he's having whether you're going
3 to treat pain or not, and then the ongoing
4 assessment while to the emergency department if
5 the patient's condition worsens.
6 Q: Okay. And, I think you might have explained
7 this, well what are critical interventions?
8 A: Critical interventions are life or limb saving
9 interventions. For example, a patient can't
10 breath and you can help them with an airway
11 would be a critical intervention. Pleural
12 decompression can be a critical intervention,
13 IV fluids, for cardiac patients who would need
14 medications and defibrillation, those are life
15 saving interventions or potentially life
16 saving.
17 Q: All right. Well let's turn back in the
18 protocols to page 5. Can you identify this GP-
19 1?
20 A: Yes. Adult airway management protocol.
21 Q: Now would that be applicable to this particular
22 patient?
23 A: It's applicable to all patients. That's why we
24 put it as number one.
25 Q: Okay. So what's the first step for complying

1 with this protocol?
2 A: For this patient, he's a major trauma patient,
3 so you'd go down to trauma. Technically he
4 should have had a non-rebreather mask at 10 to
5 15 liters per minute.
6 Q: You said technically. Is there ---
7 A: Correct.
8 Q: --- a reason why you said that?
9 A: Well the patient wasn't in any distress, but he
10 is a major trauma patient, so in that sense he
11 should have had a non-rebreather mask. The
12 patient had a, you know, good O2 saturation.
13 There didn't appear to be any distress. He was
14 a little bit anxious it looked like in the
15 video. That makes sense to be anxious in his
16 condition, but he should have had supplemental
17 oxygen.
18 Q: Okay. And what was the purpose ---
19 A: Is it a critical intervention? No. But based
20 on the protocols, any major trauma patient
21 should have IV, oxygen, cardiac monitor.
22 Q: I'm looking up here at the definitions, mild
23 distress and moderate slash severe distress.
24 A: Correct.
25 Q: Do you need mild distress or moderate to severe

1 distress in order to require oxygen,
2 supplemental oxygen?
3 A: Well the problem with writing the protocols is
4 it's hard to write them for every scenario. So
5 I would be happy with some supplemental oxygen
6 on this patient. He is a major trauma patient.
7 Would I be unhappy if he put a non-rebreather
8 mask at 10 to 15 liters per minute? No. Could
9 you say he was in mild distress and that's why
10 I'd put a nasal cannula on him? I would be
11 okay with that too, but ...
12 Q: Would you characterize this more as a best
13 practice?
14 A: Correct.
15 Q: Under trauma it mentions mechanism of injury
16 and or severe trauma. Can you explain what
17 mechanism of injury means?
18 A: Mechanism of injury is what happened based on
19 your history from the patient. So, a mechanism
20 could be hit by a car while walking, it could
21 be hit by a car while I'm in a car. It could
22 be I fell off a building. Those are all
23 mechanisms of injuries which gives us a clue to
24 what kind of injuries the patient may have
25 sustained based on that mechanism.

1 Q: Okay. What was the mechanism of injury for
2 this particular patient?
3 A: According to the patient care report, it's a
4 self inflicted stab wound to the abdomen.
5 Q: And as far as severe trauma, what's that mean?
6 A: Severe trauma is a generalization. People in
7 medicine know severe when they see it when it's
8 at the extreme. The skill level becomes seeing
9 the possibility of severe injuries when it's
10 not obvious. For example, a stab wound to the
11 abdomen in an unconscious patient with blood
12 all over the floor. An average person would
13 say, yes that's severe. But a stab wound to
14 the abdomen on somebody taking to you, you
15 might not know if it's severe or not.
16 Q: Okay. Would you consider this severe?
17 A: Yes. The mechanism of injury is severe.
18 Q: Okay. I've got a question. And I might be off
19 with this one. M-1?
20 A: So that's past cardiac?
21 Q: Yes, sir. I'm trying to find the Bates page
22 for you. It's Bates page 27.
23 A: Yes, sir.
24 Q: I know you mentioned this was a traumatic call.
25 Would this M-1 be applicable?

1 A: General medicine standards of care, just
2 looking at the title it tells me it's
3 applicable to all patients. Now you could
4 argue that this is a trauma patient, but trauma
5 patients have medical issues, so yes, I would
6 say it's applicable.
7 Q: Okay. Does this particular protocol address
8 oxygen administration?
9 A: Yes, sir.
10 Q: Okay.
11 A: On the second bullet, oxygen administration is
12 of paramount importance to the treatment of the
13 medical patient. The time oxygen
14 administration is initiated should be
15 documented on the patient care report.
16 Q: Okay. And what oxygen administered to this
17 particular patient?
18 A: Not that I'm aware of.
19 Q: Let's turn back to GP-3 please. This is on
20 Bates page 6. GP-3 is an intravenous access
21 protocol. Did you have any concerns -- well
22 first of all, would this particular protocol be
23 applicable to the patient in question?
24 A: Yes, sir.
25 Q: Okay. Why?

1 A: The patient needed IV access due to the
2 traumatic nature of his injury.
3 Q: Okay. You said IV access. Can you explain
4 that to The Court?
5 A: That's putting intravenous catheter cannulating
6 a vein so that you can administer fluids,
7 medications if need be.
8 Q: Okay. Why would that be required?
9 A: The patient's mechanism of injury has potential
10 to decompensate at any time or en route to the
11 emergency department. So having IV access is
12 very important. Sometimes we'll find that IV
13 access becomes much more difficult as the
14 patient loses blood, so you'd want to make sure
15 you put an IV in him as soon as possible, so
16 that you have an increase your chances of
17 successful IV cannulazation.
18 Q: Now I note that under EMT intermediate and EMT
19 paramedic there's saline lock and normal
20 saline?
21 A: Yes, sir.
22 Q: Can you explain the applicability or non-
23 applicability of those particular procedures?
24 A: Well a saline lock would be if you're trying to
25 keep the vein open to have access. We

1 generally use that for more medical cases,
2 traumatic injuries. It's simpler, easier to
3 hang an intravenous bag of saline solution, and
4 just run it, you know, at what we call a keep
5 open rate or just drip it in just to keep the
6 vein open and accessible.
7 Q: And what types of patients is this IV access
8 required for?
9 A: Well throughout the protocol it delineates
10 different patient complaints, patient
11 conditions that warrant IV access and IV
12 fluids. So it pretty much covers almost every
13 procedure in the protocols.
14 Q: Okay. From your review, did Mr. Davenport
15 establish IV access on this patient?
16 A: No, he did not.
17 Q: Now is attempting and establishing IV access an
18 ALS or BLS skill?
19 A: It is an intermediate and paramedic skill.
20 Q: Okay. So would Ms. Aiken, as a EMT basic be
21 allowed to provide that skill?
22 A: No, sir.
23 Q: Okay. Now if ALS care is required, who must
24 ride in the ambulance?
25 A: The paramedic.

1 Q: Okay. Well let's get to the trauma protocols.
2 It's my understanding you said those were
3 applicable. T-1, general trauma standards of
4 care is on page 42, Bates page 42 of Exhibit 1.
5 A: Yes, sir.
6 Q: Would this be applicable?
7 A: Yes, sir.
8 Q: Why is that?
9 A: Critical trauma, paramedics or EMT's must
10 remember traumatically injured patients need
11 immediate surgical -- may need, should say may
12 need immediate surgical intervention, which is
13 the case here. Talks about rapid extrication
14 which is more for car wrecks. But it's
15 important for quick assessment at the scene,
16 assess the hazards, assess the patient for
17 airway breathing, circulatory problems,
18 recognize the need for additional equipment,
19 correct any life threatening problems
20 immediately, administer oxygen airway
21 maintenance as soon as possible. Crew should
22 attempt to leave the scene within ten minutes
23 of all trauma patients that meet the load and
24 go criteria and 15 minutes for all trauma
25 patients. Notify the emergency department.

1 All IV lines should be established en route to
2 the emergency department unless the patient's
3 entrapped or the IV will delay transport.
4 Reassessment of the primary survey, vital
5 signs, neurological status is important and
6 should be done frequently while treating the
7 patient.
8 Q: Okay. Well you mentioned the titles within
9 this T-1, critical trauma and other trauma.
10 Could you explain the distinction between those
11 two terms?
12 A: Well critical trauma is -- I use the word
13 critical trauma. Major trauma is based on --
14 maybe it's on this trauma transport protocol.
15 You talking about T-02 ---
16 Q: No, sir.
17 A: --- or still on T-01?
18 Q: I was still on T-01. You were reading through
19 those bullet points and it looks like there's
20 a heading, critical traumas and other traumas
21 and geriatrics?
22 A: Yes, sir.
23 Q: So I was looking for the distinction between
24 critical trauma and other trauma if any.
25 A: Oh. The distinction for the critical trauma is

1 respiratory distress, altered mental status,
2 shock, unsafe scene that pertains to rapid
3 extrication. So it's semantics, it's difficult
4 to write sometimes what you're trying to get
5 at. But the paramedics and EMT's that go
6 through their courses and training, that
7 information is constantly reenforced. But a
8 critical trauma, another name for that could be
9 major trauma, and major trauma could be a car
10 wreck or a fall from a height, or shooting, or
11 stabbing. Those are all major traumas.
12 Q: What about high level?
13 A: High level falls?
14 Q: Trauma.
15 A: High level trauma. Not really sure what you
16 mean by that.
17 Q: Okay. Fair enough. Talked about T-1. Let's
18 move to the second page in the trauma section,
19 T-2. Would that be applicable?
20 A: Yes, sir.
21 Q: And why is that?
22 A: For patients who sustain any of the following
23 traumatic injuries or have a revised trauma
24 score of ten or less should be transported to
25 as defined by the following. So traumatic

1 injuries in this patient, he had penetrating
2 abdominal wounds. That's under blunt or
3 penetrating abdominal injury. So then it gives
4 guidelines of which trauma center to take them
5 to, and it gives guidelines for when a
6 helicopter or air medical transport could be
7 utilized.
8 Q: Okay. And did they comply with that directive?
9 A: They complied in the sense that they didn't
10 call for a helicopter because their transport
11 time, based on the DHEC I think was about 22,
12 23 minutes, maybe 24 minutes. So they're not
13 supposed to call for a helicopter if their
14 ground transport time is less than 30 minutes.
15 But they did take the patient to the closest
16 trauma center, which was AnMed.
17 Q: And that would be in accordance with the policy
18 or this protocol?
19 A: Correct.
20 Q: Okay. Next protocol, T-3, on the right of page
21 43, multiple trauma slash shock protocol.
22 Would this be applicable to this particular
23 call?
24 A: Yes.
25 Q: Can you explain why?

1 A: Well it has, for example, controlled bleeding
2 for example. Under the top part, general
3 information, level of consciousness, specific
4 injuries, respiratory rate, circulatory status,
5 those are all assessment skills to assess the
6 patient, what to evaluate in a multiple trauma.
7 Multiple trauma is kind of a misnomer because
8 the trauma is to the abdomen, but multiple in
9 the sense that it could have affected multiple
10 organs. So it delineates starting an IV,
11 control bleeding, rapid extrication techniques,
12 spinal immobilization, airway management
13 protocol which includes oxygen.
14 Q: Okay. Well we talked about oxygen. And I'm
15 looking at management for a paramedic. What
16 about spinal immobilization. Would that be a
17 requirement?
18 A: Yes and no. You'd want to minimize any
19 unneeded movement of the patient. There's a
20 potential for spinal cord injury with
21 penetrating trauma. So in that sense a back
22 board could be utilized to transfer the patient
23 from the position they were found in to the
24 stretcher.
25 Q: Well going off of that, did you have a concern

1 about this patient being transported supine
2 versus remaining in the position that he was
3 found it at the scene of the accident?
4 A: I think to move the patient to the stretcher to
5 the ambulance to the hospital with the least
6 amount of manipulation of the patient and or
7 the knife to minimize injury is the most
8 important thing. So whatever it would take to
9 -- I would be okay with whatever it took to get
10 him on the stretcher, get him to the ambulance,
11 trying to minimize movement.
12 Q: From your review, did it appear that it
13 minimized movement?
14 A: Not from the video.
15 Q: Okay. Talk about control bleeding. Would the
16 pneumothorax pleural decompression protocol be
17 applicable?
18 A: It could be. Didn't appear the patient was in
19 any respiratory distress, but to assess that
20 you have to listen for breath sounds and check
21 the other physical exam findings. It's
22 probably not applicable in this case, but ...
23 Q: Was the proximity of the wound something that
24 would require follow up?
25 A: It could cause diaphragmatic injury. It's

1 possible. Diaphragm's at the bottom part of
2 the lungs.
3 Q: Is that within the general vicinity of ---
4 A: Yes, sir.
5 Q: --- the wound? Transport load and go. Would
6 you first explain the criteria for transport
7 load and go?
8 A: Transport load and go is for the seriously
9 injured patient or the patient that has the
10 potential for serious injury or the potential
11 to have declining or worsening of their
12 condition. So the load and go name is more of
13 an acronym. Maybe that's not the best word.
14 It's what we use to delineate that speed is of
15 the essence and we -- with these types of load
16 and go patients, and we try and list them that
17 speed is of the essence to get the patient to
18 the hospital for definitive treatment.
19 Q: Okay. And I think the first bullet point with
20 general information. What does that provide as
21 far as load and go?
22 A: I didn't hear that first sentence.
23 Q: That first bullet point under general
24 information of T- 3.
25 A: T-3, general information. Altered level of

1 consciousness, respiratory distress or shock
2 are considered load and go. The patient should
3 be transported within ten minutes after
4 arrival. I can't read the next sentence.
5 Q: Unless extenuating circumstances exist?
6 A: Yes, sir.
7 Q: Okay. And would a load and go -- would this be
8 a load and go patient?
9 A: Yes.
10 Q: Could you explain why?
11 A: Because of the penetrating injury and the
12 potential for the patient's condition to
13 worsen.
14 Q: Can you explain the condition to worsen?
15 A: He could have bleeding, go into shock, have
16 cardiac arrest, and expire.
17 Q: Getting back to the management section of T-3,
18 it mentions initiate cardiac monitor lead two.
19 Excuse me, what is cardiac monitor lead two?
20 A: Lead two is a specific position that you put
21 the pads in order to hook the wires to the
22 pads. So the pads are the conduit for the
23 electrical impulse from the heart to be picked
24 up by the pad, go up through the electrical
25 wires to the monitor. So it's a standard lead

1 placement, lead two.
2 Q: Okay. What level certification must an EMT
3 have in order to ---
4 A: a paramedic level.
5 Q: Would that be applicable for this particular
6 patient?
7 A: Yes, sir.
8 Q: From your review, did Mr. Davenport comply with
9 that directive?
10 A: From what I could see from the video, or the
11 patient care report, no.
12 Q: Okay. Would the cardiac monitor -- where would
13 the cardiac monitor lead two be applied? Would
14 it be applied at the scene of the accident?
15 A: In the ambulance would probably be the most
16 expedient way to do it.
17 Q: Okay. And who was in the ambulance patient
18 compartment?
19 A: The basic EMT, Ms. Aiken.
20 Q: All right. Let's turn back a little ways to M-
21 9, and that is page 31 of the Exhibit 1, DHEC's
22 Exhibit 1. Now, Dr. Kickham, can you identify
23 that protocol?
24 A: Psychiatric emergency protocol, M-09.
25 Q: And who would that be applicable to?

1 A: History, suicidal patients under pertinent
2 findings, suicidal tendencies, depression --
3 stretching my eyeballs here. Evidence of
4 trauma or serious illness, evidence of
5 medication or toxins at the scene, threats or
6 hostility to EMS or others, substance abuse,
7 recent trauma or underlying illness.
8 Q: Would this protocol be applicable to the
9 patient in question?
10 A: Yes. Based on the fact that it was reported to
11 be self inflicted.
12 Q: Okay. Any other basis?
13 A: Not that I can think of.
14 Q: Okay. And what would this require as far as
15 demeanor or interaction with the patient?
16 A: It delineates some things here, be alert for
17 weapons, request assistance, need for
18 restraints.
19 Q: Okay. Well let's talk about that. Can you
20 explain the use of restraints for EMT's under
21 your direction and oversight?
22 A: Restraints are used to protect the patient and
23 protect the providers, the EMT's and
24 paramedics. Some patients can't control
25 themselves either due to behavioral problems,

1 drugs, alcohol, therefore restraints are
2 sometimes used to hold their hands down so they
3 can't pull their IV out or pull their oxygen
4 off or they can't hurt someone or climb out of
5 the ambulance or ... It's trying to prevent
6 injury to patient and staff members.
7 Q: How would an EMT make a determination of
8 whether to apply restraints?
9 A: It's a judgement call based I think on their
10 level of risk and their assessment of the
11 patient, whether the patient is a danger to
12 himself or others.
13 Q: From your review of this matter, did you have
14 concerns with the restraints?
15 A: Yes. I thought restraints should have been
16 used because of the weapon involved. With the
17 EMT by him or herself in the back of the
18 ambulance with the patient with the weapon, one
19 of my concerns was restraints, that they could
20 have been, should have been applied to protect
21 the patient, protect the provider.
22 Q: Okay. I think this is a bit odd. At the
23 emergency department, did you actually observe
24 this patient?
25 A: Yes, sir.

1 Q: On the night in question?
2 A: Correct.
3 Q: What was your thoughts?
4 A: I was working that night and when they wheeled
5 him by to the Operating Room, I noticed that he
6 did not have restraints on him, and one of the
7 thoughts that went through my head was, if
8 something happens in the elevator to the
9 Operating Room it's going to be very
10 unfortunate if the patient were to remove that
11 knife and attack someone in that enclosed
12 elevator space.
13 Q: Okay. Moving away from restraints, what does
14 M-9 say as far as interactions, verbal
15 interactions with a patient?
16 A: I think you're talking about the top bullet
17 under general information. Do not assume that
18 the patient condition is purely psychological.
19 You're making me read this and I can't hardly
20 read this. Rule out medical illnesses,
21 additional medical conditions that might cause
22 psychiatric problems, I think that's what that
23 says. The patient who is treated as quote
24 helpless or crazy end quote will frequently
25 behave according to those expectations. A calm

1 reassuring supportive approach is best.
2 Introduce yourself and state that you want to
3 help and explain what you intend to do. I
4 think I read that right.
5 Q: Okay. Did you have concerns with Mr.
6 Davenport's compliance with this directive?
7 A: Yes, sir.
8 Q: Okay. What were they?
9 A: Based on the video, I didn't see too much
10 compassion or calm reassurance.
11 Q: Did you see him introduce himself?
12 A: Not that I can recall. I think he knew the
13 patient from previous encounters, but I'm not
14 sure if the patient knew him.
15 Q: I think we might have discussed this some
16 already, but are there any applicable
17 medications for this patient?
18 A: That wasn't ---
19 Q: You know what, hold on. Before I move on to
20 that, there's something I forgot. I'm sorry to
21 cut you off. Moving to the management section
22 under paramedic discusses ruling out a number
23 of items. Could you explain what that process
24 is to entail?
25 A: Well it's to remind the provider that not all,

1 what seems to be psychiatric emergencies are
2 based on behavior alone. It could be due to
3 low or high blood sugar, substance abuse or
4 overdose, or oxygen problems that could affect
5 patient's mental state.
6 Q: Would that be part of the primary initial
7 assessment, or would that be something latter
8 as far as ---
9 A: I think it's both. I think it's in the initial
10 observations as well as subsequently en route
11 to the emergency department. Assessing for
12 those problems with history and or blood sugar
13 check.
14 Q: Did you have concerns with that regarding this
15 patient?
16 A: In this case, based on the video, not too much.
17 Q: Okay. All right. Moving back to medications,
18 were there any applicable medications for this
19 patient?
20 A: Not that I'm aware of. We could look at the
21 DHEC and put that in, but that's usually one of
22 the things that they would assess en route to
23 the emergency department, allergies or
24 medications.
25 Q: Well I was talking about as far as

1 administrations of medications to this
2 particular patient.
3 A: There is a concern about pain and administering
4 pain medication. The patient looked to be in
5 a lot of pain in the video. When they were
6 walking him to the ambulance he was complaining
7 of pain a lot, somewhat when he was sitting on
8 the couch. So I'm sure it was painful for him.
9 Q: Okay. Who may have administered pain
10 medications?
11 A: The paramedic.
12 Q: Can an EMT basic?
13 A: No, sir.
14 Q: Okay. All right. Well let's move onto
15 policies. And let's start with policy seven.
16 These are a little bit larger text, so
17 hopefully this will be easier to read for you.
18 Are you familiar with this policy?
19 A: Where are you at?
20 Q: I'm sorry. I'm still on Exhibit 1, it's page
21 89.
22 A: Okay. Yes, sir.
23 Q: Okay. You said you are familiar with it?
24 A: Yes, sir.
25 Q: Okay. What does it require?

1 A: It's titled authority for patient management
2 policy.
3 Q: And how does it direct to manage patient care?
4 A: Well under the policy part or the policy of
5 Anderson County EMS providers that authority
6 for patient management of and out of hospital
7 medical emergency situation shall be the
8 responsibility of the individual first on the
9 scene in attendance with the patient who is
10 most appropriately trained and knowledgeable in
11 providing pre-hospital emergency stabilization
12 and transport for the situation at hand.
13 Ideally the senior paramedic of the primary
14 responding agency will assume responsibility
15 for the patient management.
16 Q: Okay. So on this particular call, who was the
17 most appropriately trained and knowledgeable
18 for providing pre-hospital emergency
19 stabilization?
20 A: I don't know who else was on the scene, but I
21 would assume that Mr. Davenport was far and
22 away the most knowledgeable.
23 Q: Well between Ms. Aiken and Mr. Davenport?
24 A: Mr. Davenport.
25 Q: Who was the senior paramedic at the incident?

1 A: Correct.
2 Q: Correct, Mr. Davenport?
3 A: Correct, Mr. Davenport.
4 Q: Okay. Under procedure, forth paragraph talks
5 about delegation of patient management and
6 transportation. Can you explain your
7 understanding?
8 A: He she may delegate all or part of the patient
9 management and transport to others who are
10 qualified to meet the patient's immediate needs
11 and reasonably perceived needs. However he she
12 must intervene and take control at any time the
13 management of the patient becomes unacceptable.
14 That's written mostly for calls that are basic
15 calls or basic life support calls, which would
16 be minor lacerations, or sprained ankles, or
17 bee stings, or where the patient doesn't appear
18 to be in any distress or potential to be under
19 distress.
20 Q: Okay. Well was Ms. Aiken qualified to meet the
21 patient's immediate needs?
22 A: During transport, no. She could assist with
23 the patient's immediate needs ---
24 Q: And can you explain?
25 A: --- at the scene. But it's my opinion that the

1 paramedic should have ridden with the patient
2 in the ambulance en route to the emergency
3 department to assess for further problems and
4 need for intervention.
5 Q: Well what were the patient's immediate needs?
6 A: Immediate needs, kind of what we talked about
7 before, don't want to rehash that. I'm not
8 sure. Do you want to rephrase that or, I'm not
9 sure what you mean.
10 Q: Well I mean ---
11 A: I mean immediate needs are, we can go back.
12 Airway, oxygen, IV, and pain medication,
13 assessment, transporting the patient without
14 moving him as much as possible, ongoing
15 assessment en route to the emergency
16 department, and load and go criteria.
17 Q: Okay. Similar policy, policy 26. It's page
18 125.
19 A: Yes, sir.
20 Q: Can you identify this policy?
21 A: Interfacility transport policy.
22 Q: Can you go back one, page 125, it's policy 26.
23 A: Non-paramedic transport of patient's policy?
24 Q: Yes. Can you explain the requirements of this
25 policy?

1 A: The provider with the highest level of
2 certification on scene shall conduct a detailed
3 physical assessment and subjective review of
4 the patient, determine the Chief complaint and
5 level of distress. If the technician
6 determines that the patient is stable and all
7 patient needs can be managed by the lower level
8 provider, patient can be transferred to a
9 technician of lower level certification for
10 care while en route to the hospital.
11 Q: Did you have concerns with that, compliance
12 with that provision?
13 A: Correct. I did not think this was a minor
14 injury that would make it okay for a basic EMT
15 to transport the patient in the back of the
16 ambulance.
17 Q: What's the forth bullet, excuse me, fifth
18 bullet point under policy?
19 A: Paramedic performing the paramedic assessment
20 must document all the findings in the
21 assessment. Other documentation may be
22 completed by the transporting personnel. As
23 all documentation, all providers responsible
24 for the contents of the report. It basically
25 says that even though the paramedic can allow

1 the basic to transport the patient and the
2 paramedic is still responsible for the
3 documentation.
4 Q: Any concerns with Mr. Davenport's
5 documentation?
6 A: I believe he did not document. I believe all
7 the documentation was done by the basic EMT,
8 Ms. Aiken.
9 Q: Then it lists a number of patients that cannot
10 be transferred to a lower level certification.
11 Are any of those patients or anything in that
12 list applicable to this particular matter?
13 A: It says multiple trauma under the third bullet
14 down, which this patient applies to. Any
15 patient which all EMS providers on scene do not
16 agree can be safely transported without a
17 paramedic in attendance. I'm not sure that
18 that was agreed upon. Any patient that there's
19 a question as to underlying cause of the Chief
20 complaint should be a paramedic call. Any
21 patient that has received ALS intervention at
22 the scene, the paramedic must accompany the
23 patient to the hospital if the BLS crew and or
24 crew member expresses any discomfort with
25 assuming care of the patient regardless of

1 whether or not the paramedic believes all ALS
2 procedures are warranted. I think I read that
3 right.
4 Q: Okay.
5 A: It's the responsibility of the BLS crew to
6 state they're uncomfortable with managing the
7 patient.
8 Q: Okay. Moving on in the policy booklet, page
9 138 of Exhibit 1.
10 A: Patient abuse policy?
11 Q: Yes, sir. Can you explain the requirements?
12 A: Anderson County EMS providers understand that
13 as an EMS system we have the responsibility to
14 ensure that the patient and or customers, that
15 we provide medical care for and transport are
16 safe from abuse. Make sure quality patient
17 care is provided. Inform providers that
18 patient abuse will not be tolerated.
19 Q: What is abuse according to this policy?
20 A: Well there's verbal intimidation, derogatory
21 remarks, sexual advances, physical violence,
22 physical intimidation, are conduct of abuse.
23 Q: Under procedures, second paragraph it looks
24 like there a ---
25 A: Abuse of any patient in any way or any degree

1 is illegal and will not be tolerated. Patient
2 abuse is defined as being disrespectful,
3 inconsiderate, careless, unprofessional, overly
4 aggressive, or the use of unreasonable force
5 towards the patient.
6 Q: From your review, how did Mr. Davenport's
7 interactions with this patient relate to this
8 patient abuse policy?
9 A: Verbally abusive, disrespectful, careless,
10 unprofessional.
11 Q: Okay. Were there any other standards,
12 protocols that are applicable to this patient
13 that we haven't discussed?
14 A: I'm sure there are but I can't think of any.
15 Q: Okay. All right. Well following the Anderson
16 County investigation did you meet with Mr.
17 Davenport prior to rendering your remediation?
18 A: We met, myself, Scott Stoller, and Mr.
19 Davenport met. We talked about the cases that
20 we were concerned about, particularly this one.
21 Scott and I met briefly afterwards and we came
22 up with our plan of what we thought was
23 reasonable remediation at that time before
24 viewing the video, before the video was
25 available. Subsequent to that initial meeting

1 I met personally with Mr. Davenport in one of
2 the conference rooms by the emergency
3 department. He wanted to meet with me post
4 after our QI meeting. We met for a few minutes
5 before one of my shifts.
6 Q: Okay.
7 A: Those were our two meetings.
8 Q: Well, backing up. Before the second meeting,
9 what was the determined remediation for this
10 particular patient encounter?
11 A: Mr. Stoller said that there was an ethics
12 course put on by someone in Columbia. I'm not
13 sure if it was a DHEC course, but I think it
14 might have been a DHEC course. And we agreed
15 that that course might be beneficial for Mr.
16 Davenport. We also requested that he review
17 the treatment policies and procedures and
18 retake the standing orders test after he
19 reviewed those.
20 Q: Okay. And now, in relation to your second
21 meeting at the hospital, what was discussed at
22 that meeting?
23 A: Mr. Davenport wanted to meet with me, and we
24 met briefly before my shift. Basically he
25 apologized for I think putting me through that

1 kind of QI meeting, and wanted to make sure
2 that there wasn't any hard feelings, and that
3 you know we could still work together and
4 function.
5 Q: Who requested that meeting?
6 A: Mr. Davenport.
7 Q: Okay. And, did you get the impression that Mr.
8 Davenport understood your concerns?
9 A: Yes.
10 Q: He did understand your concerns?
11 A: Yes.
12 Q: Okay. And what did you base that on?
13 A: His body language more than anything.
14 Particularly the second meeting, he said, you
15 know, he apologized and we could continue to
16 work together. Mr. Davenport's role was in the
17 administration with EMS and Anderson County.
18 I'm not sure exactly what his title was, but he
19 was in administrative position with Anderson
20 County with Mr. Stoller. His office was just
21 down the hall from Mr. Stoller and right next
22 to the administrative secretary, Ms. Kaiser.
23 So we need to have a working relationship based
24 on that.
25 Q: Okay. Well let's move to Exhibit 14. Now this

1 in an email from Mr. Davenport to Mr. Stoller.
2 Second paragraph, I guess it's the second
3 sentence. The differences expressed in the
4 case review incident number 160083574 was
5 merely the action Dr. Kickham would have
6 preferred to see occur in similar situations.
7 Is that a correct understanding of your
8 concerns?
9 A: I kind of lost you a little bit. We're in the
10 second paragraph -- 'cause I was on the wrong
11 tablet. We're on the 14 tab which is
12 restoration of medical control?
13 Q: Yes, sir.
14 A: Looks like kind of an email, yes.
15 Q: From Davenport to Stoller.
16 A: Yes. Okay. I see it.
17 Q: Second paragraph, second sentence.
18 A: Yes, sir.
19 Q: Are you in agreement with that?
20 A: Furthermore the conclusion of each case review
21 is determined by Dr. Kickham that the treatment
22 rendered to the patient has been the cause of
23 question, were neither substandard, in
24 violation of, or outside the scope or depth of
25 practice for similarly trained paramedic

1 according to Anderson County EMS protocols.
2 No, I do not agree. The differences expressed
3 in the case review incident number was merely
4 the action Dr. Kickham would prefer to see in
5 similar situations. Yes. That was the -- that
6 tells me that he understood that what we
7 discussed was what should have happened in that
8 case and future cases, though he doesn't quite
9 word it that way.
10 Q: Okay.
11 A: Whereas, when he talks about the other two
12 cases that we talked about in that meeting, the
13 conclusion of the review with Dr. Kickham is
14 that I did not violate my duty to act as a
15 paramedic per Anderson County EMS treatment
16 protocol. That's not true.
17 Q: So you did determine that this was substandard
18 care?
19 A: Yes.
20 Q: Did you determine that he violated the
21 protocols?
22 A: Yes.
23 Q: Okay. And just, I think I might have asked the
24 question wrong regarding your second meeting.
25 Did you leave that meeting with the impression

1 that Mr. Davenport understood concerns you had
2 with patient care?
3 A: Yes.
4 Q: He did?
5 A: Yes.
6 Q: Okay.
7 **MR. ROTHSTEIN:** Your Honor, he's trying to coach the
8 witness. I mean, he asked this question three
9 times and he's gotten the same answer.
10 **THE COURT:** Right. Yes. It's been asked and
11 answered.
12 **MR. WICEVIC:** Okay.
13 Q: Okay, last question. And I'm not asking you
14 what you would have done, but would your
15 decision -- I know your initial decision was to
16 require the standing orders test and the PEPL
17 training. With the benefit of the body cam
18 footage, would you have had a different
19 decision as far as remediations or sanctions
20 concerning Mr. Davenport?
21 A: Yes.
22 Q: Okay. That's all I have. Please answer any
23 questions Mr. Rothstein has.
24 **THE COURT:** Okay. Before we get to Mr. Rothstein's
25 cross, we're going to take a ten minute break.

1 **(Off the record from 4:06 p.m. until 4:18 p.m.)**
2 **THE COURT:** Please take your seats. Mr. Rothstein,
3 we're ready to begin with your cross.
4 **DR. KICKHAM - CROSS-EXAMINATION BY MR. ROTHSTEIN:**
5 Q: Good afternoon, Dr. Kickham. Let's take up
6 where we left off. If you'll open up that last
7 exhibit that you were looking at, Mr.
8 Davenport's letter or email.
9 A: Yes, sir.
10 Q: The last paragraph of that letter states, if
11 this is not the case, and I was in violation of
12 Anderson County EMS treatment protocols or
13 Anderson County EMS policy, please provide to
14 me in writing the areas where protocols,
15 policies, or my duties to act was breached. Do
16 you see that?
17 A: Yes, sir.
18 Q: It says, I have high expectations of my skill
19 competency and will fully address each short
20 comings in my own follow on training. Do you
21 see that?
22 A: Yes, sir.
23 Q: Did you or Mr. Stoller ever respond to Mr.
24 Davenport in writing as he requested?
25 A: I did not. I'm not sure if Scott did or not.

1 Q: Now, you testified about the meeting with Mr.
2 Davenport and Mr. Stoller on, I think it was
3 Friday morning right after you all met with the
4 partner Kim Aiken, is that right?
5 A: Yes, sir.
6 Q: About how long did that meeting last?
7 A: The meeting with Kim, Ms. Aiken?
8 Q: No. The meeting with Mr. Davenport.
9 A: An hour and a half, two hours.
10 Q: You sure it was that long?
11 A: I'm not sure.
12 Q: Okay.
13 A: I think it started about 9:00 in the morning
14 and went till about noon. So ...
15 Q: Did you discuss -- I know Mr. Wicevic went into
16 detail with you about all these different
17 policies and procedures and protocols that you
18 now have concerns about, is that right? Did
19 you go through the policy and procedure manual
20 with Mr. Davenport in that manner and say,
21 James, you know, let's look at GP number 1 and
22 then look at GP ... Did you go through the
23 policy book with Mr. Davenport to point out
24 where you thought he had fallen short with
25 these patients?

1 A: No, sir.
2 Q: Okay. Did you even have the policy manual with
3 you during that meeting?
4 A: I'm not sure. We probably had it in Scott's
5 office.
6 Q: You think you had it available but not in the
7 meeting?
8 A: We were in Scott's office, so I'm sure there
9 was a copy in the office.
10 Q: But do you recall going through the booklet
11 with Mr. Davenport and ---
12 A: No.
13 Q: --- pointing out specific policies you had
14 concerns about?
15 A: I recall that we did not.
16 Q: Did Mr. Davenport ever directly disobey an
17 order that you provided him?
18 A: A verbal order? No.
19 Q: Verbal order. Did he ever violate a standing
20 order of yours?
21 A: Yes. Based on the testimony I just gave.
22 Q: Okay. And I think you're equating the term
23 standing order with the term protocol. Is that
24 right?
25 A: Correct.

1 Q: But let's --- did Mr. Davenport to your
2 knowledge ever violate an online Medical
3 Control Physician's order telling him to do
4 something?
5 A: No, sir.
6 Q: Okay. Did Mr. Davenport ever violate one of
7 the standing orders regarding specific like
8 drug levels or oxygen levels or treatment
9 modalities for a specific patient concern?
10 A: Well, I think I understand your question. We
11 had three cases that we went over that day with
12 Mr. Davenport. So before the meeting I asked
13 the quality improvement officer for the Iva
14 Rescue Squad, Mr. Lawless, if he had any other
15 cases of concern that he had that we needed to
16 address at that meeting. Those are the only
17 other two that I'm aware of.
18 Q: Let me ask you to look at the introduction.
19 It's Exhibit 1, it's in the big notebook.
20 A: Exhibit 1?
21 Q: Exhibit 1. And if it's easier, I know you said
22 you're having trouble seeing the smaller print.
23 If you want to use this one.
24 A: I don't have them in here but I have the
25 treatment protocols.

1 Q: Okay. If you want to look at the introduction
2 to this one ---
3 A: Sure.
4 Q: --- I'll take your word that they're the same
5 documents.
6 A: Okay.
7 Q: You referred to these, the whole document, the
8 notebook you're looking at as guidelines, don't
9 you?
10 A: Well, I don't know. It has many terms,
11 standing orders, policies and procedures, you
12 know, guidelines for treatment. Yes.
13 Q: Okay. Let me ask you to look at the second
14 paragraph in the introduction. It says, while
15 treatment and transport decisions in the field
16 vary, these guidelines, and when you use that
17 term these guidelines, you're talking about
18 this book, right? The protocols and policies
19 and procedures?
20 A: Yes, sir.
21 Q: Okay. So you called them guidelines, not
22 standing orders, right?
23 A: In that sentence, yes, sir.
24 Q: Okay. So it says, these guidelines can assist
25 the pre-hospital provider by standardizing

1 procedures for the most common and routine
2 emergencies encountered and will be considered
3 the minimum standards by Anderson County EMS.
4 Did I read that correctly?
5 A: Yes, sir.
6 Q: Okay. And then the next paragraph says,
7 therefore it is imperative that each provider
8 develops a strong understanding of the etiology
9 of an illness and the application of these
10 protocols, right?
11 A: Yes, sir.
12 Q: Okay. Next sentence says, by doing so,
13 providers will be able to evaluate each
14 patient's situation as opposed to blindly
15 following the protocols.
16 A: Yes, sir.
17 Q: Okay. So the goal in having well experienced
18 and qualified paramedics is they can think for
19 themselves instead of blindly following a
20 checklist in a protocol, isn't that right?
21 A: Yes and no.
22 Q: Okay. But isn't that what he sentence says?
23 A: Yes. That's what the sentence says. You're
24 correct.
25 Q: Sometimes blindly following protocols is bad

1 medicine, isn't that right?
2 A: It can be.
3 Q: I think Mr. -- you weren't here yesterday. I
4 don't think I saw you. But there's a protocol
5 for initiating CPR that says, if the patient's
6 in cardiac arrest immediately initiate CPR as
7 the first thing, correct?
8 A: Yes, sir.
9 Q: Mr. Davenport pointed out that if you get to a
10 patient who's in the water, the first thing
11 you've got to do is get that patient out of the
12 water before you start CPR on the patient,
13 right? Because you can't do CPR in the water.
14 Do you agree with that?
15 A: Not necessarily, but you would have to put him
16 on a back board in the water.
17 Q: So your sort of hope or goal as paramedics go
18 throughout their experience is that they
19 develop good judgement to be competent
20 providers in providing pre-hospital care, is
21 that right?
22 A: Correct.
23 Q: And these protocols are written for brand new
24 paramedics first day they've ever been on the
25 truck, right, as well as 30 year veterans

1 who've bee in the field for a career. Do you
2 agree with that?
3 A: Correct.
4 Q: Let's go down to the fifth paragraph of that
5 introduction. Last sentence there says, all
6 providers are responsible for their own
7 individual actions with regards to protocol
8 compliance, and any deviation from the
9 standards stated herein must be documented and
10 explained, correct?
11 A: Yes, sir.
12 Q: Okay. So your protocols have room for
13 deviation if the paramedic can explain it and
14 document why he didn't follow every tic mark in
15 the protocol, correct?
16 A: Correct.
17 Q: If you have a standing order for something,
18 like say a specific drug dosage, like if you're
19 going to give morphine to a patient, you give
20 him this amount of drug if he weighs a certain
21 amount. Can paramedics deviate from that
22 standing order for drug dosage?
23 A: The standing orders usually have a range of how
24 much medication you can give. It wouldn't
25 bother me if they gave less. If they gave more

1 it would be a concern.
2 Q: Do the Anderson County protocols that you've
3 been responsible for drafting for 24 years have
4 a definition for the word trauma in it?
5 A: I don't know.
6 Q: Okay. Now what is your understanding of the
7 definition of the word trauma?
8 A: Injury.
9 Q: Okay. Is a bee sting a trauma?
10 A: Yes.
11 Q: If you have a hangnail, is that a trauma?
12 A: I guess if you obtain the hangnail in a
13 traumatic manner.
14 Q: What about cutting yourself shaving, is that a
15 trauma to the body?
16 A: Yes, sir.
17 Q: Okay. Stubbing your toe, is that a trauma?
18 A: Yes, sir.
19 Q: Do the protocols themselves define the term, I
20 think you used a couple different synonyms, I
21 think you said critical trauma, major trauma,
22 and serious trauma. Do the protocols define
23 those terms?
24 A: We'd probably have to look at a specific page.
25 Q: I think you actually testified a few minutes

1 ago when Mr. Wicevic asked you if you've ever
2 heard the term high level trauma, you didn't
3 know what he was talking about, right?
4 A: No.
5 Q: Okay. I think you said that this is kind of a
6 matter of semantics, that it's difficult to
7 write what you're trying to get at in the
8 policies. Do you agree with that?
9 A: Policies can be very difficult to write, yes.
10 Q: The only place -- I've gone through these
11 polices several times. The only place I've
12 seen the phrase penetrating abdominal injury is
13 in trauma policy T-2. Do you agree with that?
14 A: No. I'm sure it's in other ---
15 Q: You think it's somewhere else?
16 A: Probably.
17 Q: Okay. Did you have a specific penetrating
18 abdominal injury protocol in place at the time
19 of Mr. Davenport's interaction with the
20 stabbing patient?
21 A: No. We did not have a protocol entitled that.
22 It's included in ...
23 Q: So if you had a brand new paramedic on the
24 scene that said, okay this is a penetrating
25 traumatic injury, the stabbing wound, and they

1 went and looked at the table of contents under
2 trauma, they would not have found anything that
3 said what to do in the event of a abdominal
4 impaled object?
5 A: They'd have to go to the multiple trauma.
6 Q: Okay. Didn't we talked about the multiple
7 trauma issue in your deposition, do you recall
8 talking about multiple trauma?
9 A: I didn't review it, but I'd be glad to discuss
10 it with you.
11 Q: Do you remember having your deposition taken on
12 June the 7th of 2017 in the Anderson County
13 Courthouse?
14 A: Yes, sir.
15 Q: I'm going to hand you a copy of that document.
16 And if you'll turn to page 110.
17 A: Yes, sir.
18 Q: Hold on a second. Let me catch up with you.
19 You see lines 9?
20 A: Yes, sir.
21 Q: I'm going to read the question at line 9. My
22 question was, did that patient have multiple
23 traumas? Okay. And your answer was, that
24 would be determined at surgery, but there would
25 be one area of trauma, would be the abdomen.

1 Did I read that correctly?
2 A: Yes, sir.
3 Q: Okay.
4 **MR. WICEVIC:** Your Honor, I request that he reads
5 the rest of the line of questioning.
6 **MR. ROTHSTEIN:** Mr. Wicevic can answer whatever he
7 wants to answer -- I mean ask him on re-direct,
8 Your Honor.
9 **THE COURT:** Right.
10 **MR. WICEVIC:** Okay.
11 Q: And then line 20, I asked, question, well you
12 said this one, referring to T-3, that was the
13 multiple trauma and shock policy, was
14 applicable. And I asked, why is it applicable,
15 correct?
16 A: Yes, sir.
17 Q: And your answer was, well the potential was
18 there for shock with a penetrating wound to the
19 abdomen. If the knife wound injured a blood
20 vessel and you had excessive bleeding, it could
21 lead to shock. So even though shock was not
22 present, it's applicable in the sense that we
23 don't want shock to develop. We want to try to
24 prevent it if possible, right?
25 A: Yes, sir.

1 Q: Okay. So this patient, at least in your review
2 of the records, did not experience shock from
3 the time that Mr. Davenport arrived at the
4 scene until the patient was dropped off at the
5 emergency department. Is that right?
6 A: From what I could read from the patient care
7 report, that's correct.
8 Q: You also talked -- I think you talked a little
9 while ago about policy M-9. Let me see if I
10 can find where that one was. And while I'm
11 looking at that, that's the psychiatric
12 emergency policy.
13 A: Yes, sir.
14 Q: And Mr. Wicevic was asking you some questions
15 about the need for restraints, and I think I
16 actually wrote this down in quotes. You said,
17 that was a judgement call to be made by the
18 paramedic on the scene. Do you recall
19 testifying to that a few minutes ago?
20 A: Yes, sir.
21 Q: Okay. Have you ever tried to put restraints on
22 a patient before?
23 A: Yes, sir.
24 Q: Okay. Do sometimes patients not want to be put
25 in restraints?

1 A: Yes, sir.
2 Q: Okay. What about patients with a significant
3 psycho-social history like this particular
4 patient? Do they sometimes not want to be put
5 in restraints?
6 A: Yes, sir.
7 Q: Okay. If Mr. Davenport had tried to put
8 restraints on this patient, and it turned into
9 some sort of a wrestling match in terms of
10 getting the restraints on there, that's a
11 pretty dangerous situation with the knife still
12 stuck in the belly of that patient, isn't that
13 right?
14 A: Yes, sir.
15 Q: In fact, I think you gave a little anecdote a
16 little while ago where you said that after the
17 patient was dropped off at the emergency
18 department, had been there for I don't know how
19 long, but he was being wheeled to have the
20 knife taken out of his belly, you noticed that
21 there were no restraints placed on the patient,
22 right?
23 A: Correct.
24 Q: So the experienced Emergency Room doctors and
25 nurses and staff at the Emergency Department

1 didn't think that it was necessary to put
2 restraints on this patient, did they?
3 A: Correct.
4 Q: Okay. So when you say something like that is
5 a judgement call, you're not suggesting that
6 when Mr. Davenport exercised his judgement by
7 not putting restraints on this patient, that he
8 violated an order that you provided him, are
9 you?
10 A: Correct.
11 Q: Now you also described this situation as a load
12 and go, if I'm not mistaking. Do you recall
13 testifying a few minutes ago about you thought
14 this was a load and go situation?
15 A: Yes, sir.
16 Q: Okay. And I'll turn your attention to Bates
17 page 42 of the first exhibit. This is the T-1
18 general trauma standard of care. You see that
19 one?
20 A: Yes, sir.
21 Q: Okay. And the third bullet point down there,
22 actually it's the second one under critical
23 trauma -- again this policy doesn't have a
24 definition of the term critical trauma, does
25 it?

1 A: Not that I'm aware of.
2 Q: Okay. But you do talk about, you say when
3 you're talking about rapid extraction says,
4 shall only be performed in the presence of load
5 and go criteria and then you have a colon
6 there, right?
7 A: Yes, sir.
8 Q: So you're describing beneath that colon what
9 the load and go criteria are for trauma
10 patients, isn't that right?
11 A: Well those little bullet boxes are under rapid
12 extrication, which often applies to like car
13 wrecks like trying to get the patient out of a
14 car, could apply to a home, extricating them
15 from the home.
16 Q: And I noticed the first part of that sentence
17 used the phrase rapid extrication. But the
18 colon before those four bullets seems to
19 indicate that you're defining the load and go
20 criteria, is that right?
21 A: Yes, sir.
22 Q: Is there anywhere else in this whole booklet
23 where you define what the load and go criteria
24 are?
25 A: It's probably under trauma transport, probably

1 under multiple trauma. Let's see, yeah.
2 Multiple trauma which is T-03 ---
3 Q: It has the phrase transport parentheses load
4 and go, but it doesn't describe what load and
5 go criteria are, does it?
6 A: It's bilateral femur fractures, pelvic
7 instability, abdominal rigidity, guarding are
8 secondary load and go criteria. Upon
9 recognizing these conditions patients should be
10 immediately transported. And above that it
11 uses the term load and go. Altered level of
12 consciousness, respiratory distress, or shock
13 are considered load and go criteria.
14 Q: Okay. Well let me ask you about that one.
15 Altered level of consciousness. Was this
16 patient, in your viewing of the video, did he
17 ever lose consciousness?
18 A: No, sir.
19 Q: Did he have an altered level of consciousness?
20 Is that what that refers to?
21 A: Didn't appear to be. There was no mental
22 status exam, so it's difficult to say. But he
23 appeared to ---
24 Q: The next criteria you have there is respiratory
25 distress. To your knowledge, did this patient

1 ever experience respiratory distress?
2 A: No, sir.
3 Q: Next it says or shock. It says, altered level
4 of consciousness, respiratory distress, or
5 shock are considered load and go criteria,
6 right?
7 A: Correct.
8 Q: Okay. And we talked a few minutes ago that
9 there was no evidence this patient was in
10 shock, right?
11 A: Correct.
12 Q: Okay. So this patient didn't meet the load and
13 go criteria, at least as you defined it in T-
14 03, right?
15 A: Well if you look to the left, it says evaluate
16 for the following, follow that all the way
17 down, mechanism of injury is like fourth from
18 the bottom. Based on his mechanism of injury,
19 in my opinion, this patient met load and go
20 criteria due to penetrating trauma.
21 Q: You agree with me that the protocols are a
22 little unclear about whether this patient met
23 load and go criteria?
24 A: I agree it's difficult for the uninitiated to
25 take these protocols word for word, sentence

1 for sentence. I do agree with that. I do
2 agree. I also think that a paramedic, EMT
3 who's been through their education training
4 process has a understanding of trauma, of
5 mechanism of injury, load and go criteria that
6 is not delineated in these protocols.
7 Q: Okay. And if you flip back to T-01, the only
8 additional bullet there that we haven't talked
9 about is unsafe scene. You believe that this
10 was an unsafe scene with three or four Police
11 Officers on ---
12 A: I think it could potentially have been an
13 unsafe scene, particularly in the ambulance en
14 route to the Emergency Department when there
15 was only one provider with the patient.
16 Q: By all accounts, everything you've seen about
17 this patient from the medical records, the
18 patient was stable at the time Mr. Davenport
19 arrived on the scene, isn't that right?
20 A: The vital signs that were documented on the
21 patient care report en route to the hospital by
22 the basic EMT shows stable vital signs.
23 Q: I'm going to show you a photograph that's been
24 introduced yesterday as Exhibit 25. And I'm
25 going to have to -- I guess you've never seen

1 that photograph before, have you?
2 A: No, sir.
3 Q: Okay. I'm going to represent to you that
4 that's the patient in the stabbing case. Is
5 that the same patient you saw the night they
6 were wheeling him into the OR?
7 A: That's the same patient I saw in the video. I
8 couldn't really see his face from that night in
9 the Emergency Department, but I believe it's
10 the same patient.
11 Q: Okay. How would you characterize his skin
12 color in that photograph?
13 A: It appears normal.
14 Q: Okay. Does his facial expression appear to
15 exhibit any extreme pain?
16 A: No, sir.
17 Q: Okay. He looks like he's resting fairly
18 comfortably even in that supine position, isn't
19 that right?
20 A: Yes, sir.
21 Q: And were you aware that Ms. Aiken, who filled
22 out the patient care report, listed the
23 patient's distress level as mild?
24 A: Yes, sir.
25 Q: Okay. And you recall that she asked the

1 patient what his level of pain on a scale of
2 one to ten was, and he said it was a four. Do
3 you agree with that?
4 A: If it's in the patient care report, I agree
5 with it.
6 Q: Okay. Is a patient with a pain level of four
7 indicated to have pain medication applied to
8 him?
9 A: I think again that's a judgement call.
10 Q: And Mr. Davenport made that judgement and
11 didn't administer any pain medicine to this
12 patient, isn't that right?
13 A: Correct.
14 Q: So you can't fault Mr. Davenport for not
15 administering pain medication?
16 A: Correct.
17 Q: Now you mentioned the video a minute ago. I
18 think the first time, if I remember your
19 testimony, you saw the video at the hospital
20 right before you were getting ready to go on
21 duty, is that right?
22 A: Yes, sir.
23 Q: Mr. Stoller brought the video over and said,
24 hey you need to see this. And he showed it to
25 you on, I think you said, it was one of the new